ALASKA LEGISLATURE COMMITTEE FILES 1999-2000 8672
9962 HOUSE LABOR & COMMERCE

SB

176

(7)

HOUSE COMMITTEE REPORT

Date Referred to Committee: February 25, 2000 FURTHER REFERRALS:

Date of Committee Action: March 6, 2000

The LABOR AND COMMERCE Committee considered: CSSB 176(RLS)

CS FOR SENATE BILL NO. 176(RLS) SEX DISCRIMINATION IN HEALTH CLUBS

"An Act permitting a physical fitness facility to limit public accommodation to only males or only females."

recommends it be replaced with the following committee substitute ~~CSSB 176(RLS)~~ [ ] the same title [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____ [ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____ [✓] zero fiscal note(s) Gov 1/12/00.

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
John L. Harris	✓			
Con Bunde			✓	
Gary Sanders			✓	
Al Adams	✓			
Vic Kohring	✓			
Shelly McGuire			✓	

CHAIR'S SIGNATURE Vic Kohring 3-6-2000

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Senator Drue Pearce

RECEIVED
FEB 24 2000

Memorandum

Date: February 24, 2000

To: Representative Norman Rokeberg, Chair
House Labor and Commerce Committee

From: Senator Drue Pearce, Senate President

RE: SB 176 "An Act permitting a physical fitness facility to limit public accommodation to only males or only females."

I respectfully request that SB 176 be scheduled for a hearing in the House Labor and Commerce Committee at your earliest possible convenience pending referral.

Thank you for your consideration.

Senator_Drue_Pearce@legis.state.ak.us

FISCAL NOTE No. 1

STATE OF ALASKA
2000 LEGISLATIVE SESSION

Bill Version: CSSB 176(L&C)
(S) Publish Date: 1/26/00

Revision Date/Time (Note if correction)
Dept. Affected: Office of the Governor
Title: Sex Discrimination in Health Clubs
BRU: Commissions and Special Offices
Component: Human Rights Commission
Sponsor: Senator Pearce
Requester: Senate Labor and Commerce Committee
Component No.: 1

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2000) cost: 0.0

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

To the Commission's knowledge only once has an Alaskan brought a discrimination claim against a health club alleging denial of access to the facilities because of sex, therefore there would be no fiscal impact on the agency.

Prepared by: Paula M. Haley, Executive Director
Division: Human Rights Commission
Phone: 276-7474 ext. 241
Date/Time: 1/12/00 9:01 AM
Approved by: David Ramseur
Agency: Office of the Governor
Date: 1/12/00

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Senator Drue Pearce

Sponsor Statement

SB 176
Segregation of Health Clubs

SB 176 allows gender-based health clubs to provide services to members wishing to exercise in the presence of only persons of their own gender. Under the Alaska Constitution, Article 1, Section 22, the right of the people to privacy is recognized and shall not be infringed.

The Alaska Human Rights Commission (AHRC) filed an action against the Anchorage Women's Club stating the Club unlawfully discriminates against men because the Club is a place of public accommodation. The AHRC based their decision on AS 18.80.230 which states that in places of "accommodation" it is unlawful to refuse, withhold from, or deny to a person any of its services, goods, or facilities based on sex. However, health clubs are not referenced in AS 18.80.300 (14), as places of accommodation.

SB 176 establishes that health clubs are not designed for public accommodation and have no public policy interests. Gender-based health clubs offer a secluded environment allowing people to feel more at ease in what is often an intimidating setting. Through this measure, Alaska will recognize the unique setting of a male-only or female-only health club based on membership and employment.

This bill in no way excludes any individual from the opportunity to exercise or work at a co-ed health club.

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Senator Drue Pearce

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Favoring SB 176

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District 10
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- Ms. Linda White
- Ms. Renee Rogers

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- Ms. Lisa Topkok
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- Ms. Laurel Racenet

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- Ms. Diana L. Woods

District 24

- Ms. Jodee Hollar
- Ms. Anna Bauman

District 25

- Ms. Trudy Brown

District 26

- Ms. Marilyn Goodman

District 28

- Ms. Sasha McIntosh

Other Constituents in Favor of SB 176

- Mr. Vic R. Harling
- Mrs. Jill Harling
- Ms. Teri A. Ford
- Mrs. Diana A. Robbins
- Ms. Annette Ducharme
- Ms. Barbara Hergesheimer
- Ms. Deyana R. Thayer
- Ms. Rose Hinkley
- Mrs. Patrice Case
- Ms. Christine King
- Mrs. Rose Carter
- Ms. Joann Garrett
- Ms. Danielle Millhouse
- Ms. Kelly Kneaper
- Ms. Katherine Rodriguez
- Ms. Christie Hill

CORRECTION

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MEMO TO LEGISLATORS

TO: ALL ALASKA LEGISLATORS: HOUSE AND SENATE
FROM: DAN COFFEY
Facsimile: (907) 274-4258. Phone: (907) 274-3385.
e mail: dcoffey@gci.net.
RE: WOMEN'S HEALTH CLUB
DATE: 12/14/99

My office represents The Women's Club, a health and fitness exercise facility with two locations in Anchorage. These facilities cater exclusively to women. This is the second Memo which we have sent to you concerning this issue and the legislation which is presently pending before you (SB 176). It is our understanding that a similar measure will be introduced by Representative Halcro at the beginning of this pending session.

You may recall that in our last Memo to all of you, we informed you that last year, the Alaska Human Rights Commission filed an action against the Women's Club alleging that the Club discriminated against men and that such discrimination was unlawful. The Human Rights Commission wants to require the Club to admit men to the Club. If this requirement stands, the Women's Club would be forced to shut its doors because the costs of renovating the Club to serve both men and women is prohibitively expensive.

The Club's main defense to the allegation of illegal discrimination is that gender based discrimination is not unlawful. The Constitution of Alaska, with its express right of privacy, allows for single gender health and fitness facilities. The Human Rights Commission staff disagrees. Further, the Human Rights Commission itself, on a vote of 3 no and 2 yes with two abstentions, voted not to support any change in the existing legislation to resolve this issue. Finally, we have recently been informed by the Human Rights Staff that the Commission cannot/will not consider the Constitution of the State of Alaska in reaching any decision on this alleged unlawful discrimination. The staff informs us that the Commission must rely solely on the statutes without consideration of the Constitution.

Based on these Commission positions, the Club prepared a proposed statutory amendment (SB 176). This amendment to existing law is based on the recognition that a women have legitimate gender-based privacy interests and that there is no overriding public policy that necessitates the inclusion of men in women's fitness clubs.

Alaska is not the first state to consider this issue. Many other states have allowed this type of gender-based privacy either by statute or by court decision. Attached to this Memo are five (5) articles which deal with the subject in a straight forward and informative manner. We appreciate your review and consideration of these materials as you consider the proposed amendment.

Finally, as we advised previously, you will undoubtedly be receiving comments from many of the women who are members in the Club dealing with their desire to exercise privately without men being in their Club. The Club and its members believe that the right to privacy in our Constitution allows for single gender health and fitness centers such as the Women's Club. This is the issue which the women members and the Club is presenting to the Alaska Legislature for resolution.

If you would like more information, please call Dan Coffey at the numbers listed above in the heading or Jeanie McAlister at the Women's Club (907) 276-6611. We will certainly be talking to you as the legislative session progresses.

Thank you for your consideration of this Memo.

INDEX TO ATTACHED ARTICLES

1) Women-Only Health Clubs: An IHRSA Position Paper

2) An Exercise in Equality: An Editorial from the Boston Globe, January 21, 1998

3) The Legal Implications of Women's Only Clubs, Briefing Paper: IHRSA.

4) Common Sense on Single-Gender Health Club: Representative Douglas W. Peterson (Massachusetts Legislature).

5) The Need for Single Sex Health and Fitness Facilities: Behavioral and Psychological Impediments to Exercise. Robert L. Tanenbaum, Ph.D.

IHRSA
263 Summer Street
Boston, MA 02210
(617) 951-0055
(800) 228-4772
Fax: (617) 951-0056
http://www.ihrsa.org

Women-Only Health Clubs

An IHRSA Position Paper

1. Women-only clubs should be allowed to exclude men from membership and employment because there is a legitimate gender-based privacy interest that needs to be protected and there is no overriding public policy that necessitates the inclusion of men in these types of clubs.

Courts and legislatures have recognized certain settings, including rest rooms, showers, and changing rooms, in which gender-based discrimination in public places is acceptable because a compelling and overriding privacy issue is involved. This same privacy issue extends to women-only health clubs. Court cases involving the privacy interest of women-only club members have affirmed this privacy right.

The privacy issue stems from the unique setting of a health club. In the course of normal business, members expose parts of their body about which they are very sensitive, focus on parts of their body which need improvement, wear revealing attire, assume awkward and compromising positions, move themselves in a manner which would be embarrassing to them if men were present, and are measured and touched by instructors.

IHRSA

International Health, Racquet & Sportsclub Association

Committed to the Profitability and Professionalism of Our Member Clubs

The right to privacy in locker rooms, shower rooms, bathrooms, and changing rooms is well established in the courts. However, the privacy interest is not limited to those situations where there is nudity or touching of "intimate areas." It is also protected in situations involving a person's body, whether they are dressed or not.

In addition, there is no public policy interest that necessitates the admission of men into women-only clubs. In this setting, members' privacy interests are entitled to protection and override laws meant to eliminate discrimination based on gender.

2. The majority of women-only club members choose such clubs primarily because of the all-female environment. The admission of men to a women-only club would undermine the club's business operation because the majority of members would stop using the club if it became coed.

3. There is no reasonable alternative to excluding men from women-only clubs. There are no accommodations which can be made that would allow men to be members because it is impossible to have men present in the club while at the same time protecting members' privacy rights.

4. Health clubs, unlike country clubs, are purely health, recreation and sports clubs. They are not social in nature and are not places where business networking takes place. Therefore, there is no economic harm in excluding men from women-only health clubs.

IHRSA is a nonprofit trade association representing more than 4,300 health, fitness and racquet sports clubs worldwide. IHRSA clubs provide services to more than four million consumers annually.

The Surgeon General has determined that lack of physical activity is detrimental to your health.

An exercise in equality

Massachusetts should allow women-only health clubs. It is a risk, with the danger that such clubs will send a legal message that discrimination is OK. And these all-women clubs could be an affront to the precious and hard-won public accommodation laws. But exceptions, when they are sincerely and vigilantly made, can succeed.

Follow the law too blindly and single-sex bathrooms could be branded as discriminatory. Except that some activities merit single-sex privacy, from dressing rooms to single-sex dormitories. Why not use this argument to gender-segregate everything from golf courses to bowling alleys? Because, like bathrooms, health clubs compel intimate types of dress and physical activities.

A glaring injustice would exist if men were systematically shut out of all health clubs. But no such pattern of pervasive discrimination exists. Just 6 to 7 percent of the country's health clubs – about 1,250 – are for women only, according to Jay Ablondi of the Boston-based International Health, Racquet & Sportsclub Association. And, the association says, in states that allow women-only clubs – either by statute or court ruling – there has been no retaliatory opening of men-only clubs.

Ablondi explains that the need for privacy is more pronounced among women who have had mastectomies, endured abuse, or who struggle with obesity. For many of these women, single-sex clubs aren't so much a protection against harassing or ogling male club members, but rather the only way they will use exercise facilities.

Opponents of single-sex clubs make a point that must be heard: Society cannot afford a slippery slide backwards into legal segregation. Single-sex health clubs demand scrupulous, eternal vigilance from lawmakers and the public, but a little common sense can go a long way, and a little privacy is not going to be the shoal upon which equality in public accommodation founders.

A bill to legalize single-sex clubs in Massachusetts awaits only final Senate approval and the governor's signature. It's a wise first step toward a sophisticated pursuit of fairness.

Editorial Boston Globe January 21, 1998

The Legal Implications of Women's Only Clubs

The Legal Implications of Women-Only Health Clubs
An IHRSA Briefing Paper

❖ Is the exclusion of men from "women-only" health clubs a violation of anti-discrimination laws?

This question raises a complicated legal issue which courts are just beginning to address. Title VII of the Civil Rights Act (the federal anti-discrimination law) as well as state laws are involved in this issue. There is no definite answer because the determination of whether or not a club is violating anti-discrimination law is based on the circumstances in each particular case.

Courts and legislatures have recognized public accommodations (including rest rooms and showers) in which gender-based discrimination is acceptable because of a compelling and overriding privacy issue. One recent court case, discussed below, has established that members' privacy interests at women-only health clubs can legally justify the exclusion of men.

A women-only policy is not discriminatory if the club can establish that the privacy right of its members is the basis for the exclusion of men. Information about the criteria required to establish a privacy-based defense of a women-only policy is discussed below.

❖ What have courts decided about women-only clubs?

Three court cases have dealt with women-only policies of health clubs. In *LivingWell (North), Inc. v. Pennsylvania Human Relations Commission*, a Pennsylvania state court ruled that a health club did not violate the state's anti-discrimination law by excluding men from its membership. *U.S. EEOC v. Audrey Sedita* dealt with the hiring policy of an Illinois health club chain. In *James J. Foster vs. Back Bay Spas, Inc., d/b/a Healthworks Fitness Center*, a Superior Court judge ruled that the exclusion of men from a health club violated Massachusetts public accommodation laws. (Massachusetts law was later amended to specifically allow for single-sex health clubs.)

LivingWell (North), Inc. v. Pennsylvania Human Relations Commission (1992)

In this case, the Pennsylvania Human Relations Commission brought a complaint against LivingWell North, alleging that the club violated the Pennsylvania Human Relations Act by refusing to admit men. LivingWell argued that its customers had a legitimate privacy interest because of the special circumstances involved in exercising, such as compromising body positions and a person's self-consciousness about her own body.

The court ruled that the club's women-only policy does not violate the state's anti-discrimination law. The Pennsylvania court found that: 1) LivingWell established that a legitimate privacy interest existed; 2) including men as members would undermine the club's business operations; and 3) there would be no other way to protect members' privacy interest besides excluding men. The court recognized that there are certain situations which "warrant the exclusion of the opposite sex for privacy reasons" and that

women-only clubs are one setting, like bathrooms and showers, in which gender-based discrimination is permissible because of privacy rights.

This case was decided in a state court and therefore the ruling is not binding in jurisdictions outside of Pennsylvania. However, other state courts can use the decision as guidance in cases with similar facts and legal questions.

U.S. EEOC v. Audrey Sedita (1990)

In this case, the U.S. Equal Employment Opportunity Commission (EEOC) brought an action against Women's Workout World in Illinois. This case addressed the issue of a women-only employment policy. The club's policy was that only women were hired for the positions of manager, assistant manager and instructor. The EEOC argued that the club was in violation of Title VII of the Civil Rights Act, which prohibits employers from discriminating against potential employees on the basis of sex except when gender is justified as a bona fide occupational qualification (a qualification which an employee must posses in order to perform the essential duties of a job).

The club argued that its hiring practice was not illegally discriminatory. It claimed that its customers prefer female personnel in the positions in question because those employees would be exposed to nudity and members in awkward positions while exercising and that those employees perform body measurements which involve intimate touching. The club submitted a petition signed by 10,000 members declaring that they would no longer patronize Women's Workout World if men were employed in the three positions in question. This was important because the livelihood of a business is one factor in determining a bona fide occupational qualification.

It is important to note that customer preference does not usually justify discrimination. However, the stakes are different when an individual's privacy rights are the issue, and this factor is at the heart of the Women's Workout World case.

The District Court initially granted summary judgment to the EEOC on procedural grounds, not on the substance of the case. However, the judge reversed herself in 1993. This case has been settled out of court.

James J. Foster vs. Back Bay Spas, Inc., d/b/a Healthworks Fitness Center (1997)

An attorney sued Healthworks, a Boston health club, because he felt the company's women-only admission policy was illegal. A Suffolk Superior Court judge ruled that Healthworks' exclusion of men was in violation of Massachusetts public accommodation laws. The judge ruled that since members are clothed when they exercise, the admission of men would not interfere with any privacy rights. The judge wrote, "While the court recognizes the impact that the admission of men may have on these women, intimidation and the assumption that all male Healthworks members will harass and leer at their exercise compatriots is still an insufficient ground on which to create a privacy exception." In early 1998, in response to this decision, the Massachusetts legislature passed a bill exempting health & wellness centers from sex discrimination law (see next question).

❖ Which states explicitly allow single-sex health clubs?

Colorado, Hawaii, Illinois, Massachusetts, New Jersey and Tennessee (as well as Pennsylvania, as discussed earlier) recognize the privacy issue involved and have exempted health clubs from laws which otherwise prohibit sex discrimination in public accommodations.

Colorado law states, *"Notwithstanding any other provisions of this section, it is not a discriminatory practice for a person to restrict admission to a place of accommodation to individuals of one sex as such restriction has a bona fide relationship to the goods, services, facilities, privileges, advantages, or accommodations of such place of public accommodation."*

Hawaii law states, *"The provision of separate facilities or schedules for female and male patrons does not constitute a discriminatory practice when such separate facilities or schedules for female and for male patrons are bona fide requirements to protect personal rights of privacy."*

Illinois public accommodations law states that it does not apply to *"Any facility, as to discrimination based on sex, which is distinctly private in nature such as rest rooms, shower rooms, bath houses, health clubs and other similar facilities for which the Department, in its rules and regulations, may grant exemptions based on bona fide considerations of public policy."*

Massachusetts' public accommodation law states, *"...this section shall not apply to bona fide fitness and wellness facilities..."*

New Jersey law creates an exemption for places of public accommodation which are, by nature, *"reasonably restricted exclusively to individuals of one sex."* The statute specifically exempts (but is not limited to) dressing rooms, swimming pools and gymnasiums.

Tennessee law states, *"Nothing in this part shall prohibit segregation on the basis of sex of bathrooms, health clubs...or other places of public accommodation the commission specifically exempts on the basis of bona fide considerations of public policy."*

❖ What criteria could be used to establish a privacy interest that would allow women-only clubs to operate without violating the law?

Courts have used a three-part test in cases involving women-only membership and employment policies.

In the *LivingWell* case, the courts described the test as follows:

A business must establish a factual basis for believing that not excluding members of one sex would undermine its business operation; that its customers' privacy interests are entitled to protection under the law; and that no reasonable alternative exists to protect the customers' privacy interests.

