IN THE SUPREME COURT

STATE OF ARIZONA

ELIZABETH HAISCH, a single person, on behalf of herself and all others similarly situated, Plaintiff-Appellant, vs. ALLSTATE INSURANCE COMPANY, Defendant.	Supreme Court No. CV-00-0272-PR Court of Appeals No. 1CA-CV 98-0703 Maricopa County Superior Court No. CV 96-02918

UNITED POLICYHOLDERS' *AMICUS CURIAE* BRIEF

RE: PETITION FOR REVIEW

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I. INTEREST OF AMICUS CURIAE UNITED POLICYHOLDERS AND SUMMARY OF ARGUMENTS

Amicus Curiae United Policyholders (UP) is a non-profit organization dedicated to educating the public and promoting greater understanding of insurance issues and consumer rights. UP's activities include organizing meetings, distributing written materials, and responding to information requests from elected officials and governmental entities, as well as from individuals.

UP has worked with thousands of home and business owners whose property was destroyed by natural disasters, such as the 1991 Oakland/Berkeley, California firestorm, and hurricanes in Florida and Texas. Through generating printed materials, sponsoring meetings and workshops, and working with disaster relief groups, UP helped the victims understand their policies and receive prompt, fair insurance settlements.

In addition to assisting communities hit by natural disasters, UP also actively monitors legal and marketplace developments affecting policyholder interests. As a public interest organization, UP has a vital interest in assisting the public and the courts on policyholders' insurance rights and in ensuring that those rights are consistently enforced throughout the country. UP has an interest in filing an *Amicus Brief* with respect to the

Haisch v. Allstate Ins. Co., 323 Ariz.Adv.Rep. 9 (App. 2000) opinion because of the following reasons.

The Majority's opinion ignores and directly contradicts controlling legal precedent imposing a duty of disclosure on insurers when selling, marketing, or interpreting insurance policies. It is undisputed that the *Haisch* case involves Allstate repeatedly selling Medical Payments ("Med Pay") coverage to consumers without disclosing that it intended to rely on an obscure state statute to severely limit that coverage if the consumer happened to be enrolled in an HMO.

The Majority's opinion approves of Allstate's conduct, thereby encouraging insurance companies to extract windfall premiums from uninformed consumers for coverage that is largely uncollectable. As correctly pointed out by the Dissent: "Only when full disclosure is made can the Mrs. Haisches of the world make an informed decision whether to still purchase the coverage or decline to purchase, recognizing that paying the premium asked, they would be getting less coverage than others who pay the same premium." (323 Ariz.Adv.Rep. 12 at ¶ 31)

In addition to virtually eliminating the insurer's duty of disclosure (a duty that has developed through the common law and the implied covenant

of good faith and fair dealing), the Majority's opinion seriously undermines the doctrine of reasonable expectations. The doctrine of reasonable expectations developed in Arizona and in other jurisdictions to protect consumers from overreaching insurers who would otherwise use a litany of hyper-technical boilerplate terms to render coverage meaningless or illusory. Clearly, consumers who purchase Med Pay coverage reasonably expect to recover those benefits without regard to their underlying choice of health insurance coverage, i.e., HMO or Indemnity Plan. If there are to be any exceptions to this reasonable expectation, then Allstate is bound to disclose them before accepting a premium.

The *Haisch* class action did not seek recovery of Med Pay benefits; rather, the action sought the return of the Med Pay premiums paid by Haisch and other similarly situated HMO insureds. The Majority's opinion's refers to the Med Pay as "bonus coverage" in the case of an HMO insured, and without explanation, assigns the windfall premium for this uncollectable "bonus coverage" to Allstate rather than returning it to the insured. Judge Sult in the Dissent recognized:

> [W]hen an insured is injured but happens to be enrolled in an HMO, a windfall situation arises. Here, the majority assigns the windfall to Allstate, which gets to pocket what in effect is an excessive premium that was obtained by unlawful silence.

(Dissent ¶ 33) Thus, the Majority sanctions the idea that an insurer can pocket an excessive premium that was obtained by deceptive means. This development in Arizona law is a substantial departure from past precedent and a clear setback in the protections afforded to consumers. It is under these circumstances that UP files this *Amicus* Brief.