This statement is analyzed below:

1) *A business must establish a factual basis for believing that not excluding members of one sex would undermine its business operation;*

Legal Opinion:
The court determined that LivingWell established such a factual basis by "offering uncontradicted testimony from customers and employees regarding the adverse effect that opening its all-female facilities to men would have on its business." Dr. Robert Tanenbaum, a psychologist specializing in "appearance matters", testified that 50% of the members interviewed stated that exercising in an all-female environment was the decisive and primary reason for choosing LivingWell.

Commentary
A club needs to show that its members feel that their privacy rights would be violated and that they would no longer use the club if men were admitted. LivingWell accomplished this through the psychologist's interviews with members and his expert testimony as well as the testimony of employees and members of the club.

2) Customers' privacy interests are entitled to protection under the law;

Legal Opinion
The court said that "the standard for recognizing a privacy interest as it relates to one's body is not limited to protecting one where there is an exposure of 'intimate area,' but such a right may also be recognized where one has a reasonable basis to be protected against embarrassment or suffer a loss of dignity because of the activity taking place."

"Privacy interests are not determined by the lowest common denominator of modesty that society considers appropriate. What is determinative is whether a reasonable person would find that person's claimed privacy interest legitimate and sincere, even though not commonly held."

"Although a privacy interest may exist, whether it is protected is determined by whether there is an overriding public policy that would outweigh that privacy interest." The court found that no overriding public policy issue existed.

Commentary
This is important because the court recognized a privacy right beyond bathroom settings and situations involving nudity or intimate touching. It recognized that working out in a coed setting may be embarrassing and cause a loss of dignity to some women and declared this privacy interest legitimate. The court decided that men would not be harmed by being excluded from the club.

3) No reasonable alternative exists to protect customers' privacy rights;

Legal Opinion
The court ruled that the club proved that no reasonable alternative to excluding men existed to protect its customers' privacy rights. It reasoned as follows: "Because it is impossible to allow men to be present while these women are exercising, and, at the same time protect their right to privacy, no reasonable alternative exists to protect LivingWell's customers' privacy interests while at the same time accommodating male members."

Commentary
There is nothing that women-only health clubs can do to protect their members' privacy interest besides excluding men.

If laws condone single-sex health clubs, will we see a proliferation of men-only health clubs?

No. IHRSA is confident that there is simply not the demand for men-only health clubs that there is for women-only clubs. However, this is a common concern. In fact, it is one reason that the National Organization for Women (N.O.W.) vehemently opposed Massachusetts' recent legalization of single-sex health clubs.

Christine Brooks of the University of Michigan's Fitness Research Center has researched what she calls "physique anxiety." Brooks describes this condition as anxiety about one's own body, its appearance, its vulnerability, and how others might react to it. Brooks discovered that this condition affects women far more pervasively and far more profoundly than it affects men.

Psychologist Robert Tanenbaum, Ph.D., testified before the Massachusetts legislature in 1997 that "single-sex fitness facilities provide an exercise option for women who, due to their own sense of dignity and need for privacy, would not exercise...in a coed environment." Tanenbaum explained that there are "background psycho-social influences on differences in dignity, privacy and appearance concerns. Women tend on average to be more concerned regarding their bodily privacy than men. For example, women are provided with individual stalls in bathrooms (as compared to men who generally use semi-public urinals). Frequently, schools accommodate girls by providing separate showers or changing stalls in school gyms (as compared to men who generally have little reservation about using communal showers)."

Dr. Tanenbaum stressed that this is not an issue of preference for these women. "They do not choose a single-sex facility simply because they want to exclude men...Rather, the issue is one of privacy and dignity. The notion of privacy concerns how much or how little one is willing to expose to the opposite sex, especially during rigorous exercise." He concluded, "It is psychologically unhealthy and unproductive for many women to be required to exercise in a coed environment and such a requirement is a barrier to exercise for thousands of women."

If men-only clubs are discriminatory, then why should a club be allowed to have a women-only policy?

Not all men-only clubs are necessarily illegally discriminatory and not all women-only clubs are necessarily legally discriminatory. There are many factors involved in determining whether a policy of excluding one gender from a club is permissible or whether it is illegal discrimination.

However, there are two primary distinctions between men-only clubs and women-only health clubs. First, membership in a men-only club has traditionally had an inherent economic benefit. Men-only clubs may offer recreational activities to its members, but a large part of these clubs' function is social and business-related. This type of setting often

produces the added benefit for its members of access to employment opportunities, establishing and maintaining business contacts, and meeting prospective clients. Denying a group of people from membership in such a club also denies that group access to any inherent economic interest, thus putting one group -- or gender -- at an advantage over the other.

Women-only health clubs have traditionally been used only for health, fitness and recreational purposes. Membership in this type of club involves a privacy issue and lacks the economic interest that is often associated with membership in a men-only social club. The primary reason women exercise in an all-female environment is privacy. Social norms and attitudes about women's bodies and modesty have had a tremendous impact on women. Many women, especially older or larger ones, feel more comfortable working out in an atmosphere of all women. To them, this type of setting is more supportive and makes it easier for them to become physically fit.

In addition, the activities of a health club make it unique. Nudity, intimate touching, assuming awkward positions, having one's body measured, and wearing revealing attire are all a part of the normal activities at a health club.

As courts have stated, a customer-based privacy interest can be an occupational qualification which could allow women-only health clubs to legally discriminate, despite the Title VII prohibition against discrimination. There is also no public policy interest which would override a person's privacy interest in this case.

Laws and the courts have permitted different treatment in public accommodations based on gender where there is an obvious privacy issue, such as bathrooms or showers. However, the issue of single-sex health clubs has yet to be fully played out. To date, there are no federal precedents dealing with this issue. In a changing world of social norms, the law has some catching up to do. Until courts or legislatures send a clear message, the best thing a club can do is cover all of its bases and have solid basis for its membership and hiring policies.

last modified: 3/3/98

THE
FOLLOWING
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Common Sense on Single-Gender Health Club

Rep. Douglas W. Petersen

Legislation I introduced to authorize single-gender health and fitness clubs in Massachusetts has unleashed a torrent of calls to legislators from women across the state. My office has received so many calls supporting single-gender health clubs that it leads me to believe that more women are interested in preserving their privacy than I previously realized.

It is particularly interesting that the women who support this proposal have taken a position opposite that of the National Organization for Women (NOW). NOW opposes the measure because it "would legalize discrimination based upon gender." However, it's clear from the women — including many NOW members — whose calls are flooding Beacon Hill that this is not an issue of equality, but one of an individual's right of privacy.

I filed House Bill 5057, "An Act Relative to the Membership of Fitness and Wellness Facilities in the Commonwealth," in conjunction with more than 30 of my colleagues, in response to a recent court ruling that a women-only health club was in violation of the Massachusetts Public Accommodations law. The court stated that since customers "have no privacy right to be protected, the court cannot consider whether [the club's] policy is reasonable." This bill, simply put, would allow for single-gender health and fitness facilities in Massachusetts.

The court was responding to a lawsuit brought by a Boston attorney who wanted to join a downtown women's fitness center, thus requiring it to convert to a coed facility. As an aside, this lawyer had previously filed 10 or more court actions in New York State against bars which serve free drinks to women.

The court's ruling was a stunning setback for women who require a single-gender club for their fitness needs. The outcome also makes it clear that state law must be changed to maintain these health and fitness facilities throughout Massachusetts.

In Massachusetts alone, there are 30 women-only health clubs which serve more than 40,000 members. The Joint Committee on Commerce and Labor recently heard testimony from medical and fitness experts who explained that there is a real need among many women, based on legitimate privacy considerations, to engage in fitness activities at health centers without the presence of male customers. Psychologist Robert J. Tanenbaum, Jr., Ph.D., testified that "single-sex fitness facilities provide an exercise option for women who, due to their own sense of dignity and need for privacy, would not exercise in a coed environment."

This proposed legislation adopts a common sense approach in recognizing that men and women have separate and distinctive fitness needs. These women-only facilities offer their members a full range of fitness and health services which address female issues. In addition to exercise equipment, many clubs offer a variety of health classes to address situations unique to women, including prenatal fitness programs, osteoporosis prevention, breast health and menopause. These are vital services that many women members would not receive if women-only clubs were no longer available to them.

It is important that we recognize the needs of women who, for a variety of reasons, require private fitness facilities. The members of women-only clubs include:

- Those experiencing or recovering from health or medical issues (including pregnancy) who desire a supervised fitness program in an environment that protects their privacy;
- Women who have been victims of, and are in recovery from, domestic violence and physical or sexual abuse who seek a safe, secure facility in which to rehabilitate their mental and physical fitness;
- Members of certain religions which prohibit exercising in a coed setting; and
- Seniors and other members in need of a supervised fitness and health program but who are too intimidated to exercise in a coed setting. For many who join a women-only fitness club there are no other exercise options — they will either workout at their current club or they simply won't work out at all.

A recent survey done by the Massachusetts Department of Public Health found that 70 percent of Massachusetts residents don't get enough exercise. At a time when everyone from local physicians to the U.S. Surgeon General is urging Americans to exercise, we should not eliminate facilities that are allowing more than 40,000 Massachusetts residents the opportunity to improve their physical and mental health. It is time that Massachusetts add its name to the list of states which guarantee residents their duly deserved right of privacy.

Rep. Douglas W. Petersen, D-Marblehead, represents the Eighth Essex District.

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THE NEED FOR SINGLE SEX HEALTH AND FITNESS FACILITIES: BEHAVIORAL AND PSYCHOLOGICAL IMPEDIMENTS TO EXERCISE

Legislative Testimony of Robert L. Tanenbaum, Ph.D. in Favor of House Bill 5057

I. INTRODUCTION

Good afternoon. My name is Robert Tanenbaum. I am a licensed psychologist with a doctorate in Clinical Psychology. I have provided the Committee with a copy of my curriculum vitae, which includes my professional qualifications, appointments, experience, publications and the like. I have extensive clinical experience in several relevant areas. I bring a knowledge of gender differences, body image and weight regulation and the reduction of performance anxiety in individual and group settings. In particular, I have significant experience in evaluating the need for single sex fitness facilities for individuals. My findings are based on clinically verifiable observations involving concerns for personal privacy and dignity, and individual differences in anxiety level and bodily awareness. I will note that my findings are in keeping with mainstream psychological thought.

I must stress that this is not an issue of preference for these women. They do not choose a single sex facility simply because they want to exclude men. In fact, it was clear from my study that male animus was not motivating these women. Rather, the issue is one of privacy and dignity. The notion of privacy concerns how much or how little one is willing to expose to the opposite sex, especially during rigorous exercise.

The law, as it now stands, allows only a coed setting for women who wish to exercise in a controlled environment. Under these conditions, many women will be too uncomfortable or self-conscious to exercise. It is important to recognize that such physical acts involve spreading their legs and thrusting their pelvis, and exposing their chest while bouncing up and down. They are engaging in these activities while dressed in exercise attire which typically consists of spandex shorts and a jog bra or T-shirt. Under these circumstances, the mere presence of men represents a significant intrusion, despite their actual proximity or limited verbal communication.

I have performed psychological evaluations to assess the needs of women who exercise in single sex fitness facilities. The main focus was to understand why some women cannot commit to exercise in a coed facility, thereby foregoing the regular exercise needed for good health.

My findings and conclusions are based upon the following sources of information:

- Visits to several exercise facilities in the Northeast in order to assess the physical environment.

- Interviews of over 100 members of single sex facilities.

- Review of survey responses from approximately 500 women members of single sex facilities.

- Use of background professional knowledge, as applied to the present case of understanding fitness goals and obstacles for women.

II. FINDINGS AND CONCLUSIONS

A. Overview

It is psychologically unhealthy and unproductive for many women to be required to exercise in a coed environment and such a requirement is a barrier to exercise for thousands of women.

B. Background Psycho-Social Influences on Differences in Dignity, Privacy and Appearance Concerns

There are background psycho-social influences on differences in dignity, privacy and appearance concerns. Women tend on average to be more concerned regarding their bodily privacy than men. For example, women are provided with individual stalls in bathrooms (as compared to men who generally use semi-public urinals). Frequently, schools accommodate girls by providing separate showers or changing stalls in school gyms (as compared to men who generally have little reservation about using communal showers). Contemporary healthcare facilities, such as hospitals, are being (re)designed on a gender sensitive basis which recognizes fundamental psycho-biological differences between the sexes. As one example, there are now women's hospitals where reproductive cancer care is a primary focus and a total medical/psychological treatment environment is provided. Recent articles in the health care area further acknowledge certain physiological differences between men and women, which require different exercise programming.

C. Performance Anxiety

Women experience high levels of distress about the extreme degree of bodily exposure associated with certain exercise positions and workout attire, typical of aerobic workouts and yoga exercises. As mentioned earlier, three examples of exercise positions can lead to pronounced performance anxiety as follows:

"Bouncing in place with chest exposed"
"Spreading legs with pelvic thrusts"
"Bending over with arms outstretched"

Performance anxiety is not limited to the exercise community or to women. My clinical experience with entertainers, performance artists and athletes points to the generalizability of performance anxiety.

Of significant importance was the fact that all the women interviewed and all survey responses reviewed focused on issues of personal privacy and the exposure of one's body.

D. Summary Profile

The women interviewed displayed the following relevant characteristics:

- Have limited fitness experience, goals, or success prior to joining a same sex club. These women also responded that exercising at home did not work. Self discipline was difficult to achieve, there was no peer support, no instruction, and there was interference from outside weather conditions.

- Perceive themselves as "out of shape", deconditioned.

- Experience a high level of performance anxiety (feel intimidated and anticipate difficulties) when exercising in public, especially in the presence of men.

- Join a fitness and wellness facility exclusively to improve their physical fitness, not to socialize or conduct business. Many stated that they exercise because it is prescribed by a doctor or physical therapist.

- Focused on improving their health and physical condition and do not want to be concerned with a sexualized dynamic and the concurrent emphasis on appearance. Over 80% of the members who submitted comment forms and who were interviewed said that their motivation to exercise in a same sex environment was the most important reason or the decisive reason for joining a single-sex facility; many of these women expressed concern about being observed and judged physically by members of the opposite sex, at a time when they are focused on gaining control over the function and appearance of their bodies. Unwanted exposure to members of the opposite sex has a negative effect

on the 'work environment,' limiting the amount and manner of exercise for some, preventing many from exercising at all. Women who sought a single sex environment were not motivated by a dislike of men, but by a need to control exposure of their bodies to the opposite sex while engaging in bodily positions and activities which are often viewed as having sexual associations or connotations.

- Members across a wide age span, but especially those between 30 and 50 (pregnant, nursing, post-partum, menopausal, or aging) have strong feelings about exercising in the presence of the opposite sex. Many of the women have children and have experienced bodily changes associated with pregnancy and childbirth which alter their appearance. Some women have experienced the embarrassment of menstrual staining during exercise. Also, older members who have recently gone through menopause are still adjusting to the functional changes in their bodies as they go through the normal aging process. Still other women struggle with changes in their appearance due to physical problems, such as mastectomies, osteoporosis and back pain. As a result of various bodily changes, these women are much more conscious of their bodies and feel intimidated and exposed when exercising in a coed environment;

- Struggling to regain stability as a result of past physical/sexual abuse or injury; many bodily concerns or vulnerabilities relate specifically to the psychology of women.

- Some women, based upon their religious beliefs, are forbidden from exercising in the presence of men.

SB

177

(7)

HOUSE COMMITTEE REPORT

Date Referred to Committee: March 23, 2000

FURTHER REFERRALS: Judiciary
Finance

Date of Committee Action: April 12, 2000

The LABOR AND COMMERCE Committee considered: CSSB 177(L&C)

CS FOR SENATE BILL NO. 177(L&C) INSURANCE TRADE PRACTICES & ACTS

"An Act relating to insurance trade practices; and providing for an effective date."

recommends it be replaced with the following committee substitute HCS CS SB 177 (L+C) [✓] the same title [ ] a new title

[ ] additional referral to _____ Committee
[ ] attached amendment(s)

ADOPTS: _____ Letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[ ] fiscal note(s) _____

_____

[ ] zero fiscal note(s) _____

_____

APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____

_____

[✓] zero fiscal note(s) DCED 3/1/00

_____

SIGNING WITH RECOMMENDATIONS	DP	DNP	NR	AM
			✓	
	✓			
			✓	
	✓			
		✓		
			✓	

CHAIR'S SIGNATURE _____ 4-12-2000

ALASKA STATE LEGISLATURE
HOUSE LABOR AND COMMERCE COMMITTEE

State Capitol
Juneau, AK 99801-1182
Telephone: (907) 465-4954
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APRIL 12, 2000 MEETING

Proposed CS for SB 177

1-LS0902\K
Ford
4/11/00

HOUSE CS FOR CS FOR SENATE BILL NO. 177( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIRST LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR DONLEY

A BILL

FOR AN ACT ENTITLED

"An Act relating to insurance trade practices; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

SHORT TITLE. This Act may be known as the Alaska Insurance Consumers Protection Act.

*** Sec. 2.** AS 21.36.010 is amended to read:

Sec. 21.36.010. Purpose. The purpose of this chapter is to regulate **an act or** **a** trade **practice** [PRACTICES] in the business of insurance in accordance with the intent of Congress as expressed in **15 U.S.C. 1011 - 1015 (McCarran-Ferguson Act)** [THE ACT OF CONGRESS OF MARCH 9, 1945 (P.L. 79-15; CH. 20, 59 STAT. 33),] by defining or providing for determination of all the practices in this state that constitute **an** unfair **method** [METHODS] of competition or **an** unfair or deceptive **act**

New Text Underlined [DELETED TEXT BRACKETED]

or practice [ACTS OR PRACTICES] and by prohibiting them.

* Sec. 3. AS 21.36.020 is amended to read:

Sec. 21.36.020. Unfair methods, deceptive acts prohibited. A person may not engage in an act or a trade practice in this state or relative to a subject resident, located, or to be performed in this state that is defined in this chapter as, or determined under this chapter to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

* Sec. 4. AS 21.36.070(b) is amended to read:

(b) A person providing the director with information concerning the financial condition or an act or a practice [PRACTICES] of a licensee of the division is immune from liability for defamation.

* Sec. 5. AS 21.36.125 is amended to read:

Sec. 21.36.125. Unfair claim settlement practices. A person may not commit [OR ENGAGE IN WITH SUCH FREQUENCY AS TO INDICATE A PRACTICE] any of the following acts or practices:

(1) misrepresent facts or policy provisions relating to coverage of an insurance policy;

(2) fail to acknowledge and act promptly upon communications regarding a claim arising under an insurance policy;

(3) fail to adopt and implement reasonable standards for prompt investigation of claims;

(4) refuse to pay a claim without a reasonable investigation of all of the available information and an explanation of the basis for denial of the claim or for an offer of compromise settlement;

(5) fail to affirm or deny coverage of claims within a reasonable time of the completion of proof-of-loss statements;

(6) fail to attempt in good faith to make prompt and equitable settlement of claims in which liability is reasonably clear;

(7) compel

(A) an insured [INSUREDS] to litigate for recovery of an amount [AMOUNTS] due under an insurance policy [POLICIES] by offering

substantially less than **an amount** [THE AMOUNTS] ultimately recovered in **an action** [ACTIONS] brought by **the insured; or**

(B) a third-party claimant regarding a claim in which liability is not at issue to litigate for recovery of an amount due under an insurance policy by offering an amount that does not have a reasonable basis in law and fact [THOSE INSUREDS];

(8) attempt to make an unreasonably low settlement by reference to printed advertising matter accompanying or included in an application;

(9) attempt to settle a claim on the basis of an application that has been altered without the consent of the insured;

(10) make a claims payment without including a statement of the coverage under which the payment is made;

(11) make known to **an insured or third-party claimant** [INSUREDS OR CLAIMANTS] a policy of appealing from **an** arbitration **award** [AWARDS] in favor of **an insured or third-party claimant** [INSUREDS OR CLAIMANTS] for the purpose of compelling **the insured or third-party claimant** [THEM] to accept **a settlement or compromise** [SETTLEMENTS OR COMPROMISES] less than the amount awarded in arbitration;

(12) delay investigation or payment of claims by requiring submission of unnecessary or substantially repetitive claims reports and proof-of-loss forms;

(13) fail to promptly settle claims under one portion of a policy for the purpose of influencing settlements under other portions of the policy;

(14) fail to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; or

(15) offer a form of settlement or pay a judgment in any manner prohibited by AS 21.89.030.

*** Sec. 6.** AS 21.36.125 is amended by adding a new subsection to read:

(b) The provisions of this section do not create or imply a private cause of action for a violation of this section.

*** Sec. 7.** AS 21.36 is amended by adding a new section to read:

Sec. 21.36.212. Prohibited denial of claim for causation. An insurer may not deny a claim if a risk, hazard, or contingency insured against is the dominant cause of a loss and the denial occurs because an excluded risk, hazard, or contingency is also in a chain of causes but operates on a secondary basis.

* **Sec. 8.** AS 21.36.320(g) is amended to read:

(g) In determining the penalty imposed under (d) and (e) of this section, the director shall consider the amount of loss caused by the violation and the amount of benefit derived by the person by reason of the violation and may consider other factors, including the seriousness of the violation, **whether the violation was a single act or a trade practice,** and deterrence of the violator or others.

* **Sec. 9.** This Act takes effect January 1, 2001.

203 W.Va. 477

Robert L. MURRAY and Janet L. Murray, his wife; Bernie W. Rees and Julie A. Rees, his wife; and Robert J. Withrow, Plaintiffs below, Appellees,

v.

STATE FARM FIRE AND CASUALTY COMPANY, a Foreign Corporation; Allstate Insurance Company, a Foreign Corporation, Defendants below, Appellants,

and

Robert J. Harris, Defendant below, Appellee.

Nos. 24759, 24760.

Supreme Court of Appeals of West Virginia.

Submitted April 29, 1998.

Decided July 21, 1998.

Insureds sued their homeowner's insurers for breach of contract and bad faith after the insurers denied coverage for a rockfall from an abandoned quarry's highwall that damaged their houses. The Circuit Court, Jackson County, Charles E. McCarty, J., granted summary judgment to the insureds, and the insurers appealed. The Supreme Court of Appeals, Starcher, J., held that: (1) whether the policies' earth movement exclusions applied was a fact issue, and (2) covered losses could exist in the absence of structural damage to the insured property.

Reversed and remanded for trial.

1. Appeal and Error ⇐893(1)

Appellate review of the grant of partial summary judgment is de novo.

2. Appeal and Error ⇐863

Appellate court reviewing summary judgment applies the same test that the trial court should have used initially, and must determine whether it is clear that there is no genuine issue of fact to be tried and inquiry concerning the facts is not desirable to clarify the application of the law.

3. Insurance ⇐1863

Determination of the proper coverage of an insurance contract when the facts are not in dispute is a question of law.

4. Insurance ⇐1822

Language in an insurance policy should be given its plain, ordinary meaning.

5. Insurance ⇐1807, 1812, 1822

Where the provisions of an insurance policy contract are clear and unambiguous they are not subject to judicial construction or interpretation, but full effect will be given to the plain meaning intended.

6. Insurance ⇐1808

Whenever the language of an insurance policy provision is reasonably susceptible of two different meanings or is of such doubtful meaning that reasonable minds might be uncertain or disagree as to its meaning, it is "ambiguous."

See publication Words and Phrases for other judicial constructions and definitions.

7. Insurance ⇐1832(1)

Ambiguous terms in insurance contracts are to be strictly construed against the insurance company and in favor of the insured.

8. Insurance ⇐2097, 2101

Recovery under an "all-risk" insurance policy is allowed for all losses arising from any fortuitous cause, unless the policy contains an express provision excluding the loss from coverage.

See publication Words and Phrases for other judicial constructions and definitions.

9. Insurance ⇐2144(1)

Plain, ordinary meaning of the word "landslide" in an insurance policy contemplates a sliding down of a mass of soil or rock on or from a steep slope.

See publication Words and Phrases for other judicial constructions and definitions.

10. Insurance ⇐2144(1)

Plain, ordinary meaning of the word "erosion" in an insurance policy contemplates a natural process that includes weathering,

dissolution, abrasion, corrosion, and transportation whereby material is removed from the earth's surface.

See publication Words and Phrases for other judicial constructions and definitions.

11. Insurance ⇐2144(1)

Naturally-occurring rockfall is included within the common definition of "landslide" in an insurance policy.

12. Insurance ⇐2144(1)

Process of weathering to rock is included as a component of the natural process of "erosion" under an insurance policy.

13. Insurance ⇐2117

Insurance company seeking to avoid liability through the operation of an exclusion has the burden of proving the facts necessary to the operation of that exclusion.

14. Insurance ⇐1835(2), 1836

Exclusionary policy language will be strictly construed against the insurer in order that the purpose of providing indemnity not be defeated.

15. Insurance ⇐1808

Provision in an insurance policy may be deemed "ambiguous" if courts in other jurisdictions have interpreted the provision in different ways; this rule is based on the understanding that one cannot expect a mere layman to understand the meaning of a clause respecting the meaning of which fine judicial minds are at variance.

16. Contracts ⇐156

Contract construction principles of ejusdem generis and noscitur a sociis require that, in an ambiguous phrase mixing general words with specific words, the general words are not construed broadly but are restricted to a sense analogous to the specific words.

17. Insurance ⇐2144(1)

When an earth movement exclusion in an insurance policy contains terms not otherwise defined in the policy, and the terms of the exclusion relate to natural events (such as earthquakes or volcanic eruptions), which events, in some instances, may also be attributed to a combination of natural and man-made causes (such as landslides, subsidence or erosion), the terms of the exclusion must be read together and limited to exclude naturally occurring events rather than man-made events.

18. Insurance ⇐2103(1)

When examining whether coverage exists for a loss under a first-party insurance policy when the loss is caused by a combination of covered and specifically excluded risks, the loss is covered by the policy if the covered risk was the efficient proximate cause of the loss, and no coverage exists for a loss if the covered risk was only a remote cause of the loss, or conversely, if the excluded risk was the efficient proximate cause of the loss.

19. Insurance ⇐2103(1)

"Efficient proximate cause" of a loss is the risk that sets others in motion; it is not necessarily the last act in a chain of events, nor is it the triggering cause; the doctrine looks to the quality of the links in the chain of causation to find the predominating cause of the loss.

See publication Words and Phrases for other judicial constructions and definitions.

20. Insurance ⇐2120

Question of which event was the efficient proximate cause of a loss is generally one of fact.

21. Insurance ⇐2202

Judgment ⇐181(23)

Whether erosion and a landslide on the one hand, or negligent construction and maintenance on the other, was the efficient proximate cause of a rockfall from an abandoned quarry's highwall that damaged three insured houses was a fact question for the jury; thus, the ...plication of earth movement exclusions in the all-risk homeowner's policies covering the houses could not be decided on summary judgment.

22. Insurance ⇐2140

Term "external," as used in a "lead-in" clause of an all-risk homeowner's policy which emphasized that excluded events were not covered regardless of whether the event

arose from natural or "ex
compassed natural risks a
or outside the property;
man-made forces.

See publication Wor
for other judicial constr
initions.

23. Insurance ⇐2165(1)

"Lead-in" clause of
owner's policy, which en
cluded events were not co
how the event was caused
strued as defeating the
cause doctrine without v
able expectations of poli
had to be read as allo
losses proximately caused
and as barring coverage
cepted risk was the effici
of the loss.

24. Insurance ⇐1817

With respect to insu
doctrine of "reasonable
the objectively reasonabl
plicants and intended be
the terms of insurance c
ored even though pains
policy provisions would
expectations.

See publication W
for other judicial cons
initions.

25. Insurance ⇐1817

Before the doctrine
tations is applicable to a
there must be an amb
terms of that contract.

26. Insurance ⇐2140

Insurance policy
"sudden and accidental
tal direct physical loss"
requires only that the
not destroyed; losses
including those render
erty unusable or uninh
the absence of structu
sured property.

See publication
for other judicial co
initions.

Syllabus by the Court

1. "Language in an insurance policy should be given its plain, ordinary meaning." Syllabus Point 1, *Soliva v. Shand, Morahan & Co., Inc.*, 176 W.Va. 430, 345 S.E.2d 33 (1986).

2. "Whenever the language of an insurance policy provision is reasonably susceptible of two different meanings or is of such doubtful meaning that reasonable minds might be uncertain or disagree as to its meaning, it is ambiguous." Syllabus Point 1, *Prete v. Merchants Property Ins. Co. of Indiana*, 159 W.Va. 508, 223 S.E.2d 441 (1976).

3. "It is well settled law in West Virginia that ambiguous terms in insurance contracts are to be strictly construed against the insurance company and in favor of the insured." Syllabus Point 4, *National Mut. Ins. Co. v. McMahon & Sons, Inc.*, 177 W.Va. 734, 356 S.E.2d 488 (1987).

4. The plain, ordinary meaning of the word "landslide" in an insurance policy contemplates a sliding down of a mass of soil or rock on or from a steep slope.

5. The plain, ordinary meaning of the word "erosion" in an insurance policy contemplates a natural process that includes weathering, dissolution, abrasion, corrosion and transportation whereby material is removed from the earth's surface.

6. "An insurance company seeking to avoid liability through the operation of an exclusion has the burden of proving the facts necessary to the operation of that exclusion." Syllabus Point 7, *National Mut. Ins. Co. v. McMahon & Sons, Inc.*, 177 W.Va. 734, 356 S.E.2d 488 (1987).

7. When an earth movement exclusion in an insurance policy contains terms not otherwise defined in the policy, and the terms of the exclusion relate to natural events (such as earthquakes or volcanic eruptions), which events, in some instances, may also be attributed to a combination of natural and man-made causes (such as landslides, subsidence or erosion), the terms of the exclusion must be read together and limited to exclude naturally-occurring events rather than man-made events.

arose from natural or "external" forces, encompassed natural risks arising from beyond or outside the property; it did not include man-made forces.

See publication Words and Phrases for other judicial constructions and definitions.

23. Insurance ⇐2165(1)

"Lead-in" clause of an all-risk homeowner's policy, which emphasized that excluded events were not covered regardless of how the event was caused, could not be construed as defeating the efficient proximate cause doctrine without violating the reasonable expectations of policyholders; thus, it had to be read as allowing coverage for losses proximately caused by a covered risk and as barring coverage only when an excepted risk was the efficient proximate cause of the loss.

24. Insurance ⇐1817

With respect to insurance contracts, the doctrine of "reasonable expectations" is that the objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations.

See publication Words and Phrases for other judicial constructions and definitions.

25. Insurance ⇐1817

Before the doctrine of reasonable expectations is applicable to an insurance contract, there must be an ambiguity regarding the terms of that contract.

26. Insurance ⇐2140

Insurance policy provision covering a "sudden and accidental loss" or an "accidental direct physical loss" to insured property requires only that the property be damaged, not destroyed; losses covered by the policy, including those rendering the insured property unusable or uninhabitable, may exist in the absence of structural damage to the insured property.

See publication Words and Phrases for other judicial constructions and definitions.

8. When examining whether coverage exists for a loss under a first-party insurance policy when the loss is caused by a combination of covered and specifically excluded risks, the loss is covered by the policy if the covered risk was the efficient proximate cause of the loss. No coverage exists for a loss if the covered risk was only a remote cause of the loss, or conversely, if the excluded risk was the efficient proximate cause of the loss. The efficient proximate cause is the risk that sets others in motion. It is not necessarily the last act in a chain of events, nor is it the triggering cause. The efficient proximate cause doctrine looks to the quality of the links in the chain of causation. The efficient proximate cause is the predominating cause of the loss.

9. "With respect to insurance contracts, the doctrine of reasonable expectations is that the objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations." Syllabus Point 8, *National Mut. Ins. Co. v. McMahon & Sons, Inc.*, 177 W.Va. 734, 356 S.E.2d 488 (1987).

10. An insurance policy provision providing coverage for a "sudden and accidental loss" or an "accidental direct physical loss" to insured property requires only that the property be damaged, not destroyed. Losses covered by the policy, including those rendering the insured property unusable or uninhabitable, may exist in the absence of structural damage to the insured property.

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Ted M. Kanner, Esq., The Ted Kanner Law Office, Charleston, West Virginia, J. Nicholas Barth, Esq., Barth, Thompson & George, Charleston, West Virginia, Attorneys for Appellees Murray, Rees and Withrow.

Larry L. Skeen, Esq., Ripley, West Virginia, Attorney for Appellee Harris.

STARCHER, Justice:

The appellants and defendants below, State Farm Fire and Casualty Company ("State Farm") and Allstate Insurance Company ("Allstate"), appeal an order of the Circuit Court of Jackson County granting summary judgment to several homeowners in a dispute concerning policy exclusions in two homeowners' insurance policies. The policyholders' homes were damaged by rocks falling from the highwall of a 40–year old abandoned rock quarry situated next to the homes. The policyholders' insurance carriers denied coverage, claiming that the applicable insurance policies excluded losses caused by "landslides" and "erosion." The circuit court concluded that the policies did not exclude from coverage losses caused by "rockfalls" and "weathering," and that the plaintiffs' losses were the result of those events. The circuit court held that the plaintiffs were entitled to coverage under the policies.

After reviewing the record, we conclude that questions of material fact exist concerning whether coverage exists under both policies. We reverse the circuit court's order granting summary judgment and remand the case for trial.

I.

Factual Background

The plaintiff-appellees in this case—Robert and Janet Murray, Bernie and Julie Rees, and Robert Withrow—are the owners of three adjacent properties on Spring Street in Ripley, West Virginia. The plaintiffs' homes were constructed on their properties in the 1970's. Immediately adjacent to the rear of the three houses is a man-made highwall standing nearly 50 feet high. This vertical highwall is the result of quarrying operations conducted in the 1950's. The highwall is allegedly located on property owned by defendant-appellee Robert B. Harris.

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harleston, West Virginia, Attorneys
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HER, Justice:

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On February 22, 1994, several large boulders and rocks fell off the highwall and onto the houses owned by plaintiffs Murray and Withrow, causing extensive damage. The house owned by plaintiffs Mr. and Mrs. Rees was not damaged by rocks. However, firemen compelled all three families to leave their homes because of the possibility that additional rocks could fall, and turned off all electricity and water. An engineer who examined the highwall several days later concluded that further rockfalls would "continue to occur, some with potentially disastrous results."[1] None of the three families has lived in their homes since February 22, 1994.[2]

Several engineers and geologists examined the property and highwall in the following weeks. Each gave, to some extent, an opinion that what occurred on Spring Street was primarily a "rockfall" and not a "landslide," because no "sliding" was involved: a layer of shale supporting a layer of sandstone "weathered," removing support for the sandstone, and sandstone blocks broke loose and dropped onto the plaintiffs' homes.[3] One expert said that he thought of a rockfall as "almost a vertical displacement free-falling through the air off of a cliff, a highwall, an escarpment." However, several of the experts conceded that rock falls are considered to be a type of landslide, and are accepted as a sub-category of a landslide; and they further agreed that erosion contributed to the moving of the rocks in the instant case.

Furthermore, there is evidence in the record that negligent construction of the highwall behind the plaintiffs' residences, namely the cutting of the rock face at a near vertical angle, contributed to the rockfall. Expert George A. Hall indicated that "the design of the cut-slope on Spring Street did not meet standards which you would reasonably and

1. The March 2, 1994 report from engineer Eric G. Denemark to Mr. Rees stated:

> Looking at the highwall from the Church Street end up to and past the Withrow's yard, there is evidence of other past rockfalls. We feel that this wall is inherently unstable and that these events will continue to occur over time. Immediately behind the Withrow home a large block is already wedged off the sandstone unit and sits, precariously and temporarily, on what is left of the underlying shale. This is an extremely dangerous situation that, in our opinion, places the Withrow home at immediate risk.
>
> The situation behind your home has not advanced quite as far.... It is only a matter of time before it too will fail resulting in a rockfall similar to that which occurred last week.
>
> Another factor perhaps worthy of consideration, is that, typically, small pieces of rock will "spall" off the wall sporadically but relatively continuously.... While the potential for structural damages is minimal, a relatively small fragment, grapefruit-size for example, can easily inflict a serious or fatal injury should it strike a person or animal. You may want to consider this when contemplating letting your children or pets play near the highwall. We would consider anywhere in the backyard to be potentially dangerous.