II. THE MAJORITY'S OPINION PERMITS INSURERS TO COLLECT A PREMIUM FOR ILLUSORY COVERAGE AND INSULATES THE INSURANCE INDUSTRY FROM THE DUTY TO ACCURATELY DISCLOSE POLICY LIMITATIONS

On the one hand, the Majority freely acknowledges that "it is undisputed that Allstate did not and does not explain its interpretation of its Med Pay provisions to its prospective or current policy holders, either orally or in writing, in advance of the customer's decision to buy or add Med Pay coverage." (323 Ariz.Adv.Rep. 9, at ¶ 5) Nevertheless, the Majority still held that Allstate's practice of severely limiting Med Pay benefits available to HMO insureds based on its hidden intention to rely on A.R.S. §20-1072, and a highly technical definition of "incurred," **did not** constitute a violation of the Consumer Fraud Act or a "misrepresentation" sufficient to support liability for common-law fraud, negligent misrepresentation, or violation of A.R.S. § 20-443.

"It is undisputed that Allstate **never told** Mrs. Haisch what the consequences to her medical payments coverage would be if she enrolled in an HMO rather than purchase indemnity health insurance." (323 Ariz.Adv.Rep. 9, at ¶ 5) It is also undisputed that Haisch did not read the auto policy or understand the scope of coverage afforded by her Med Pay coverage. (Id.) She was never told that her status as an HMO enrollee had any impact on her ability to recover Med Pay benefits. (Id.) She twice considered dropping the Med Pay coverage, but her agent discouraged her from doing so by telling her that it would not reduce her premium appreciably, and she should "keep her Med Pay coverage because she had health insurance through an HMO." (Id. at page 10, ¶ 7)

The Majority opinion held that Allstate's "unlawful silence" during the sale of the insurance, and its subsequent encouragement to keep the Med Pay coverage (despite being aware of Haisch's HMO status and its impact on coverage), **were not** deceptive or fraudulent acts as contemplated by Arizona's Consumer Fraud Act and other pertinent statutes. A.R.S. § 44-1522(A); *see also,* A.R.S. § 20-443 and A.R.S. § 20-444(A) (prohibiting untrue, deceptive or misleading representations with regard to business of insurance or any person in conduct of insurance business).

In addition, the Majority also held that Allstate's actions did not constitute a fraud or misrepresentation under the common law. The Majority ignored established precedent holding that fraudulent misrepresentations can result from a failure to disclose information, as well as from incorrect statements. Restatement (Second) of Torts § 551(I) (1977); *Formento v. Encanto Business Park,* 154 Ariz. 495, 499, 744 P.2d 22, 26 (Ct. App. 1987) ("[N]ondisclosure may be equated with and given the same legal effect as fraud and misrepresentation."); *Alaface v. National Inv. Co.,* 181 Ariz. 586, 598, 892 P.2d 1375, 1387 n.3 (Ct. App. 1994) (omission or nondisclosure of facts may constitute negligent misrepresentation).

Interestingly, on the one hand, the Majority points out,

> Where the defendant has a legal or equitable obligation to reveal material information, his failure to do so is equivalent to a misrepresentation and may therefore support a claim of actionable fraud where the remaining elements of that tort are proved. [citations omitted]

323 Ariz.Adv.Rep at 10, ¶ 14. However, the Majority still held that Allstate **did not** have a duty under statutes or common law to disclose to Haisch and other HMO enrollees that the Med Pay coverage they were paying premiums for was largely illusory. The Majority's holding clearly

does not follow a straightforward application of established law to the undisputed facts of this case.

Generally, the business of insurance is one affected by the public interest, requiring that insurers act in good faith, abstain from deception, and practice honesty and equity in all insurance matters.[1] Insurance policies are special contracts that must be interpreted and administered by the insurer in good faith. Good faith demands that the insurer deal with laymen as laymen and not as experts in the subtleties of law and underwriting. In

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[1] Insurance contracts are different from other commercial contracts because insurance is more a necessity than a matter of choice. Therefore, insurance is a business affected with a public interest, as reflected in legislative and judicial decisions. Lorimer, James J., et al., The Legal Environment of Insurance 179 (4th ed. 1993). As one commentator has noted,

> The insurers' obligations are . . . rooted in their status as purveyors of a vital service labeled quasi-public in nature. Suppliers of services affected with a public interest must take the public's interest seriously, where necessary placing it before their interest in maximizing gains and limiting disbursements . . . [A]s a supplier of a public service rather than a manufactured product, the obligations of good faith and fair dealing encompass qualities of decency and humanity inherent in the responsibilities of a fiduciary. Insurers hold themselves out as fiduciaries, and with the public's trust must go private responsibility consonant with that trust.