2. The Rees allege that after moving from their home they were unable to afford the mortgage payments. They were forced to convey the property back to the bank holding the deed of trust. The bank then moved the house and relocated it to another site.

As to the remaining houses, a letter from the City of Ripley Building inspector states that:

> Presently the houses are unsightly, unsafe, and are creating a health hazard. We are requesting they be torn down and removed from their location. We feel it would be unsafe to repair or rebuild either house at their present site. The city will not issue any building permit for rebuilding or repairing either house without first having the rockfall stabilizing and secured.

3. Hobart M. King, an expert hired by the City of Ripley, stated in a letter to the mayor that:

> Because the distinction between a rockfall and a landslide is sometimes important for insurance purposes, I made special effort to determine what had happened....

Mr. King discussed this distinction in his deposition testimony:

> A. In a landslide, what you have is a mass [of] rock or soil that is sliding over an underlying surface. That sliding takes place across a plane. There is a plane or a surface of failure at the base of the moving material. When I was looking at what had happened in Spring Street, there was no surface of failure along which sliding occurred. Sandstone blocks had fallen from the higher elevation above that shale layer that I previously discussed was underneath the sandstone. So, those two reasons would be why I would call that a rockfall....
>
> Q. Would you agree that a rockfall is a type of landslide?
>
> A. No. Slide[s] take place over a surface of failure. A fall occurs when a piece of the earth has broken away and falls independently, no sliding involved.

normally expect for civil engineering purposes of designing cut-slopes." He also said that had proper civil engineering techniques been used when the highwall was created, the danger of a fall like the one that occurred would not be present.

Plaintiffs Murray and Rees filed claims for the losses to their homes with their homeowner's insurance carrier, defendant State Farm. Plaintiff Withrow filed a similar claim with his insurance carrier, defendant Allstate. Insurance agents notified the plaintiffs that State Farm and Allstate would not cover the losses, citing to numerous policy provisions and exclusions, including an exclusion for losses caused by landslide or erosion.

The plaintiffs then filed the instant lawsuit against defendants Allstate and State Farm alleging breach of contract and bad faith. The plaintiffs also sued defendant Harris for nuisance, trespass, and failing to protect the plaintiffs' property from the "dangerous, artificial manmade condition existing on the defendant's property[.]" Defendant State Farm filed a counterclaim against the plaintiffs seeking a declaratory judgment regarding State Farm's obligations under its policies.

The plaintiffs and defendants State Farm and Allstate filed motions for summary judgment concerning coverage under the disputed insurance policies. Through a letter ruling on January 3, 1997 and a subsequent order on March 17, 1997, the circuit court granted summary judgment to the plaintiffs. The circuit court held that the rockfall "is a loss covered under the plaintiffs' respective insurance policies." The court also held that whether the plaintiffs' damages were caused by a rockfall, and the extent of those damages, were issues to be determined by a jury.

State Farm and Allstate now appeal the circuit court's order.

II.

Standard of Review

[1, 2] This appeal arises from the circuit court's granting of partial summary judgment to the plaintiff. Our review is *de novo*. Syllabus Point 1, *Painter v. Peavy*, 192 W.Va. 189, 451 S.E.2d 755 (1994). In reviewing summary judgment, this Court will apply the same test that the circuit court should have used initially, and must determine whether "it is clear that there is no genuine issue of fact to be tried and inquiry concerning the facts is not desirable to clarify the application of the law." Syllabus Point 3, *Aetna Casualty & Surety Co. v. Federal Insurance Co. of New York*, 148 W.Va. 160, 133 S.E.2d 770 (1963).

[3] In this case we are primarily asked to review the circuit court's interpretation of an insurance contract. In *Payne v. Weston*, 195 W.Va. 502, 506–07, 466 S.E.2d 161, 165–66 (1995), we discussed the applicable standard of review in such cases, stating that "[t]he interpretation of an insurance contract, including the question of whether the contract is ambiguous, is a legal determination which, like the court's summary judgment, is reviewed *de novo* on appeal." "Determination of the proper coverage of an insurance contract when the facts are not in dispute is a question of law." *Pacific Indemnity Co. v. Linn*, 766 F.2d 754, 760 (3d Cir.1985).

[4, 5] When a court interprets an insurance policy, the "[l]anguage in an insurance policy should be given its plain, ordinary meaning." Syllabus Point 1, *Soliva v. Shand, Morahan & Co., Inc.*, 176 W.Va. 430, 345 S.E.2d 33 (1986). "Where the provisions of an insurance policy contract are clear and unambiguous they are not subject to judicial construction or interpretation, but full effect will be given to the plain meaning intended." Syllabus, *Keffer v. Prudential Ins. Co. of America*, 153 W.Va. 813, 172 S.E.2d 714 (1970).

[6, 7] However, "[w]henever the language of an insurance policy provision is reasonably susceptible of two different meanings or is of such doubtful meaning that reasonable minds might be uncertain or disagree as to its meaning, it is ambiguous." Syllabus Point 1, *Prete v. Merchants Property Ins. Co. of Indiana*, 159 W.Va. 508, 223 S.E.2d 441 (1976). "It is well settled law in West Virginia that ambiguous terms in insurance contracts are to be strictly construed against the insurance company and in favor of the insured." Syllabus Point 4. *Ins. Co. v. McMahon & Sons* 734, 356 S.E.2d 488 (1987).

With these principles in r take a plenary review of the language to determine whet homeowners' policies from state and State Farm provide factual situation presented.

III.

Discussion

[8] Defendants Allstate provided the plaintiffs with owner's insurance policies.[4] risk policy, recovery is allov arising from any fortuitous policy contains an express ing the loss from coverage. *St. Paul Fire & Marine Ins.* 978, 987 (S.D.Ohio 1975). Draper, *Coverage Under ance*, 30 A.L.R.5th 170 (199

Both Allstate and State F the losses suffered by t barred from coverage by e visions excluding losses resu movement, including but n landslide ... [or] erosion[.]"

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With these principles in mind, we undertake a plenary review of the disputed policy language to determine whether the plaintiffs' homeowners' policies from defendants Allstate and State Farm provide coverage in the factual situation presented.

III.

Discussion

[8] Defendants Allstate and State Farm provided the plaintiffs with "all-risk" homeowner's insurance policies.[4] Under an all-risk policy, recovery is allowed for all losses arising from any fortuitous cause, unless the policy contains an express provision excluding the loss from coverage. *Essex House v. St. Paul Fire & Marine Ins. Co.*, 404 F.Supp. 978, 987 (S.D.Ohio 1975). *See generally*, J. Draper, *Coverage Under All-Risk Insurance*, 30 A.L.R.5th 170 (1995).

Both Allstate and State Farm contend that the losses suffered by the plaintiffs are barred from coverage by express policy provisions excluding losses resulting from "earth movement, including but not limited to ... landslide ... [or] erosion[.]"

The defendants challenge the circuit court's order on four grounds. First, both defendants challenge the circuit court's summary judgment order finding that coverage existed under the policies because the plaintiffs' losses were the result of a "rockfall" caused by "weathering," and not excluded by policy provisions regarding "landslide" and "erosion." Second, both defendants argue that the earth movement exclusions are clear and unambiguous, and should therefore not be construed but instead applied to exclude coverage for the plaintiffs. Third, defendant State Farm argues that even if the earth movement exclusion could be construed as ambiguous, an extensive "lead-in" clause in its policy clarifies any ambiguity and excludes any coverage as to plaintiffs Murray and Rees. Lastly, both defendants argue that the plaintiffs cannot recover for the total loss of their homes due to the potential for a future rockfall, but can only recover for the actual physical damage sustained.

We address these arguments in turn.

A.

The Circuit Court's Summary Judgment Order

We first address the circuit court's order. While the circuit court's letter ruling and subsequent order are less than perfectly clear, it appears that the circuit court concluded that the boulders that damaged the plaintiffs' homes arose from a "rockfall" rather than a "landslide." Based in part upon the expert testimony in the record, the circuit court construed the policy language strictly against the insurance carriers and found that "the language therein did not include or contemplate a rockfall[.]" The circuit court further referred to expert testimony, apparently to hold that the rockfall was the result of "weathering" as opposed to "erosion," and that the plaintiffs were therefore covered under their homeowners' policies.

Defendants Allstate and State Farm first contend that the circuit court erred in finding that a "rockfall" is not included within the definition of "landslide." The defendants cite to *Dupps v. Travelers Ins. Co.*, 80 F.3d 312 (8th Cir.1996), where the court, addressing a landslide triggered by a sinkhole, stated that "[t]he ordinary meaning of the term 'landslide' includes rocks falling down a bluff.... [T]he only reasonable interpretation of the policy prohibits recovery for rocks which have fallen...." 80 F.3d at 314. Similarly, the court in Syllabus Point 4 of *Olmstead v. Lumbermens Mut. Ins. Co.*, 22 Ohio St.2d 212, 259 N.E.2d 123 (1970) concluded that "[t]he common ordinary meaning of the word

4. Allstate insured Mr. Withrow's home under a "Deluxe Homeowners Policy" which provided that Allstate would pay for any "sudden and accidental physical loss to the property described in the Dwelling Protection Coverage, except as limited or excluded by this policy."

The State Farm Homeowners Policy (Special Form 3) provided to the Murrays and Rees indicates that the policy "insure[s] for accidental direct physical loss to the property described in Coverage A except as provided in SECTION I—LOSSES NOT INSURED."

'landslide' is a sliding down of a mass of soil or rock on a steep slope."

[9] We agree with the defendants that the circuit court erred. We hold that the plain, ordinary meaning of the word "landslide" in an insurance policy contemplates a sliding down of a mass of soil or rock on or from a steep slope. *See generally*, 13A G. Couch, *Couch on Insurance 2d* 48:180 (1982) ("What Constitutes a Landslide").

Allstate and State Farm also argue that the circuit court erred in concluding that "weathering" is different from "erosion," and therefore any loss resulting from weathering is not excluded from coverage. The *Dictionary of Geological Terms* defines "erosion" as "the group of processes whereby earth or rock material is loosened or dissolved and removed from any part of the earth's surface," specifying that it includes the processes of "weathering, solution, corrosion and transportation." The *American Heritage Dictionary* also includes within its definition of erosion the "natural processes, including weathering, dissolution, abrasion, corrosion and transportation, by which material is removed from the earth's surface."

[10] We again agree that the circuit court erred. We hold that the plain, ordinary meaning of the word "erosion" in an insurance policy contemplates a natural process that includes weathering, dissolution, abrasion, corrosion and transportation whereby material is removed from the earth's surface.

[11, 12] Applying these definitions to the circuit court's order, it is clear that the circuit court's granting of partial summary judgment to the plaintiffs was incorrect. A naturally-occurring "rockfall" is included within the common definition of "landslide," and the process of "weathering" to rock is included as a component of the natural process of erosion. We further hold that the circuit court erred in finding that as a matter of law coverage existed under the policies by applying these definitions. However, as discussed below substantial questions of fact remain to be resolved concerning the existence of coverage.

B.

Earth Movement Exclusion

Both insurance policies in this case contain exclusions for "earth movement." The policy issued by Allstate excludes coverage for any loss resulting from:

> 2. Earth movement, including, but not limited to, earthquake, volcanic eruption, landslide, subsidence, mud flow, sinkhole, erosion, or the sinking, rising, shifting, expanding, bulging, cracking, settling or contracting of the earth. This exclusion applies whether or not the earth movement is combined with water.

Similarly, the policy issued by State Farm excludes coverage for losses resulting from:

> b. Earth Movement, meaning the sinking, rising, shifting, expanding or contracting of earth, all whether combined with water or not. Earth movement includes but is not limited to earthquake, landslide, mudflow, sinkhole, subsidence and erosion.

[13, 14] When a policyholder shows that a loss occurred while an insurance policy was in force, but the insurance company seeks to avoid liability through the operation of an exclusion, the insurance company has the burden of proving the exclusion applies to the facts in the case. Syllabus Point 7, *National Mut. Ins. Co. v. McMahon & Sons, Inc.*, 177 W.Va. 734, 356 S.E.2d 488 (1987). "Where the policy language involved is exclusionary, it will be strictly construed against the insurer in order that the purpose of providing indemnity not be defeated." Syllabus Point 5, *Id.*

Both of the earth movement exclusions in this case refer to "earth movement" including, but not limited to "earthquake," "volcanic eruption," "landslide," "subsidence," "mud flow," "sinkhole," "erosion," "sinking," "shifting," or "settling." None of these terms is further defined in the insurance policies. The defendant insurance companies argue that the facts in this case show that the rocks and earthen debris that fell on the plaintiffs' homes constitute a "landslide" caused by "erosion," an event within the earth movement exclusions.

The plaintiffs, however facts show the damage tc caused by the negligent cr wall in the 1950's and its nance by defendant Harris that would be covered by t

On the one hand, the e the defendants' policies c for solely *natural* event quakes, volcanic eruptior On the other hand, the sar to events which could be r subsidence or earth mov equipment or a broken w alleged in this case, earth r caused by *both man and r* od of time, such as landsl the earth sinking, shifting cause the policy language ceptible to different mea that the earth movement insurance policies at issu and must have a more lim that assigned to it by the c

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The plaintiffs, however, argue that the facts show the damage to their homes was caused by the negligent creation of the highwall in the 1950's and its negligent maintenance by defendant Harris today, two events that would be covered by the policies.

On the one hand, the exclusions cited in the defendants' policies could bar coverage for solely *natural* events such as earthquakes, volcanic eruptions, and sinkholes. On the other hand, the same exclusions refer to events which could be *man-made*, such as subsidence or earth movement caused by equipment or a broken water line. Or, as alleged in this case, earth movement could be caused by *both man and nature* over a period of time, such as landslides, mudflows, or the earth sinking, shifting, or settling. Because the policy language is reasonably susceptible to different meanings, we believe that the earth movement exclusions in the insurance policies at issue are ambiguous, and must have a more limited meaning than that assigned to it by the defendants.

[15] The majority of courts that have considered earth movement exclusions have found them to be ambiguous.[5] Having found the clause to be ambiguous, courts have used two methods of policy construction to examine whether coverage exists or is excluded under the earth movement exclusion.

First, courts have applied two doctrines of construction, *ejusdem generis* and *noscitur a sociis*, to limit the application of the earth movement exclusion to natural, catastrophic events, rather than man-made events.

Second, courts have examined the particular causes of the loss presented by the policyholder, and although an excluded event (such as earth movement) may have been a concurring or contributing cause of a loss, courts have allowed policyholders to recover under an insurance policy if the proximate cause of the loss was an event insured by the policy.

We believe that both approaches are applicable in this case.[6] We therefore examine exclusions in the instant case using the same two approaches.

[16] First, having determined that the earth movement exclusions at issue in this case are ambiguous, we apply the construction principles of *ejusdem generis* and *noscitur a sociis*. Under the doctrine of *ejusdem generis*, "[w]here general words are used in a contract after specific terms, the general words will be limited in their meaning or restricted to things of like kind and nature with those specified." Syllabus Point 4, *Jones v. Island Creek Coal Co.*, 79 W.Va. 332, 91 S.E. 391 (1917). The phrase *noscitur a sociis* literally means "it is known from its associates," and the doctrine implies that the meaning of a general word is or may be known from the meaning of accompanying specific words. *See* Syllabus Point 4, *Wolfe v. Forbes*, 159 W.Va. 34, 217 S.E.2d 899 (1975). The doctrines are similar in nature, and their application holds that in an ambiguous phrase mixing general words with specific words, the general words are not construed broadly but are restricted to a sense analogous to the specific words.

In the seminal case of *Wyatt v. Northwestern Mutual Ins. Co. of Seattle*, 304 F.Supp. 781 (D.Minn.1969), the district court considered a summary judgment motion where an insurance company sought, through the operation of an earth movement

5. A provision in an insurance policy may be deemed to be ambiguous if courts in other jurisdictions have interpreted the provision in different ways. This rule is based on the understanding that "one cannot expect a mere layman to understand the meaning of a clause respecting the meaning of which fine judicial minds are at variance." C. Marvel, *Division of Opinion Among Judges on Same Court or Among Other Courts or Jurisdictions Considering Same Question, as Evidence That Particular Clause of Insurance Policy is Ambiguous*, 4 A.L.R.4th 1253, § 2[a] (1981).

6. While every insurance policy must be analyzed based upon its own language, numerous courts faced with analogous policy language have reached nearly identical conclusions. A clear majority of courts continue to find earth movement exclusions ambiguous, and limited in application only to naturally-occurring catastrophic events such as earthquakes. However, a few jurisdictions have concluded that earth movement exclusions are not ambiguous, and apply to absolve the insurance company from any liability under the policy regardless of the cause or type of earth movement.

A collection of these cases is found in Appendix A, attached to this opinion.

exclusion, to avoid liability for losses caused by the negligence of a contractor excavating land adjacent to the policyholder's home. While holding that the exclusionary language was intended to remove from coverage losses resulting from natural causes and natural phenomena, such as earthquakes, the court concluded that questions of fact remained as to whether the movement of earth that damaged the policyholder's house was caused by the actions of third parties. The court reasoned that the earth movement exclusion was created by insurance companies

> ... to relieve the insurer from occasional major disasters which are almost impossible to predict and thus to insure against. There are earthquakes or floods which cause a major catastrophe and wreak damage to everyone in a large area rather than one individual policyholder. When such happens, the very basis upon which insurance companies operate is said to be destroyed. When damage is so widespread no longer can insurance companies spread the risk and offset a few or the average percentage of losses by many premiums. Looking at the special exclusionary clause in the policy here in question, it seems to cover situations where one single event could adversely affect a large number of policyholders.... All of these are phenomena likely to affect great numbers of people when they occur.
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> This gives some force to the view that the various exclusions were not intended to cover the situation as here where "earth movement" occurred under a single dwelling, allegedly due to human action of third persons in the immediate vicinity of the damage.

304 F.Supp. at 783. We believe that similar reasoning underlies the exclusions in this case.

Examining the exclusionary terms used by Allstate and State Farm in their context, and applying the rule that ambiguities must be resolved in favor of the insured, we conclude that both earth movement exclusions must be read to refer only to phenomena resulting from natural, rather than man-made, forces.

[17] Therefore, when an earth movement exclusion in an insurance policy contains terms not otherwise defined in the policy, and the terms of the exclusion relate to natural events (such as earthquakes or volcanic eruptions), which events, in some instances, may also be attributed to a combination of natural and man-made causes (such as landslides, subsidence or erosion), the terms of the exclusion must be read together and limited to exclude naturally-occurring events rather than man-made events.

The second approach consistently taken by courts in construing insurance policies is that for coverage to exist under an insurance policy, policyholders are required to prove that the efficient proximate cause of the loss was an insured risk.[7] For example, in *Huntington, Ashland & Big Sandy Transportation Co. v. Western Assur. Co. of Toronto, Ont.*, 61 W.Va. 324, 57 S.E. 140 (1907), an insurance policy on the policyholder's steamboat excluded coverage for "loss, damage or expense resulting from stranding or grounding, unless caused by stress of weather." The evidence suggested that heavy, gusting winds caused the steamboat to run aground. This Court held that high wind was a "stress of weather," and whether wind was a proximate cause of the loss was a question of fact for the jury. 61 W.Va. at 325–26, 57 S.E. at 140. The Court sustained a jury verdict for the policyholder.

Another example is *LaBris v. Western National Ins. Co.*, 133 W.Va. 731, 59 S.E.2d 236 (1950), where a policyholder sought to recover for the collapse of the roof of a tire repair shop under a policy insuring against "direct loss by windstorm." We stated that in order for a policyholder to recover under such a policy, "wind must be an efficient cause of the loss, and the qualifying word 'direct' in referring to the cause of the loss means 'proximate or immediate.'" 133 W.Va. at

7. As one court indicated, the efficient proximate cause rule is "a rule of construction because certain consequences follow from the terms of the contract and from a legal policy applicable to the situation. Insurers cannot circumvent the rule by redefining causation." *Sunbreaker Condominium Association v. Travelers Ins. Co.*, 79 Wash.App. 368, 375 n. 8, 901 P.2d 1079, 1082 n. 8 (1995) (citations omitted).

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739, 59 S.E.2d at 240. We stated in Syllabus Point 2 that "it must be established by a preponderance of the evidence that a windstorm of itself was sufficient to, and did cause the alleged damage to the property insured, though there may be other contributing causes." We concluded that there was no coverage for the policyholder because the evidence showed that the roof collapse was caused by water accumulating on the roof, and not wind. *In accord, Lewis v. St. Paul Fire & Marine Ins. Co.*, 155 W.Va. 178, 182 S.E.2d 44 (1971) (no coverage because policyholder failed to prove damage to building was a "direct loss by windstorm").

The scope of coverage under an all-risk homeowner's policy includes all risks except those risks specifically excluded by the policy. A majority of jurisdictions use the "efficient proximate cause" doctrine[8] in adjudicating coverage issues for all-risk insurance policies, where both a covered and a non-covered peril contribute to a loss.[9] When a loss is caused by a combination of covered and specifically excluded risks, the loss is covered if the covered risk was the proximate cause of the loss. Two leading treatises support this position. According to *Couch on Insurance:*

> In determining cause of loss for purposes of fixing insurance liability, if there is evidence of concurrent causes for the damage, the "proximate cause" to which the loss is to be attributed is the dominant, efficient one that sets the other causes in operation; causes which are incidental are not proximate, even though they may be nearer the loss in both time and place. Where it is said that the cause to be sought is the direct and proximate cause, it is not meant that the cause or agency which is nearest in point of time or place to the result is necessarily to be chosen, since there may be a dominant cause even though concurrent or remote in point of time or place.

L. Russ, 7 *Couch on Insurance 3d* § 101:44 (1997). Similarly, Professor Appleman's treatise states that "where the insured risk was the last step in the chain of causation set in motion by an uninsured peril, or where the insured risk itself set into operation a chain of causation in which the last step may have been an excepted risk," recovery may be allowed. J. Appleman, 5 *Insurance Law and Practice* § 3083 (1969).[10]

8. Courts use varying terms such as "proximate cause," "efficient proximate cause," "efficient cause," "predominant cause" or "moving cause." As one court grappling with the meaning of the efficient proximate cause doctrine noted,

> Regardless of the name of the doctrine or number of adjectives within it, the law requires a decision as to what event will be held accountable as *the cause* of the loss ... Given the weight of authority, [and] the similarity if not identicalness of efficient proximate cause to proximate cause ... the Court finds that the predominating cause of the loss is the appropriate standard.

Pioneer Chlor Alkali Co., Inc., v. National Union F... Co. of Pittsburgh, Pa., 863 F.Supp. 1226, 12... (D.Nev.1994). The court went on to say in a footnote that:

> Although perhaps containing an unnecessary adjective, and not at all making the doctrine more clear, the Court will use the majority term "efficient proximate cause." To invent a new term would only add to the confusion in this legal nebula where case precedents filled with the legal jargon of efficient proximate cause offer little guidance in the doctrine's application and result.

Id., n. 6. We believe this reasoning is equally applicable to the instant case.

9. By one commentator's count, 34 jurisdictions (including West Virginia in *LaBris v. Western National Ins. Co.*, 133 W.Va. 731, 59 S.E.2d 236 (1950)) have adopted some form of concurrent or proximate cause analysis in examining coverage under first-party and/or third-party insurance policies. *See* F. MacLaughlin, *Third-Party Liability Policies: The Concurrent Causation Doctrine and Pollution Exclusions*, 24 Brief 20, 22–23 (1995).

10. A current revision to Appleman holds similarly:

> Various problems occur where there is dual, concurring or intervening causation leading to the loss of claim for which coverage is sought. In such a situation, the reasonable expectations of the insured should be considered and upheld which usually means that coverage will be found.... [T]he court may utilize the rule that the efficient proximate cause rule permits a recovery under the policy where the loss occurs due to a loss from a covered peril which also sets into motion a chain of events occurring in an unbroken sequence culminating in damage from an excluded peril.

E. Holmes, 2 *Appleman on Insurance 2d* § 6.2 (1996).

[18, 19] We hold that, when examining whether coverage exists for a loss under a first-party insurance policy when the loss is caused by a combination of covered and specifically excluded risks, the loss is covered if the covered risk was the efficient proximate cause of the loss. No coverage exists for a loss if the covered risk was only a remote cause of the loss, or conversely, if the excluded risk was the efficient proximate cause of the loss. The efficient proximate cause is the risk that sets others in motion. It is not necessarily the last act in a chain of events, nor is it the triggering cause. The efficient proximate cause doctrine looks to the quality of the links in the chain of causation. The efficient proximate cause is the predominating cause of the loss.[11]

[20] One more point is made clear by courts considering the problem of concurrent risks: the question of which event was the efficient proximate cause of the loss is generally a question of fact. *State Farm Fire & Cas. Co. v. Von Der Lieth*, 54 Cal.3d 1123, 1131, 2 Cal.Rptr.2d 183, 188–89, 820 P.2d 285, 290–91 (1991).

[21] After reviewing the record, we conclude that substantial questions of material fact remain for jury resolution. The earth movement exclusions apply to exclude naturally occurring risks. The plaintiffs argue that the evidence currently in the record suggests that the rocks fell from the quarry highwall due to its negligent vertical con-

11. An example of the efficient proximate cause doctrine in action is *Frontis v. Milwaukee Ins. Co.*, 156 Conn. 492, 242 A.2d 749 (1968). The policyholder owned the Frontis building, a four-story building sharing a common wall with an adjoining building. A fire in the adjoining building destroyed the building, requiring its demolition and removal. The only fire damage caused to the Frontis building was a broken window. However, without the lateral support of the adjoining building, the shared common wall could no longer support the Frontis building, requiring the removal of the third and fourth floors of the Frontis building.

The court in *Frontis* was asked to address whether the removal of the top two floors of the Frontis building was a "direct loss by fire" within the meaning of an insurance policy. The court concluded that the loss was covered, holding that a fire can be the proximate, dominant, active and efficient cause of a loss even if the fire starts outside the insured premises and never extends to them in the form of combustion. 156 Conn. at 497, 242 A.2d at 752.

Another example is *Brian Chuchua's Jeep, Inc. v. Farmers Ins. Group*, 10 Cal.App.4th 1579, 13 Cal.Rptr.2d 444 (1992). The policyholder purchased earthquake insurance. An earthquake damaged an underground gasoline tank, and leaking gasoline damaged the soil. The insurance carrier refused coverage for the gasoline clean-up costs citing a pollution exclusion. The court determined that because the risk of earthquake was insured against, if "the trier of fact determines the earthquake was the efficient proximate cause of the leakage, the cleanup expenses will be covered." 10 Cal.App.4th at 1583, 13 Cal.Rptr.2d at 446. Insurance companies sought to have *Brian Chuchua's Jeep* "depublished" by the California Supreme Court arguing its publication would compromise their pollution exclusions because it "mandates an analysis of whether, despite the exclusion, the cause of the loss is covered." The Court refused to depublish the opinion. *See Third-Party Liability Policies: The Concurrent Causation Doctrine and Pollution Exclusions*, 24 Brief 20, 43 (1995).

For other examples, *see Pioneer Chlor Alkali Co., Inc., v. National Union Fire Ins. Co. of Pittsburgh, Pa.*, 863 F.Supp. 1226 (D.Nev.1994) (rag negligently left in pipeline diverted flow of brine; brine concentrated in pipes corroding small holes; brine then mixed with chlorine creating acidic solution that corroded main pipelines, causing release of chlorine gas; insurance company refused coverage citing exclusion for losses caused by "corrosion;" district court ruled that jury question existed over whether rag or corrosion was the efficient proximate cause of loss); *State Farm Fire & Cas. Co. v. Von Der Lieth*, 54 Cal.3d 1123, 2 Cal.Rptr.2d 183, 820 P.2d 285 (1991) (policyholder alleged that third-party negligence by the state, county, developer and homeowners' association proximately caused landslide that damaged home; insurance carrier refused coverage under "earth movement" and "water damage" exclusions; court held that issue of whether third-party negligence was the efficient proximate cause of the loss was jury question); *Wallach v. Rosenberg*, 527 So.2d 1386 (Fla.App. 1988) (next-door-neighbor failed to maintain sea wall and it collapsed during storm; collapse caused policyholder's sea wall to collapse; insurance carrier denied coverage under exclusion for "earth movement" or "water damage;" court held that jury question was created whether neighbor's negligence, a covered event, was the efficient proximate cause of the loss); and *Vormelker v. Oleksinski*, 40 Mich.App. 618, 199 N.W.2d 287 (1972) (contractor disregarded engineer's report that soil was unstable and built policyholder's house on soil; soil shifted and house damaged, and insurance carrier denied claim citing earth movement exclusion; court held that jury was properly instructed that if earth movement was the sole proximate cause of the collapse, it should return a verdict for defendants).

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struction in the 1950's, and its negligent maintenance by the current owner. These risks facially appear to be covered by the language in both policies. Conversely, the defendants argue that the plaintiffs' losses are the result of the excluded event of a landslide caused by another excluded event, erosion. We believe that whichever of these events was the efficient proximate cause of the plaintiffs' losses is a question for the finder of fact.

C.

State Farm's Lead–In Clause

[22] State Farm contends in its reply brief that a "lead-in" clause in the "Losses Not Insured" section of its policy precludes coverage to plaintiffs Murray and Rees, and excludes coverage for all forms of earth movement, regardless of whether resulting from natural or man-made causes. The State Farm lead-in clause states:

> SECTION I—LOSSES NOT INSURED
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> * * *
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> 2. We do not insure under any coverage for any loss which would not have occurred in the absence of one or more of the following excluded events. We do not insure for such loss regardless of: (a) the cause of the excluded event; or (b) other causes of the loss; or (c) whether other causes acted concurrently or in any sequence with the excluded event to produce the loss; or (d) whether the event occurs suddenly or gradually, involves isolated or widespread damage, arises from natural or external forces, or occurs as a result of any combination of these:

The policy then goes on to list numerous occurrences that are excluded, including the previously discussed "earth movement."

State Farm uses unique language in the "Losses Not Insured" section of its policy (which includes the earth movement exclusion), language not employed by other insurance companies in standard all-risk insurance policies. As one court recently recognized in construing an earth movement exclusion,

> ... State Farm adopted language peculiar to itself, and one of plaintiffs' [insurance] experts describes State Farm as a "deviated company" which employs its own language and is "known in the industry as ones who try to push earth movement as broadly as they can."

Winters v. Charter Oak Fire Ins. Co., 4 F.Supp.2d 1288, 1292 (D.N.M.1998).

The court in *Cox v. State Farm Fire & Cas. Co.*, 217 Ga.App. 796, 459 S.E.2d 446 (1995) considered State Farm policy language nearly identical to that at hand and held the lead-in clause to be ambiguous. The policyholders in *Cox* alleged that their home had been damaged by vibrations from explosions, and that explosions were a covered peril under their homeowner's policy. As in this case, State Farm in that case denied coverage under the earth movement exclusion, and argued that man-made earth movement was excluded by the lead-in clause which expanded the exclusion to cover "natural or external forces." The court stated that:

> Because "external" is not defined in the policy, ... we must give the word its usual and common meaning. As we have found no definition of the word that means anything other than apart, beyond, exterior or connected to the outside (see Webster's Third New International Dictionary), we cannot define the word to include a concept of non-natural or man-made forces as State Farm would have us do. Therefore, we must interpret this provision as excluding coverage arising from natural forces from beyond or outside the property.

217 Ga.App. at 797, 459 S.E.2d at 448 (citation omitted).

We believe a similar analysis applies here. The policy language at issue in this case does not define the term "external," and we must therefore give the word its "plain, ordinary meaning." We can find no definition for "external" that means anything other than outside, apart, or beyond, and we cannot define the word to include man-made forces as State Farm would have us do. As with the court in *Cox*, we interpret the provision as excluding from coverage natural risks arising from beyond or outside the property.

[23] State Farm also argues that its lead-in clause operates to defeat the efficient proximate cause doctrine, and argues that if earth movement in any way contributes to a loss, regardless of the proximate cause, then under the lead-in clause the entire loss is excluded from coverage under the all-risk policy. The plaintiffs, however, argue that such a construction reaches a result contrary to the reasonable expectations of policyholders. We agree with the plaintiffs' argument.

[24, 25] "With respect to insurance contracts, the doctrine of reasonable expectations is that the objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations." Syllabus Point 8, *National Mut. Ins. Co. v. McMahon & Sons, Inc.*, 177 W.Va. 734, 356 S.E.2d 488 (1987).[12]

As in the instant case, where third-party negligence is alleged to be the proximate cause of a loss, we believe a policyholder could reasonably expect to be covered under State Farm's policy. Only through a painstaking review of the lengthy "Losses Not Included" section would a policyholder discover the language suggesting that, because the negligence occurred in conjunction with an excluded event, the loss would not be covered. "Insureds with all-risks insurance likely have heightened expectations because of the comprehensive nature of the coverage and the greater premium rates. These expectations would not often be given effect if recovery was denied whenever an exception or exclusion contributed to the loss." R. Fierce, *Insurance Law—Concurrent Causation: Examination of Alternative Approaches*, 1985 S.Ill.U.L.J. 527, 544 (1986).

An example of the overbreadth of State Farm's position was suggested by the court in *Wyatt v. Northwestern Mut. Ins. Co. of Seattle*, 304 F.Supp. at 783, which stated:

> It seems hard to contend that the insurance policy meant to exclude all earth movements, for it is difficult to distinguish between a situation where a piece of heavy equipment breaks loose and hits a house causing serious damage and a situation where that equipment instead hits only an embankment next to a house but causes the earth to move and thereby damages the house. Certainly not all earth movements, or at least those where some human action causes such are included in the exclusion.

However, applying State Farm's interpretation of its policy to the fact pattern proffered by the court in *Wyatt*, there would be no coverage. We believe such an interpretation clearly goes against the reasonable expectations of the parties.

We agree with the court's statement in *Howell v. State Farm Fire & Cas. Co.*, 218 Cal.App.3d 1446, 267 Cal.Rptr. 708 (1st Dist. 1990), that:

> Indeed, if we were to give full effect to the State Farm policy language excluding coverage whenever an excluded peril is a contributing or aggravating factor in the loss, we would be giving insurance companies carte blanche to deny coverage in nearly all cases. A similar point was made by the Supreme Court in *Garvey* [*v. State Farm Fire & Cas. Co.*, 48 Cal.3d 395, 408, 257 Cal.Rptr. 292, 299, 770 P.2d 704, 711]. There, the court noted that the *insured* cannot be permitted to claim coverage merely because an included peril is a contributing cause of a loss. The court reasoned that since "[i]n most instances, the insured can point to some arguably covered contributing factor" such a rule would transform an "'all-risk'" policy into an "'all-loss'" policy, and would make the insurer liable in almost every case.

The present case presents the inverse situation. Here, the State Farm policies would deny coverage whenever an *excluded* peril is a contributing factor to the loss. Since, in most instances, an insurer can point to some arguably excluded contributing factor, this rule would effectively trans-

12. "Before the doctrine of reasonable expectations is applicable to an insurance contract, there must be an ambiguity regarding the terms of that contract." Syllabus Point 2, *Robertson v. Fowler*, 197 W.Va. 116, 475 S.E.2d 116 (1996). As noted previously, the policy language at issue in the State Farm policy is subject to several interpretations, and is therefore ambiguous.

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R. Fierce, *Insurance Law—
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form an "all-risk" policy into a "no-risk" policy.