Goodman & Seaton, *Ripe for Decision, Internal Workings and Current Concerns of the California Supreme Court,* 62 Cal.L.Rev. 309, 346-47 (1974).

all insurance contracts, there is an implied covenant of good faith and fair dealing that the insurer will not do anything to injure the right of its policyholder to receive the benefits under the contract. See *Noble v. National Amer. Life Ins. Co.*, 128 Ariz. 188, 624 P.2d 866 (1981).

For several decades, Allstate has repeatedly stressed the importance of acquiring coverage from a company that places its insureds in "good hands." "Good hands" are, of course, helping hands. The image of "helping hands" provides an excellent approach to conceptualizing an appropriate scope for an insurer's duty of disclosure. The duty of good faith does not permit the insurer passively to assume that its insured is aware of his rights under the policy; rather, the insurer must take affirmative steps to make sure that the insured is informed about the scope and extent of coverage. *Sarchett v. Blue Shield,* 729 P.2d 267, 276-77 (Cal. 1987); Alan I. Widiss, *Obligating Insurers to Inform Insureds About the Existence of Rights and Duties Regarding Coverage, Losses,* 1 Conn.Ins.LJ 67 (1995); *Anderson v. State Farm Mut. Ins. Co.,* 2 P.3d 1029 (Wash. Ct. App. 2000) (holding that *as a matter of law,* the failure to mention the availability of

benefits was a breach of the duty of good faith and a violation of the Consumer Protection Act.).[2]

As explained in *Rawlings v. Apodaca & Farmers Ins. Co. of Arizona, 151 Ariz. 149, 726 P.2d 565 (1986),* an insurance contract is not an ordinary commercial bargain; "implicit in the contract and the relationship is the insurer's obligation to play fairly with its insured." *Rawlings,* 151 Ariz. at 154, 726 P.2d at 570. In *Rawlings,* the Court observed: "We hold . . . that one of the benefits that flow from the insurance contract is the insured's expectation that his insurance company will not wrongfully deprive him of the very security for which he bargained. *Rawlings,* 726 P.2d at 571.

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[2] *See also, Dercoli v. Pennsylvania Nat'l Mut. Ins. Co.,* 554 A.2d 906, 909 (Pa. 1989) ("the duty of an insurance company to deal with the insured fairly and in good faith includes the duty of full and complete disclosure as to all of the benefits and every coverage that is provided by the applicable policy or policies along with all requirements, including any time limitations for making a claim."); *Gatlin v. Tennessee Farmers Mut. Ins. Co.,* 741 S.W.2d 324, 326 (Tenn. 1987) ("As pointed out in MFA Mutual Insurance Co. v. Flint . . . an insurer has the duty to deal with its insured fairly and in good faith. This includes informing an insured as to coverage . . ."); *Bolwer v. Fidelity & Casualty Co.,* 250 A.2d 580, 588 (N.J. 1969) ("When a loss occurs which because of its expertise the insurer knows or should know is within coverage, and the dealings between the parties reasonably put the company on notice that the insured relies upon its integrity, fairness and honesty of purpose, and expects his right to payment to be considered, the obligation to deal with him takes on the highest burden of good faith."); *Ramirez v. USAA*

More recently, in *Zilisch,* the Court reemphasized that insurance companies have some "duties of a fiduciary nature," including "equal consideration, fairness and honesty." *Zilisch,* 995 P.2d 276, 279. *Zilisch* held that an insurer breaches its duty of good faith and fair dealing "when it seeks to gain unfair financial advantage of its insured through conduct that invades the insured's right to honest and fair treatment." 995 P.2d at 279-280, ¶ 20.