218 Cal.App.3d at 1456–57 n. 6, 267 Cal.Rptr. at 715 n. 6 (citation omitted).

A statement in a concurring opinion to *Howell* makes clear how State Farm's interpretation of the lead-in clause goes against the reasonable expectations of policyholders. Justice Barry–Deal stated that "[n]o reasonable person would pay for insurance against some future peril if it were possible for the insurer to avoid liability by discovering an excluded peril somewhere in the chain of causation.... [W]here an insurer chooses to insure against the direct and proximate results of a certain peril, it may not rely on the concurrence of an excluded cause to deny coverage." 218 Cal.App.3d at 1476, 267 Cal. Rptr. at 728–29.[13]

Our examination of the State Farm lead-in clause leads us to a similar conclusion. As indicated previously, when an insurance carrier chooses to insure against a loss proximately caused by a particular peril, it may not rely on the mere concurrence of an excluded peril to deny coverage. The excluded peril must itself be the efficient proximate cause of the loss. Because State Farm's lead-in clause conflicts with the reasonable expectations of the parties, it should be construed to allow coverage for losses proximately caused by a covered risk, and deny coverage only when an excepted risk is the efficient proximate cause of the loss.[14]

13. Another commentator reviewing similar State Farm policy language stated:

> This [lead-in] clause, applied at face value, would clearly negate coverage in case of a concurring excepted cause. The clause may clear up any ambiguities in the minds of insurance counsel, but whether it would do so for the insurance consumer is questionable. Indeed, whether such a clause would actually be read by the insurance consumer is questionable. The change should have little impact on the objectively reasonable expectations of the insurance consumer. If anything, the clause is more confusing to the layman than was the old "contributed to, or aggravated by" exception.
>
> Many courts allow recovery when an excepted cause acts concurrently with a covered cause despite increasingly explicit exclusionary language. This trend seems likely to continue regardless of the insurance industry's persistent efforts to refine their policies. Courts appear to look at the exclusionary language only to determine which causes or events are covered and which are not, and pay little attention to surplus verbiage. This approach is most likely explained as a *sub silentio* application of the doctrine of reasonable expectations.

R. Fierce, *Insurance Law—Concurrent Causation: Examination of Alternative Approaches*, 1985 S.Ill.U.L.J. 527, 538 (1986).

14. We acknowledge that jurisdictions are in conflict over the effect of the State Farm lead-in clause in landslide cases. At least two jurisdictions hold the clause has no effect on limiting coverage: California (*Howell v. State Farm Fire & Cas. Co.*, 218 Cal.App.3d 1446, 267 Cal.Rptr. 708 (1st Dist.1990)); and Georgia (*Cox v. State Farm Fire & Cas. Co.*, 217 Ga.App. 796, 459 S.E.2d 446 (1995)). At least five jurisdictions hold that the lead-in clause is enforceable: Alaska (*State Farm Fire & Cas. Co. v. Bongen*, 925 P.2d 1042 (Alaska 1996)); New York (*Kula v. State Farm Fire & Cas. Co.*, 212 A.D.2d 16, 628 N.Y.S.2d 988 (N.Y.A.D.1995)); Utah (*Alf v. State Farm Fire & Cas. Co.*, 850 P.2d 1272 (Utah 1993) and *Village Inn Apartments v. State Farm Fire & Cas. Co.*, 790 P.2d 581 (Utah App.1990)); Nevada (*Schroeder v. State Farm Fire & Cas. Co.*, 770 F.Supp. 558 (D.Nev.1991)); and Arizona (*Millar v. State Farm Fire & Cas. Co.*, 167 Ariz. 93, 804 P.2d 822 (1990)).

> We question the holdings of these latter jurisdictions, as they found the earth movement policy language to be unambiguous and clear, and suggested that the policyholder's reasonable expectations were more in line with being a "fervent hope usually engendered by loss." *Millar*, 167 Ariz. at 97, 804 P.2d at 826. These latter jurisdictions also suggest that the policyholder and insurance company freely negotiated and defined the scope of coverage, and intended to exclude the efficient proximate cause doctrine. Such a position is contrary to the position we have taken in our case law that "[i]nsurance contracts are notoriously complex ... and border on the status of contracts of adhesion. Under this view the insured and insurer do not stand in *pari causa*, and therefore, the insured's assent to the agreement lacks completeness in relation to that of the insurer." *Bell v. State Farm Mut. Auto. Ins. Co.*, 157 W.Va. 623, 628–29, 207 S.E.2d 147, 150–151 (1974) (citations omitted). As we said in *National Mut. Ins. Co. v. McMahon & Sons, Inc.*, 177 W.Va. 734, 741–42 n. 6, 356 S.E.2d 488, 495–96 n. 6 (1987):
>
> > While this rule may equitably be enforced with regard to a contract negotiated at arm's length between parties of reasonably equivalent bargaining power and signed by each, it would be unfair to apply the general rule in the case of the modern insurance contract. These policies are contracts of adhesion, offered on a take-it-or-leave-it basis, often sight unseen until the premium is paid and accepted, full of complicated, almost mystical, language. "It is generally recognized the insured will not read the detailed, cross-referenced, standardized, mass-

D.

Whether the Plaintiffs Suffered a "Direct Physical Loss" To Their Property

[26] As indicated previously, the Allstate policy provides coverage for any "sudden and accidental loss to the property," while the State Farm policy "insure[s] for accidental direct physical loss to the property[.]" Defendants Allstate and State Farm do not dispute the fact that the plaintiffs' losses were "sudden" and "accidental." Instead, the defendants argue that as a matter of law the insurance carriers cannot be held responsible for the total loss of the plaintiffs' property. The defendants essentially contend that while their policies might cover the actual physical damage to the Murray and Withrow homes, the policies do not cover any losses occasioned by the potential damage that could be caused by future rockfalls.

The appellants cite us to only one case in support of their argument, *Hoffman v. State Farm Fire & Cas. Co.*, 16 Cal.App.4th 184, 19 Cal.Rptr.2d 809 (2nd Dist.1993), and we believe that case is factually and legally inapplicable here.

In *Hoffman*, the court held that policyholders were not entitled to recover under an all-risk homeowner's policy when the damage became apparent over a year *after* the policyholders sold their home, canceled the policy and moved out. The policyholders contended that, a year after they moved out of their home, they discovered an entire region surrounding their former home was subjected to a massive, slow-moving landslide, and that their former home suffered some structural damage. The policyholders contended that they were entitled to recover for the damage to their former home, and to recover for the "just discovered" diminished market value of the property when it was sold. The court stated, in *dicta*, that "[d]iminution in market value is not a covered peril. In fact, insuring land values is illegal in California, and doing so is a felony misdemeanor." 16 Cal.App.4th at 190, 19 Cal.Rptr.2d at 812 (citations omitted).

Hoffman fails to mention four other California cases where the courts held policyholders *could* recover for losses to their homes other than tangible physical damage caused by landslides. *See Strickland v. Federal Ins. Co.*, 200 Cal.App.3d 792, 246 Cal. Rptr. 345 (2nd Dist.1988); *Snapp v. State Farm Fire & Cas. Co.*, 206 Cal.App.2d 827, 24 Cal.Rptr. 44 (2nd Dist.1962); *Hughes v. Potomac Ins. Co.*, 199 Cal.App.2d 239, 18 Cal.Rptr. 650 (1st Dist.1962); and *Pfeiffer v. General Ins. Corp.*, 185 F.Supp. 605 (N.D.Cal.1960). In each case, the cosmetic damage to the policyholders' homes was relatively minor, while the cost of making the home inhabitable usually exceeded the policy limits. In each case, the insurance company refused coverage, and in each case the court held the insurance company liable for the total cost of making the property liveable.

For instance, in *Hughes, supra*, the policyholders awoke one morning to discover 30 feet of their backyard had washed into a creek, leaving their home standing on the edge of a newly-formed 30-foot cliff. The landslide deprived the house of subjacent and lateral support essential to the stability of the house. An insurance adjuster concluded that the house sustained only $50.00 in damage, but that the cost of a retaining wall and fill to support the dwelling was $19,000.00. The insurance carrier denied coverage contending its policy only insured the physical damage to the dwelling. The court rejected this argument and found the appellant insurance carrier liable for the entire loss to the use of the property. The court stated:

> To accept appellant's interpretation of its policy would be to conclude that a building which has been overturned or which has been placed in such a position as to overhang a steep cliff has not been "damaged" so long as its paint remains intact and its

produced insurance form, nor understand it if he does." *C & J Fertilizer, Inc. v. Allied Mutual Insurance Co.*, 227 N.W.2d 169, 174 (Iowa 1975); *accord*, 3 *Corbin on Contracts* § 559 (1960); Keeton, [*Insurance Law Rights at Variance with Policy Provisions,*] 83 Harv.L.Rev. [961] at 968 [1970]. The majority rule is that the insured is not presumed to know the contents of an adhesion-type insurance policy delivered to him, 7 *Williston on Contracts* § 906 B (1963), and we hereby adopt the majority view.

We therefore decline to follow these latter jurisdictions.

MURRAY

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e decline to follow these latter juris-

walls still adhere to one another. Despite the fact that a "dwelling building" might be rendered completely useless to its owners, appellant would deny that any loss or damage had occurred unless some tangible injury to the physical structure itself could be detected. Common sense requires that a policy should not be so interpreted in the absence of a provision specifically limiting coverage in this manner. Respondents correctly point out that a "dwelling" or "dwelling building" connotes a place fit for occupancy, a safe place in which to dwell or live. It goes without question that respondents' "dwelling building" suffered real and severe damage when the soil beneath it slid away and left it overhanging a 30–foot cliff. Until such damage was repaired and the land beneath the building stabilized, the structure could scarcely be considered a "dwelling building" in the sense that rational persons would be content to reside there.

199 Cal.App.2d at 248–49, 18 Cal.Rptr. at 655.

We believe similar reasoning is applicable to the case at hand. The policies in question provide coverage against "sudden and accidental loss" and "accidental direct physical loss" to property. "'Direct physical loss' provisions require only that a covered property be injured, not destroyed. Direct physical loss also may exist in the absence of structural damage to the insured property." *Sentinel Management Co. v. New Hampshire Ins. Co.*, 563 N.W.2d 296, 300 (Minn. App.1997) (citations omitted).

The properties insured by Allstate and State Farm in this case were homes, buildings normally thought of as a safe place in which to dwell or live. It seems undisputed from the record that on February 22, 1994 all three of the plaintiffs' homes became unsafe for habitation, and therefore suffered real damage when it became clear that rocks and boulders could come crashing down at any time. The record suggests that until the highwall on defendant Harris' property is stabilized, the plaintiffs' houses could scarcely be considered "homes" in the sense that rational persons would be content to reside there.[15]

We therefore hold that an insurance policy provision providing coverage for a "sudden and accidental loss" or an "accidental direct physical loss" to insured property requires only that the property be damaged, not destroyed. Losses covered by the policy, including those rendering the insured property unusable or uninhabitable, may exist in the absence of structural damage to the insured property.

IV.

Conclusion

We reverse the circuit court's summary judgment ruling that found as a matter of law that coverage existed under the Allstate and State Farm policies. Because we find substantial questions of material fact in the record concerning the existence of coverage, we remand the case for further proceedings to determine whether the plaintiffs sustained a loss, and whether that loss was proximately caused by the covered risk of third-party negligence, or proximately caused by the excluded natural events of a landslide or erosion.

Reversed and remanded.

Appendix A

Cases Construing Earth Movement Exclusions

A. Jurisdictions holding that earth movement exclusions are ambiguous, and limited in application only to naturally-occurring catastrophic events include: *Winters v. Charter Oak Fire Ins. Co.*, 4 F.Supp.2d 1288 (D.N.M. 1998) (water line broke in policyholder's clubhouse, causing soil beneath clubhouse to shift and damaging building; court held that cov-

15. *See, e.g., Sentinel Management Co. v. New Hampshire Ins. Co.*, 563 N.W.2d 296 (Minn.App. 1997) (contamination of apartment building by release of asbestos fibers constituted direct, physical loss to property under all-risk policy); *Farmers Ins. Co. of Oregon v. Trutanich*, 123 Or.App. 6, 858 P.2d 1332 (1993) (landlord-policyholder's house contaminated by odors from methamphetamine lab run by subtenant in basement; cost of removing odors was a direct physical loss under policy); *Western Fire Ins. Co. v. First Presbyterian Church*, 165 Colo. 34, 437 P.2d 52 (Colo.1968) (policyholder-church, which was rendered unusable due to saturation of soil under and around church with gasoline, sustained a direct physical loss under policy).

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Via Hand-Delivery
February 29, 2000

Senator Jerry Mackie
Capital Building, Room 427
Juneau, Alaska
Chairman of Senate Labor & Commerce Committee

Re: SB177

Dear Senator Mackie:

I am writing to you on behalf of State Farm regarding SB177. At the outset, I would like to give you some brief background information on State Farm's role in the Alaska marketplace. In 1998, State Farm had approximately 27.7 percent of the automobile insurance market. State Farm Fire and Casualty Company had approximately 40.4 percent of the homeowner insurance market. In 1998, State Farm Mutual returned $6.2 million dollars to Alaska consumers. In 1997, State Farm Mutual returned $6.6 million dollars to Alaska consumers.

In 1998, State Farm had approximately 38,095 auto claims in Alaska and of those claims, State Farm paid approximately 30,635. State Farm had approximately 7,300 homeowner claims and paid approximately 5,050 of those claims.

As you know, not every claim presented is a valid claim. Virtually every claim presents the opportunity for the exercise of judgment. Certainly every denial presents the opportunity for disagreement and ultimately a complaint to the Division. According to the Division of Insurance statistics, the Division received 52 complaints for State Farm in calender year 1997 and 43 complaints for State Farm in calendar year 1998. Since the Division only reports the number of complaints received, we unable to determine how many of these complaints the Division found to have merit. Nonetheless, the number of consumers unsatisfied enough to make a complaint remains incredibly low.

SB177 addresses the subject of claim settlement practices, a subject State Farm has great interest in given the number of claims it handles every year. While we have spoken to the Director of the Division of Insurance and Senator Donley's staff, the messages we have received are conflicting and we remain unclear as to exactly what problems justify this proposed legislation and what exactly it is intended to achieve. We will summarize our concerns below.

1. Is There A Need For This Legislation?

At the outset, we are wondering what the need is for this legislation. The number of complaints handled by the Division do not appear to be increasing. While we do not know how many of the complaints the Division receives are ultimately found to have merit, the number of complaints over the last 2 years has been stable, despite a very public television campaign by the previous Director requesting those with complaints to make them.

Nor has there been testimony indicating that the type of complaint received by the Division justifies the proposed changes. We are not aware of any kind of a trend showing an increase in complaints by third party claimants. Nor are we aware of specific examples of conduct that the Director cannot reach under the statutory scheme currently in place.

We simply have not seen any evidence which indicates a need, based on what is happening in current claims practice, to support these changes. There certainly does not appear to be such a need based on the number of complaints being made with the Division.

2. The History of Alaska's Unfair Claims Settlement Act

Alaska's version of the Unfair Claims Settlement Act was introduced at the request of Governor Hammond in 1976. At the outset, two comments about the intent of Governor Hammond are important. First, he intended that the Director have the power to address both acts as well as practices. Second, Governor Hammond intended the Act to be regulatory in nature. He did not intend to create new private causes of action through this Act.

Governor Hammond's legislation was modeled after the 1971 National Association of Insurance Commissioner's Model Act. There has been a great deal of debate before your Committee regarding power of the Director of Insurance under the Act. Governor Hammond's January 14, 1976 letter to the Speaker of the House best explains his intent: "The bill gives the director of the division of insurance authority to investigate complaints and issue orders requiring persons to stop acts or practices in violation of the chapter." (Emphasis added). Clearly it was Governor Hammond's belief that this legislation allowed the director to address both individual acts as well as practices.

Just as important was Governor Hammond's belief that the Act was intended to be regulatory in nature:

> "This bill is a strong, consumer-oriented measure which gives the director of the division of insurance more power to deal with unfair and deceptive practices than he presently has. The remedies in this bill provide broad relief to the insurance consumer through the insurance director."

(Emphasis added). Attachment 1. Governor Hammond's intent was not to create a new private

cause of action through this Act, but rather to provide relief to the consumer through the insurance director.

3. The Act Itself Provides That The Director Already Has The Power to Investigate and Penalize Individual Acts.

A.S. 21.36.150 by its express terms allows the Director to take action if he believes someone in the insurance business is engaged in "an unfair or deceptive act or practice" (emphasis added). Section 21.36.320 again specifically allows a Director to conduct an investigation to determine whether a person is engaged in an "unfair or deceptive act or practice" . (emphasis added.) 21.36.320(d) then allows the Director to order the person to cease and desist, order restitution and then assess a penalty of "not more than $2,500 for each violation or $25,000 for engaging in a general business practice". Finally, A.S. 21.36.320(e) allows the Director to impose an additional penalty in the event the person charged knew or should have known they were acting in violation of not more than "$25,000 for each violation or $250,000 for engaging in the general business practice."

It is crystal clear that the Director has the authority right now to take action on the basis of an individual act. Otherwise there would be no reason for the legislature to adopt the statutory scheme set forth above which expressly allows the Director to take action for an individual act or to create a different level of penalties for an individual act as opposed to a general business practice.

While we have carefully considered the legal opinion submitted by the Director, that legal opinion flies in the face of the clear and specific authority given to the Director in A.S. 21.36.320 and 21.36.150. Curiously, neither the legal opinion the Director submitted to you or his testimony addresses the very specific authority quoted above. While our new Director has evidently chosen not to utilize this authority, no one can credibly argue that it does not exist.

This very clear and specific authority should be viewed in light of the regulations adopted by the Director under the general authority given to him by A.S.21.36.150(d). For example, 3 AAC 26.010, again sets forth the same general tier of violations, depending upon whether there was a violation of a standard, or a business practice, or whether the violation occurred by someone who knew or should have known. 3 AAC 26.300(6) specifically defines a general business practice to include "violation of one standard committed on one or more percent of claims handled within a twelve month period or the repeated violation of a single standard without reasonable explanation".

There was a great deal of discussion with the Division regarding this language. The Division took the position that while it did not want to punish innocent mistakes, it did want to have a concrete definition of what a general business practice was so it could reach both the insurer with many claims as well as the insurer with only a few claims. For example, the Director expressed concern about small companies that may only write insurance or handle claims in Alaska on an occasional basis. We suggest to you that even if the Director is correct and that the language which gives him authority to take action for a "unfair or deceptive act or practice" under A.S. 21.36.150

and 21.36.320 is insufficient, the Director would clearly have the authority under his own regulations to address the type of situation he seems to be concerned with.

3 AAC 26.300, which was adopted by a previous Director after a great deal of thought and discussion which we were personally involved in, defines "frequency as to indicate a general business practice" as "violation of any one standard committed on one or more percent of claims handled within a twelve month period or the repeated violation of a single standard without reasonable explanation". This negotiated balance was intended to provide a flexible yet meaningful definition as to what a general business practice was and to clarify the expressed intent of previous directors that their concern was not one of an innocent mistake, but of a repeated violation.

The comments regarding the statutory scheme presently in place have been at best confusing. The primary concern has been one of a perceived lack of authority where there is a single "egregious" act. No examples of such a situation were given. We would respectfully submit that in the absence of a clear need to change this statutory scheme, as evidenced by specific examples of improper conduct the Director has been unable to investigate and penalize, there is insufficient reason to change the current statutory scheme.

4. The NAIC Model Unfair Claims Settlement Act.

We have suggested to Senator Donley and the Director that if their true concern is to clarify the power of the Director, they should consider the Model Unfair Claims Settlement Practices Act adopted by the National Association of Insurance Commissioners. (Attachment 2). The Alaska Act is based on the predecessor to the NAIC Model Act. It was introduced at the request of Governor Hammond, who wrote that it was intended to be regulatory in nature.

The NAIC has now updated its Model Act at in effort to recognize the proper balance between the regulator, the insurers and the public. This Model Act on the one hand would address the single act concern, which is what we understand to be the major concern of Senator Donley and the Director. On the other hand, the Model Act would address our major concern, which is to ensure that a new cause of action is not created. The Model Act strikes a balance by allowing administrative action if an act is "committed flagrantly and in conscious disregard of this Act or any rules promulgated hereunder" or if the act is "committed with such frequency to indicate a general business practice." While we believe the Director already has the power to investigate and penalize an "unfair or deceptive act" under the statutory scheme presently in effect in Alaska, if the issue needs clarification we would recommend the language of the Model Act to you. It has never been the purpose of either our Act or the Model Act to penalize a single mistake, but rather to address the more serious or repeated situation.

5. No New Cause of Action Should Be Created.

As set forth above, the Alaska Act was originally intended to be regulatory in nature. It was not intended to create a new private civil cause of action. The NAIC Model Act likewise is not

intended to create a new private cause of action. In fact, the NAIC Model Act emphasizes this intent: "Nothing herein shall be construed to create or imply a private cause of action for violation of this Act."

We remain confused about Senator Donley's intentions in this regard. Clearly Senator Donley's original intent was to create a new private civil cause of action. In Senator Donley's Sponsor Statement, he wrote that one of the purposes of this bill was in fact to create a claim for third party bad faith: "SB 177 expands the prohibition against such bad faith actions to third party claimants". He recently expressed the same intent in a legal publication. Attachment 3.

While Senator Donley indicated to the Committee it was not his intent to create a cause of action for third party bad faith, the proposed Committee Substitute we have received from his office makes this anything but clear. The proposed Committee Substitute states only that Sections (a)(7) and (11) do not create a private cause of action against an insurer by a third-party claimant. Does Senator Donley intend to change the existing law regarding the other sections to create a private civil cause of action for violation in either the first or third-party situation? We are very concerned about anything which could be construed to create a cause of action for violation of the Alaska Act, as we believe such a cause of action would ultimately have dire consequences for Alaska insurance consumers.

The Model Act also makes it very clear that the Act should not "be construed to create or imply a private cause of action for violation". Thus far, violations of the Alaska Act have not been construed to create a private civil cause of action. Changing this language, especially in the manner proposed by Senator Donley, will increase the risk that a single violation will be construed to create such a private civil cause of action. Regardless of what changes you end up making, we strongly encourage the inclusion of language similar to the Model Act to make it clear that nothing contained in the Act is intended to create or imply a private cause of action for its violation.

6. Third Party Claimants Should Not Be The Subject of This Act.

Several sections of the proposed legislation attempts to create a relationship between an insurer and a third party claimant. The NAIC Model Act does not attempt to create such a relationship, we believe for good reason. When a third party is making a claim against an insured, the duty owed by the insurer is to the insured. Likewise, the insured owes duties to the insurer. The insured is the only person an insurer has a contractual relationship with.

Under this proposed legislation, new duties would be created by the insurer to the third party claimant. Such duties may well conflict with the duties owed to the insured. Such duties are also unilateral–no similar duty is owed by the third party claimant to the insurer.

There is no reason for the creation of such duties. The 1997 Tort Reform legislation contained new offer of judgment provisions that penalize any party to litigation for acting irresponsibly. It is both unnecessary and unfair to create a further penalty which would apply only

to one party, but not the other.

7. The Legislature Should Not Mandate a Policy Change.

Section 7 of the proposed Committee Substitute would change existing law on policy provisions no matter how clearly a policy is written. State Farm has long opposed such legislative mandates. It strongly believes the law of free market supply and demand is ultimately the best way of determining what should and should not be covered.

The very issue advanced by Section 7 of this provision was recently before our Supreme Court in the case of State Farm Fire and Casualty Company v Bongen, 925 P.2d 1042 (Alaska 1996). Our Supreme Court there rejected the very policy arguments now being made by the proponents of this provision:

> "We favor the majority rule. It is well established that '[t]he obligations of insurers are generally determined by the terms of their policies.' ('The intention of the parties as to the coverage of a policy is determined by the words which they have used.') We have held that where an insurer 'limits the coverage of a policy issued by it in plain language, this court recognizes the restriction.' We can discern no sound policy reason for preventing the enforcement of the earth movement exclusion to which the parties in this case agreed. We therefore align ourselves with those courts holding that an insurer may expressly preclude coverage when damage to an insured's property is caused by both a covered and an excluded risk."

Bogen, 925 P.2d at 1044 (citations omitted).

The issue is not whether the policy language in question might be used to deny coverage where the excluded peril is an insignificant or trivial part of the loss. It is a well established principle of property insurance law that "remote" causes must be disregarded in determining whether or not a loss is covered. The present exclusion would not even be triggered in those cases in which the excluded peril is only incidentally involved. The exclusion is only triggered when the excluded peril is at least a substantial factor in bringing about the loss.

Aside from the policy reasons which have led most courts and states to reject the approach suggested by Section 7 of this proposed legislation, there are other practical concerns raised. The issue of determining what is "the dominant cause" is in many cases not an easy one. Such determinations are likely to be challenged and thus litigated. Even more important, is that such provisions may actually discourage people from purchasing coverage which would directly cover such risks. For example in California because of a concurrent causation ruling, it was reported that insurers paid out about 70% of the Coalinga earthquake claims even though only a relatively few Coalinga residents carried earthquake coverage.

The Alaska Supreme Court saw no sound reason to not enforce a clear policy provision

which was agreed to by the parties. The Court's reasoning is sound and we hope you will agree with it.

Thank you for the opportunity to comment on this very important legislation.

Sincerely,

LESSMEIER & WINTERS

By: Michael L. Lessmeier
Michael L. Lessmeier

Enclosures: 1/4/76 Letter from Jay S. Hammond
Unfair Claims Settlement Practices Act
Alaska Bar Rag Article

cc: Senator Tim Kelly
Senator Donley
Senator Hoffman
Senator Leman

MLL:wmg
0015-006/Mackie-MLL-02-04-00.wpd

HB 558 HOUSE BILL NO. 558 by the Rules Committee by request of the Governor, entitled:

"An Act relating to the regulation of insurance practices."

was introduced, read the first time and referred to the Committees on Commerce and Judiciary.

"January 14, 1976

The Honorable Mike Bradner
Speaker of the House
Alaska State Legislature
Juneau, Alaska 99811

Dear Mr. Speaker:

In accordance with AS 24.30.060(b) and the Uniform Rules of the Alaska State Legislature, I am transmitting a bill to revise the insurance trade practices and frauds statute (AS 21.36) and other insurance regulatory provisions.

This bill substantially conforms to segments of the "Model Unfair Trade Practices Act" proposed by the National Association of Insurance Commissioners in 1971.

Although complete understanding of the effectiveness and potential of that model Act, as modified in this bill, requires a careful reading, the following summary of some of the areas with which the bill deals may be helpful.

The bill clarifies and expands the defined unfair trade practices by persons and explicitly includes health care service contractors in the definition of person for purposes of the bill. The bill also defines prohibited unfair claim settlement practices. Insurer claims practices have long been an object of criticism and concern. However, this bill establishes the necessary standards of unfair claim practices by which insurers and regulators may be guided.

The bill gives the director of the division of insurance authority to investigate complaints and issue orders requiring persons to stop acts or practices in violation of the chapter. Once an order is issued, the bill provides that the director may also order a penalty of as much as $10,000 for each violation of the chapter and suspend or revoke the violator's license. In addition, the bill gives the director authority to seek injunctive relief to aid in the enforcement of the chapter.

This bill is a strong, consumer-oriented measure which gives the director of the division of insurance more power to deal with unfair and deceptive practices than he presently has. The remedies in this bill provide broad relief to the insurance consumer through the insurance director.

Sincerely,

[signature]

Jay S. Hammond
Governor"

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Sincerely,

Jay S. Hammond
Governor"

UNFAIR CLAIMS SETTLEMENT PRACTICES ACT

Table of Contents

Prefatory Note: By adopting this model act in June 1990, the NAIC separated issues regarding unfair claims settlement practices into a free-standing act apart from the NAIC Model Unfair Trade Practices Act. This change focuses more attention on unfair claims as a function of market conduct surveillance separate and apart from general unfair trade practices. By doing so, the NAIC is not recommending that states repeal their existing acts, but states may modify them for the purpose of capturing the substantive changes. However, for those states wishing to completely rewrite their comprehensive approach to unfair claims practices, this separation of unfair claims from unfair trade practices is recommended.

Section 1. Purpose

The purpose of this Act is to set forth standards for the investigation and disposition of claims arising under policies or certificates of insurance issued to residents of [insert state]. It is not intended to cover claims involving workers' compensation, fidelity, suretyship or boiler and machinery insurance. Nothing herein shall be construed to create or imply a private cause of action for violation of this Act.

Drafting Note: A jurisdiction choosing to provide for a private cause of action should consider a different statutory scheme. This Act is inherently inconsistent with a private cause of action. This is merely a clarification of original intent and not indicative of any change of position. The NAIC has promulgated the Unfair Property/Casualty Claims Settlement Practices and the Unfair Life, Accident and Health Claims Settlement Practices Model Regulations pursuant to this Act.

Section 2. Definitions

When used in this Act:

A. "Commissioner" means the Commissioner of Insurance of this state;

Drafting Note: Insert the title of the chief insurance regulatory official wherever the term "commissioner" appears.

B. "Insured" means the party named on a policy or certificate as the individual with legal rights to the benefits provided by the policy;

C. "Insurer" means a person, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, brokers, adjusters and third party administrators. Insurer shall also mean medical service plans, hospital service plans, health maintenance organizations, prepaid limited health care service plans, dental, optometric and other similar health service plans as defined in Section [insert applicable section]. For purposes of this Act, these foregoing entities shall be deemed to be engaged in the business of insurance;

D. "Person" means a natural or artificial entity, including, but not limited to, individuals, partnerships, associations, trusts or corporations;

E. "Policy" or "certificate" means a contract of insurance, indemnity, medical, health or hospital service, or annuity issued. "Policy" or "certificate" for purposes of this Act, shall not mean contracts of workers' compensation, fidelity, suretyship or boiler and machinery insurance.

Drafting Note: The term "policy" is intended to cover the product issued by medical, health or hospital service plans and should be changed to conform to the laws of each state.

The Federal Employee Retirement Income Security Act (ERISA) preempts certain entities and some activities of those entities from the application of state laws. The purpose of these definitions is to include within this Act and regulations issued pursuant to it, all entities and activities to the extent not preempted by ERISA.

Section 3. Unfair Claims Settlement Practices Prohibited

It is an improper claims practice for a domestic, foreign or alien insurer transacting business in this state to commit an act defined in Section 4 of this Act if:

A. It is committed flagrantly and in conscious disregard of this Act or any rules promulgated hereunder; or

B. It has been committed with such frequency to indicate a general business practice to engage in that type of conduct.

Section 4. Unfair Claims Practices Defined

Any of the following acts by an insurer, if committed in violation of Section 3, constitutes an unfair claims practice:

A. Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue;

B. Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;

C. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;

D. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;

E. Compelling insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;

F. Refusing to pay claims without conducting a reasonable investigation;

G. Failing to affirm or deny coverage of claims within a reasonable time after having completed its investigation related to such claim or claims;

H. Attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application;

I. Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured;

J. Making claims payments to an insured or beneficiary without indicating the coverage under which each payment is being made;

K. Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form;

L. Failing in the case of claims denials or offers of compromise settlement to promptly provide a reasonable and accurate explanation of the basis for such actions;

M. Failing to provide forms necessary to present claims within fifteen (15) calendar days of a request with reasonable explanations regarding their use;

N. Failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by or required to be used by the insurer are performed in a workmanlike manner.

Section 5. Statement of Charges

Whenever the commissioner has reasonable cause to believe that an insurer doing business in this state is engaging in any unfair claims practice and that a proceeding in respect thereto would be in the public interest, the commissioner shall issue and serve upon the insurer a statement of the charges in that respect and a notice of hearing, which shall set a hearing date not less than thirty (30) days from the date of the notice.

Drafting Note: If a formal hearing procedure exists, states may wish to incorporate the timeframes from that existing procedure.

Section 6. Cease and Desist and Penalty Orders

If, after hearing, the commissioner finds an insurer has engaged in an unfair claims practice, the commissioner shall reduce the findings to writing and shall issue and cause to be served upon the insurer charged with the violation a copy of the findings and an order requiring the insurer to cease and desist from engaging in the act or practice and the commissioner may, at the commissioner's discretion, order:

A. Payment of a monetary penalty of not more than $1,000 for each violation but not to exceed an aggregate penalty of $100,000, unless the violation was committed flagrantly and in conscious disregard of this Act, in which case the penalty shall not be more than $25,000 for each violation, but not to exceed an aggregate penalty of $250,000 pursuant to hearing; and/or

B. Suspension or revocation of the insurer's license if the insurer knew or reasonably should have known it was in violation of this Act.

Section 7. Penalty for Violation of Cease and Desist Orders

An insurer that violates a cease and desist order of the commissioner and, while the order is in effect, may, after notice and hearing and upon order of the commissioner, be subject, at the discretion of the commissioner, to:

A. A monetary penalty of not more than $25,000 for each and every act or violation not to exceed an aggregate of $250,000 pursuant to hearing; and/or

B. Suspension or revocation of the insurer's license.

Section 8. Regulations

The commissioner may, after notice and hearing, promulgate reasonable rules, regulations and orders as are necessary or proper to carry out and effectuate the provisions of this Act. The regulations shall be subject to review in accordance with Section [insert applicable section].

Drafting Note: Insert section number providing for review of administrative orders.

Section 9. Severability

If any provision of this Act, or the application of the provision to any person or circumstances, shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

Legislative History (all references are to the Proceedings of the NAIC).

1972 Proc. I 15, 16, 443-444, 491, 495-496 (claims settlement practices made part of Unfair Trade Practices Act).
1990 Proc. II 7, 13-14, 160, 177-179 (adopted free-standing claims settlement practices act).
1991 Proc. I 9, 15, 192-193, 203-206 (amended and reprinted).

Bill allows state to investigate insurance practices

By Senator Dave Donley

Last legislative session I introduced Senate Bill 177 "The Alaska Insurance Consumers Protection Act" to give injured Alaskans and insurance consumers a fairer playing field when dealing with insurance companies. The Alaska Division of Insurance supports SB 177.

SB 177 makes a major step toward better consumer protection by allowing the Division of Insurance to investigate individual acts of unfair or deceptive trade practices. Amazingly, under existing law, the division does not have the jurisdiction to investigate individual acts of unfair insurance claims practices. The division is powerless to investigate an individual insurer until a pattern of deceptive trade practices has developed. Such a pattern is often very difficult to prove and can require staffing the division currently does not have. This lack of jurisdiction promotes bad claims practices by insurance companies since they know that there is little enforcement to protect individual injured victims and consumers.

Senate Bill 177 also affords Alaskans more opportunity to pursue fair and equitable claims through arbitration. Many consumers and even insurance agents are sometimes intimidated from pursuing a fair settlement because of fear of retaliation from the insurer. This discourages claimants from pursuing a fair settlement and hinders the consumer protection ability of the Division of Insurance, as they are unable to gain access to information needed to effectively protect consumers. SB 177 provides immunity from liability for defamation for those persons who provide the division with information regarding an unfair act or practice. This provision will better protect both agents and insurance consumers.

At the specific request of the Division of Insurance SB 177 also prohibits insurers from denying a claim in which multiple causes caused the loss to occur and there is a secondary cause that is not covered by the policy. SB 177 ensures that a claim is covered when a loss has more than one cause and the dominant cause is covered by the policy.

Under existing law, third party claimants are not entitled to the same protections as first party claimants. Insurers know this and often will require an injured third party to pay the costs of arbitration or mediation before the process even begins. If the amount at issue is less than the cost of arbitration the insurer can unfairly "low ball" the injured party. Additionally, insurers often use the high cost of litigation, which also may exceed the value of the claim, as leverage in coercing legitimate third party claimants to accept settlements that do not adequately compensate them for their injuries. Under current law such practices are prohibited as to first party claims but not as to third party claims.

SB 177 expands the prohibition against such bad faith actions to third party claimants and affords them a fair arbitration claims process while also curtailing unnecessary litigation. Affording and expanding insurance claims protections to both first and third party claimants is fair, equitable and good public policy.

Injured Alaskans and insurance consumers deserve better protection from insurance company unfair claims practices. We need a Division of Insurance that has the authority necessary to protect consumers. Your support and passage of Senate Bill 177 will help provide just that.

The B-2130 is really small at 8"x pounds, includes a 400 megahert DRAM, and 10.4" TFT screen wit output, an internal 56K modem Ethernet. It is the least expensive s magnesium metal case.

5. Compaq's Armada M300 is a pounds. The Armada M300 costs large 11.3" active matrix screen plus modem, a 4.3 gigabyte hard disk, usual, the CD-ROM drive, which i programs, is an extra cost item.