It is under this legal backdrop that the Majority considered whether Allstate had a statutory or common law duty to disclose that it would rely on a hyper-technical interpretation of its policy language and an obscure state statute to defeat full Med Pay benefits for HMO enrollees.[3] Rather than encourage insurers to conduct their business operations so that securing benefits does not become a game of "hide and seek," the Majority's opinion encourages insurers to use their superior knowledge and bargaining position to extract windfall premiums for illusory coverage. This is a

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Casualty Ins. Co., 235 Cal.Rptr. 757, 761 (Cal. Ct. App. 1991) ("It is basic that an insurer has a duty to disclose policy terms to its insureds.").

[3] It is ironic that the Majority cited the Court's decision in *Rawlings,* but ignored its major thrust. In *Rawlings*, the Court held that the insurer acted in bad faith by failing to disclose an investigative report implicating another one of the insurer's policyholders as responsible for the insured's loss. *Rawlings, supra.*

serious departure from well-established precedent holding that insurers have fiduciary-like duties of honesty and fairness and should not take unfair financial advantage of insureds. *Zilisch,* 995 P.2d at 279-280.

III. THE MAJORITY'S OPINION DOES VIOLENCE TO THE DOCTRINE OF REASONABLE EXPECTATIONS AND APPROVES OF A PREMIUM WINDFALL FOR INSURERS WHO DECEPTIVELY SELL COVERAGE THAT IS LARGELY ILLUSORY.

The Majority appears to blame Haisch because she neither read the auto policy nor understood the scope of her Med Pay coverage, and criticizes her for believing that the premium she was paying was for *fully* collectable benefits. First, most consumers of insurance do not read and understand the terms and conditions contained in their insurance policy.

> Purchasers of insurance frequently do not understand many of the terms set forth in the documents, usually referred to as an insurance policy, that specify the contractual arrangements. For example, when asked about coverage provisions in insurance policies, including those characterized by insurers as "plain talk" or "E-Z read," individuals often respond that the forms are bewildering. Even college graduates enrolled in law school have considerable difficulty explaining what is meant by the terms used in standard forms and ascertaining whether coverage is provided for specific occurrences.

Widiss, 1 Conn.Ins. L.J. 67.[4] [emphasis added]

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[4] *See also, Zuckerman v. Transamerica Ins. Co.,* 133 Ariz. 139, 144, 650 P.2d 441, 446 (1982) ("The insured is given no choice regarding the

Second, and more importantly, even if Haisch read and understood her insurance policy, she **would not** have known that Allstate intended to rely on a hyper-technical interpretation of "incurred" and an unknown state statute, which is nowhere mentioned in the policy language, to severely limit coverage. Such a situation falls squarely outside the reasonable expectations of Haisch and other ordinary insureds.[5]

Because the typical consumer buying insurance has not assented to the myriad of essentially invisible boilerplate terms and conditions in the insurance contract, special contract interpretation rules have developed in

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terms and conditions of coverage which are contained on forms which the insured seldom sees before the purchase of the policy, which often are difficult to understand, and which usually are neither read nor expected to be read by either the person who sells the policy or the person who buys it."); Restatement (Second) of Contracts § 211 comment b (1979) (party who regularly uses standardized forms does not ordinarily expect customers to understand or even to read standard terms).

[5] Although the *Haisch* class action did not involve a claim for breach of contract, the doctrine of reasonable expectations is still relevant because it illustrates how Haisch and other similarly situated insureds could be deceived by Allstate's "unlawful silence" about the recoverability of Med Pay benefits for HMO enrollees. In other words, insureds who purchase insurance coverage have a reasonable expectation that if a covered event takes place, they will be able to recover under the policy. Here, Allstate thwarted these reasonable expectations through its hidden intention to rely on a technical definition of "incurred" and an unknown state statute.

the common law.[6] In *Darner,* the Court adopted the "reasonable expectations" doctrine to "recognize the realities of the insurance business and the methods used in modern insurance practice," and to dispel the fiction that insureds actually "bargain" for the terms of their coverage, are aware of and understand the terms of their coverage, or have any power to eliminate boilerplate provisions in a standardized form. *Darner Motor Sales, Inc. v. Universal Underwriters Ins. Co.,* 140 Ariz. 383, 389, 682 P.2d 388, 394 (1984).