6. Toshiba's Libretto 110 sub-not It's the smallest Windows 98 notet mostly for light duty work, such as so use. Some people deride the Libretto of st of a CD-ROM driv fc k system. It includes p egabytes DRAM, a 4 T ealistically, that's p any of our readers a

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SUMMARY OF SURVEY RESULTS

The Division of Insurance recently polled all the states on the following questions. The following states responded. This is a very brief paraphrase and summary of the results. Most state laws have some variations and unique features not mentioned here. The relevant statutes and regulations should be consulted.

	"Regarding unfair trade practices, unfair methods and deceptive acts, does your statute prohibit single incidents, or only ongoing patterns and practices?	**Regarding unfair claim settlement practices, does your statute protect insureds only, or does it also protect third-party claimants? Does your statute specifically mention insured and/or third party claimants, or simply refer to any person or any claimant?**	**Cite:**
California	Knowingly on one occasion or frequently enough to indicate a practice.	Some regulations protect insureds, others protect all claimants.	California Insurance Code section 790.03; 10 CCR 2695.1
Connecticut	Single acts, except claim settlement practices which must be committed or performed with such frequency to indicate a general business practice.	All claimants, except that "insureds" cannot be compelled to litigate claims.	CT. Gen. Stat. 38a-816(6), as amended 10/1/99 by Public Act 99-284 §30.
Florida	Isolated events and business practices, but some claim settlement practices must be done with such frequency to indicate a general practice.	Insureds and "other persons."	FS §626.9541(1)
Idaho	Single incident.	No reference to either 1st or 3rd party; insurer must perform reasonably and fairly.	
Indiana	Single incidents prohibited.	Different sections protect insureds, insureds and beneficiaries, and claimants. Insureds cannot be compelled to litigate.	Ind. Code §27-4-1-4.5, 6
Kentucky	Not specified. Commissioner has authority and discretion for all issues.	Commissioner authority and discretion	KRS 304.1, 304.12
Maryland	Single incidents and general business practices.		MD Code Ann., Ins. §§27.301-305; COMAR 31.15.07.08.

Nebraska	Flagrantly and in conscious disregard, or a general business practice, with a statutory exception elsewhere in statutes for "victims of abuse" protection.	Claimants and insureds. May not compel "insureds and beneficiaries" to litigate.	Neb. Stat. 44-1539-1544.
Oregon	Single incidents prohibited. Unfair practices specified by administrative rule.	Acts are simply prohibited.. Any reference is to a "claimant."	ORS 746.075, 100, 110, 160, 240; OAR 836-080-0205 et seq.
Pennsylvania	Commissioner has some discretion in isolated incidents, but by precedent an ongoing practice is generally required for enforcement action. Claims practice must be frequent enough to indicate business practice.	Some generically without reference to "claimant" or "insured," others specifically reference claimants, insureds, and beneficiaries.	40 PS §1171.1-15.
Rhode Island	Flagrant disregard of law or committed with such frequency. Enforcement action usually taken for patterns.	All claimants, first and third party.	RI §27-9.1
Tennessee	Statute does not specify, except unfair settlement practices which must be a general business practice.	Various sections refer to insured, claimant, or both, or are silent.	TCA 56-8-101 et seq.
Wisconsin	Single incidents prohibited.	The rule specifically promotes fair and equitable treatment of policyholders, claimants, and insurers. Compelling "insureds and claimants" to litigate prohibited.	§628.34 Wis.Stat.; Ins 6.11, Wis. Adm. Code

MEMORANDUM

State of Alaska

Department of Law

TO: Robert A. Lohr
Director
Division of Insurance
Department of Community &
Economic Development

DATE: January 25, 2000

FILE NO.:

TEL. NO.: 269-5229

FROM: Virginia A. Rusch
Assistant Attorney General
Fair Business Practices Section
Anchorage

SUBJECT: AS 21.36.150

In connection with a pending bill that would modify AS 21.36.010, AS 21.36.020 and AS 21.36.125 to prohibit a single unfair and deceptive act (as well as repetitive acts constituting an unfair and deceptive practice), you have asked for an interpretation of AS 21.36.150.[1] Specifically, you asked

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1 This statute provides:

Sec. 21.36.150. Procedures as to undefined practices.

(a) If the director believes that a person engaged in the insurance business is engaging in this state in an unfair method of competition or in an unfair or deceptive act or practice in the conduct of the business that is not defined as being unfair or deceptive under this chapter, the director shall hold a hearing on the matter, if the director believes it would be in the public interest to do so after giving notice of the hearing and of the charges. Upon conclusion of the hearing the director shall make a written report of the findings of fact relative to the charges and serve a copy upon the person and any intervenor at the hearing.

(b) If the report charges a violation of this chapter and if the method of competition, act, or practice has not been discontinued, the director may, through the attorney general of this state, at any time after the service of the report, cause an action to be instituted to enjoin and restrain the person from engaging in the method, act, or practice. In the action the court may grant a restraining order or injunction upon just terms, but the state may not be required to give security before the issuance of the order or injunction. If a record of the proceedings in the hearing before the director was made, a certified transcript, including all evidence taken and the report and findings, shall be received in evidence in the action.

(c) If the director's report made under (a) of this section, or order on hearing made under AS 21.36.320 does not charge a violation of this chapter, an intervenor in the

whether this statute authorizes the director of the Alaska Division of Insurance to determine that a single act, rather than a pattern of repetitive acts, constitutes a violation of these provisions of the trade practices and frauds chapter of the Alaska Insurance Code.

Briefly, the answer to your question is that AS 21.36.150 authorizes and establishes a procedure for the state insurance regulator to examine whether an activity that is not otherwise prohibited in the trade practices and frauds chapter, AS 21.36, or by regulations adopted under it, is unfair and deceptive, and should therefore be forbidden. Nothing in the language of this statute suggests that is is intended to authorize the director to determine that a single act is a violation of statutory provisions that forbid a practice of, or repetitive acts of, a defined unfair or deceptive activity. Even if AS 21.36.150 can be interpreted to give the director this authority, the process described in AS 21.36.150 would be a cumbersome way to enforce the prohibitions against unfair or deceptive acts .

The discussion below explains this answer by reviewing commentary on the source from which this section was derived and some examples of past orders issued under it.

AS 21.36.150 was adopted in 1966 as part of a major revision of the Alaska Insurance Code. It is derived from the National Association of Insurance Commissioners (NAIC) Model Unfair Trade Practices Act initially approved in 1946. According to the legislative history (See NAIC Model Regulation Service, p.880-19), this model act was the result of one of the first efforts to develop state laws regulating insurance after Congress passed the McCarran –Ferguson Act of 1945 (P.L. 79-15) that provided for continued state regulation of insurance. P.L. 79-15 contained a moratorium from the application of federal law to permit the states time to develop laws, but provided for federal regulation if the states did not take on the responsibility.

Five years after the Alaska legislature adopted AS 21.36.150 in 1966, the NAIC substantially revised the model act provisions on which this statute was based. The historical commentary for sections 7 and 8 of this model act reports that the commissioners concluded that the procedure for dealing with "undefined" unfair trade practices was too cumbersome. (NAIC Model Regulation Service, p. 880-30). The NAIC revised these sections of the model act to authorize a state insurance commissioner to hold hearings, issue cease and desist orders and impose penalties. In 1976, the Alaska legislature added AS 21.36.320, which gave the director of the Alaska division of insurance authority similar to the NAIC's revised sections 7 and 8. But the Alaska legislature left AS 21 36.150 in place, making only slight changes in 1985 (substituting a reference in subsection (c) to AS 21.36.320 for AS 21.36.140, which was repealed), and in 1992 (adding subsection (d) with other stylistic changes). The addition of subsection (d) in 1992 made clear that the director can also use the regulation adoption process to define unfair and deceptive trade practices.

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proceedings may appeal from the order or report within the time and in the manner provided for appeals from the director generally.

(d) In addition to the unfair methods and unfair or deceptive acts or practices expressly defined in this title, the director may adopt regulations to define other methods of competition and other acts and practices related to the business of insurance that are unfair or deceptive.

This history, as well as the language of AS 21.36.150, therefore shows the statute was intended to deal with "undefined" practices. It is a procedure to determine whether questioned practices are unfair and deceptive, rather than a procedure to determine whether a person is guilty of conduct that has previously been defined as unfair and deceptive. The statute incorporates due process protections, including requirements for notice of the issue to the person who is carrying on the activity, a hearing, and a written report with findings of fact. But this section gives the director no authority to order a cease and desist order or impose penalties for a violation. The director is required to apply to a court for enforcement orders. In contrast, under AS 21.36.320, the director is authorized to issue cease and desist orders and impose penalties for violations of the trade practice and frauds chapter, AS 21.36.

Among orders of the director of the division of insurance compiled in the National Insurance Law Service (NILS Publishing Company, Chatsworth, CA) are two examples issued under this statute in 1970. In Order R70-1, Workmen's Compensation Deposit Insurance Premium Unfair Practice (Dec 14, 1970), the director concluded that a practice of billing a voluntary expiration or termination payroll report and continuing to hold the deposit premium until a physical audit of the payroll records often resulted in substantial excess worker's compensation premiums being held by insurers. The director declared this an unfair practice and defined a practice to be used instead.

In Order R70-2, Trans-Alaska Pipeline Wrap-Up (April 17, 1970), the director held a hearing on a complaint from the Alaska Association of Insurance Agents that the proposed insurance program of the Trans-Alaska Pipeline System was an unfair practice in the insurance business. The director rejected the complaint finding that there was no evidence that the pipeline consortium "is or was at any time engaged in the insurance business or contemplates engaging the insurance business."

Conclusion. Based on the language of the statute, the historical commentary on the NAIC model on which it is based, and examples of how AS 21.36.150 has been used in the past, we conclude that its purpose is to establish a procedure for determining whether a particular activity in the insurance business should be prohibited as unfair or deceptive. More recent legislative enactments give the director other means to both define unfair and deceptive trade practices in the insurance business and enforce the prohibition against them. But we find nothing in AS 21.36.150 that authorizes the director to determine that a single act is a violation of a statute that prohibits a practice of certain defined conduct in the business of insurance.

VAR:jem

Proposed language for Sec. 6:

Nothing in this section shall be construed to create or imply a private cause of action for violation of this section.

Proposed language for CSSB 177 Sec.5 (7):

(7) compel an insured or third-party claimant in a case where liability is clear to litigate for recovery of an amount due under an insurance policy by offering an amount that does not have a reasonable basis in fact and law.

SENATOR DAVE DONLEY
ALASKA STATE LEGISLATURE

MEMORANDUM

To: Representative Norman Rokeberg
Chair, House Labor & Commerce Committee

From: Senator Dave Donley

Re: Hearing Request for SB 177 - "The Alaska Insurance Consumers Protection Act"

Date: March 30, 2000

I request that you schedule CS for Senate Bill 177 (L&C), "The Alaska Insurance Consumers Protection Act", for a hearing in your committee. CS SB 177 (L&C) passed the Senate by a 19-1 vote.

CS SB 177 (L&C) will give injured Alaskans and insurance consumers a fairer playing field when dealing with insurance companies by allowing the Division of Insurance to take corrective action on individual acts of unfair or deceptive insurance trade practices.

The Alaska Division of Insurance strongly supports this legislation.

I have included the sponsor statement for your review.

If you have any questions, please contact James Armstrong of my staff at 3887.

DD/jja

Vice-Chair, Senate Finance Committee • Chair, Capital Budget Subcommittee • Co-Chair, Anchorage Caucus
Member: Senate Judiciary Committee • Senate Labor & Commerce Committee • Legislative Council

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SENATOR DAVE DONLEY

ALASKA STATE LEGISLATURE

Sponsor Statement
for
CS for SB 177 (L&C)
"The Alaska Insurance Consumers Protection Act"

Senate Bill 177 "The Alaska Insurance Consumers Protection Act" will give injured Alaskans and insurance consumers a fairer playing field when dealing with insurance companies. The Alaska Division of Insurance supports SB 177.

Section #3 of SB 177 makes a major step toward better consumer protection by allowing the Division of Insurance to take corrective action on individual acts of unfair or deceptive insurance trade practices. Amazingly, under existing law, the division does not have the jurisdiction to take action on individual acts of unfair insurance claims practices. The division is powerless to take action on an individual insurer until a pattern of deceptive trade practices has developed. Such a pattern is often very difficult to prove and can require staffing the division currently does not have. This lack of jurisdiction promotes bad claims practices by insurance companies since they know that there is little enforcement to protect individual injured victims and consumers.

Section #4 of Senate Bill 177 also protects consumers by protecting those who blow the whistle on illegal insurance acts. Many consumers and even insurance agents are sometimes intimidated from pursuing a fair settlement because of fear of retaliation from the insurer. This discourages claimants from pursuing a fair settlement and hinders the consumer protection ability of the Division of Insurance, as they are unable to gain access to information needed to effectively protect consumers. SB 177 provides immunity from liability for defamation for those persons who provide the division with information regarding an unfair act or practice. This provision will better protect both agents and insurance consumers.

Section #5 of SB 177 increases protections against unfair claims practices against injured Alaskans. Under existing law, injured third party claimants are not entitled to the same statutory protections as first party claimants. Insurers know this and often will require an injured third party to pay the costs of arbitration or mediation before the process even begins. If the amount at issue is less than the cost of arbitration the insurer can unfairly "low ball" the injured party. Additionally, insurers often use the high cost of litigation, which also may exceed the value of the claim, as leverage in coercing legitimate third party claimants to accept settlements that do not adequately compensate them for their injuries. Under current law such practices are prohibited as to first party claims but not as to third party claims. SB 177 expands the

Vice-Chair, Senate Finance Committee • Chair, Capital Budget Subcommittee • Co-Chair, Anchorage Caucus
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prohibition against such bad faith actions to third party claimants and affords them a fair arbitration claims process while also curtailing unnecessary litigation. Affording and expanding insurance claims protections to both first and third party claimants is fair, equitable and good public policy.

Section #6 of SB 177 clearly states that the provisions of AS 21.36.125, which define unfair claims practices, do not create a private cause of action which is the current status quo.

Section #7 of SB 177, at the specific request of the Division of Insurance, prohibits insurers from denying a claim in which multiple causes caused the loss to occur and there is a secondary cause that is not covered by the policy. SB 177 ensures that a claim is covered when a loss has more than one cause and the dominant cause is covered by the policy.

Section #8 of SB 177 makes it clear that the Division of Insurance can take into account the fact that a potential violation was a single act or trade practice.

Injured Alaskans and insurance consumers deserve better protection from insurance company unfair claims practices. Senate Bill 177 will help provide the Division of Insurance with the necessary authority it needs to protect injured Alaskans and insurance consumers.

DD/jja

SENATOR DAVE DONLEY

ALASKA STATE LEGISLATURE

Sectional Analysis
for
Senate Bill 177
"The Alaska Insurance Consumers Protection Act"

Section #1 - Describes the short title of the legislation.

Section #2 - Specifies that the purpose of AS 21.36 is to regulate not only unfair methods or trade practices but also single acts or a deceptive practice.

Section #3 - Specifies that single or multiple trade practices that are unfair or deceptive are prohibited.

Rationale: Under existing law, the Division of Insurance does not have the jurisdiction to take administrative action concerning individual acts of unfair insurance practices. In many instances, the division will not even investigate an individual insurer until a pattern of deceptive trade practices has developed. This lack of jurisdiction promotes bad practices by insurance companies since they know that there is little enforcement to regulate their practices. This language would allow the Division of Insurance to investigate and take action relative to individual acts of unfair or deceptive trade practices and to better track patterns of abuse.

Section #4 - Specifies that a person who provides the director of the division of insurance with information regarding an act or practice of a licensee is immune from liability for defamation.

Rationale: In reported instances, consumers and even insurance agents are sometimes intimidated from pursuing a fair settlement because of fear of retaliation from the insurer. This type of activity hinders the consumer protection ability of the Division of Insurance, as they are unable to gain access to information needed to effectively protect the consumer. This section will provide increased consumer protection and better protect the insured.

Section #5 - Expands existing first party protections to third parties by specifying that neither an insured or a third-party claimant can be compelled to litigate by offering to

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settle an insurance claim for substantially less than the amount that would be entitled to recover in a civil action or arbitration.

It specifies that both an insured or a third-party claimant cannot be compelled to accept an arbitration settlement or compromise by informing the insured or third party of a policy of appealing an arbitration award in favor of the insured or third party claimant.

Rationale: In some instances, an insurer may threaten or require an injured third party to pay the costs of arbitration or mediation before the process even begins. This type of activity discourages claimants from pursuing a fair settlement, especially when the amount at issue is less than the cost of arbitration. This section prohibits such bad faith action against injured third parties and affords them a fair opportunity to pursue equitable claims.

Making these provisions applicable to both first and third party claimants is fair, equitable and good public policy.

Section #6 - States that the provisions of AS 21.36.125, which define unfair claims practices, do not create a private cause of action which is the current status quo.

Section #7 - Specifies that an insurer may not deny a claim if the risk insured is the dominant cause of the loss and denial occurs because an excluded risk is also in the chain of the causes but operates on a secondary basis.

Rationale: In some situations, the insurer will not cover a claim if there are multiple causes which caused the loss to occur, thus escaping liability because of a secondary cause that is not covered. This section ensures that a claim is covered when a loss has more than one cause and the dominant cause is covered.

Section #8 - Makes it clear that the Division of Insurance can take into account the fact that a potential violation was a single act or trade practice.

Section #9 - Specifies the effective date of the legislation.

Rationale: Gives insurance companies the necessary time to implement the provisions enacted in this legislation.

DD/jja

FISCAL NOTE

No. 1

STATE OF ALASKA
2000 LEGISLATIVE SESSION

BILL NO. Bill Version: CSSB 177(L&C)
(S) Publish Date: 3-1-00

Revision Date/Time (Note if correction) _____
Dept. Affected Community & Economic Development
Title An Act relating to insurance trade practices; and providing for an effective date.
BRU Insurance
Component Insurance
Sponsor Senator Donley
Requester S (L&C)
Component No. 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2000) cost: _____

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*
This bill has no fiscal impact on this component.

Prepared by: Robert A. Lohr Phone 269-7900
Division Insurance Date/Time 1/18/00 8:58 AM
Approved by Commissioner Deborah B. Sedwick Date _____
Agency Community & Economic Development

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