After *Darner,* the Court clarified the scope of the reasonable expectations doctrine, holding that even unambiguous boilerplate terms in standardized insurance contracts would not be enforced in a limited number of situations:

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[6] Dean Roscoe Pound, more than 50 years ago in *The Spirit of the Common Law* (1929) noted, "we have taken the law of insurance practically out of the category of contract, and we have established that the duties of public service companies are not contractual, as the nineteenth century sought to make them, but are instead relational." In the modern era, the adhesive terms found in most insurance contracts are self-protective, i.e., designed to limit or defeat coverage; their major purpose and effect often is to ensure that the drafting party will prevail if a dispute goes to court. *Gordinier v. Aetna Cas. & Sur. Co.,* 154 Ariz. 266, 742 P.2d 277 (1987) (citing Rakoff, *Contracts of Adhesion: An Essay in Reconstruction,* 96 Harv.L.Rev. 1174, 1229, 1237 (1983). As a result, the common law has developed certain legal doctrines, like the

1. Where the contract terms, although not ambiguous to the court, cannot be understood by the reasonably intelligent consumer who might check on his or her rights, the court will interpret them in light of the objective, reasonable expectations of the average insured;

2. Where the insured did not receive full and adequate notice of the term in question, and the provision is either unusual or unexpected, or one that emasculates apparent coverage;

3. Where some activity which can be reasonably attributed to the insurer would create an objective impression of coverage in the mind of a reasonable insured;

4. Where some activity reasonably attributable to the insurer has induced a particular insured reasonably to believe that he has coverage, although such coverage is expressly and unambiguously denied by the policy.

Gordinier v. Aetna Cas. & Sur. Co., 154 Ariz. 266, 272-73, 742 P.2d 277, 283-84 (1987). Although the reasonable expectations doctrine addresses the more common scenario where the insured is being denied coverage based on the enforcement of unusual, unexpected, or oppressive boilerplate policy provision, the doctrine can equally be applied here to protect the reasonable expectations of Haisch and other insureds who purchased Med Pay coverage from Allstate.

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doctrine of reasonable expectations, to better protect the public's expectations of coverage.

First, applying the pertinent language in *Gordinier,* Allstate did not give its insured "full and adequate notice" that it intended to rely on a hyper-technical interpretation of "incurred" and an obscure state statute to severely limit Med Pay benefits. Second, the practical effect of Allstate's actions in this case serve to "emasculate apparent coverage" by applying an "unusual or unexpected" hyper-technical and legalistic approach to Med Pay coverage for HMO enrollees.

Third, Allstate did create an "objective impression of [full] coverage" in the mind of Haisch and other HMO insureds by accepting their premiums without special qualification. Fourth, Allstate "induced" Haisch "to believe that [she] has [full] coverage, although such coverage is expressly and unambiguously" limited by Allstate's definition of "incurred" and the operation of a little known state statue. This type of non-disclosure is not only contrary to reasonable expectations, but is in reality deception.

In summary, Allstate's conduct was clearly contrary to Haisch's reasonable expectations of coverage, and deceptive under Arizona statutes and common law. Allowing the Majority's published opinion to stand is a serious blow to the doctrine of reasonable expectations and the equitable

doctrine that insurers should not be able to reap windfall premiums for largely superfluous and illusory insurance.

IV. CONCLUSION

The Majority's opinion is a serious infringement on Arizona's insurance law and is a major setback in the rights afforded to Arizona consumers. Because the opinion encourages non-disclosure and deception of consumers to reap premiums for largely uncollectable insurance, and for the reasons set forth above, it should be reversed. The Dissenting opinion recognizes the evolution of principles of disclosure, honesty and fair dealing in the insurer/insured relationship and should be adopted. Under the facts here, the issue of whether Allstate is guilty of consumer fraud, negligent misrepresentation and misrepresentation under the common law, at minimum, should be submitted to a jury for consideration.

Respectfully submitted: October 20, 2000.

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Certificate Of Compliance

Pursuant to Rule 14(b), A.R.C.A.P., I certify that the Brief of Amicus Curiae United Policyholders is proportionately spaced, has typeface of 14 points or more and contains 3,534 words according to undersigned's word processing program.

Dated this 20th day of October, 2000.

Calvin C. Thur

Certificate Of Service

I, Calvin C. Thur, hereby certify that the original and six copies of Amicus Curiae Brief of Unied Policyholders was delivered this 20th day of October, 2000, to:

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