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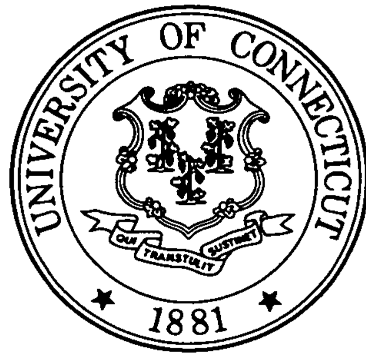

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CONNECTICUT INSURANCE LAW JOURNAL

VOLUME 1 SPRING 1995 NUMBER 1

PREFACE

Welcome to the inaugural issue of *Connecticut Insurance Law Journal*, the only academic periodical devoted exclusively to insurance law.

What is this "insurance law," for which we undertake to provide a forum? It is a body of law in and of itself, developing out of the unique relationship whereby one party contracts to assume the risk of another party's loss. At the primary level, *Connecticut Insurance Law Journal* explores the legal implications peculiar to that relationship—i.e., rights and duties arising specifically within the context of insurance contracts and phenomena unique to such contracts. The *Journal* also addresses generic contractual controversies that significantly affect the insuring relationship.

Further, *Connecticut Insurance Law Journal* emphasizes the role of insurance as a social construct. It explores the public policy implications of insurance and alternatives to insurance. This necessarily embraces discussion of the regulatory state and its dual role with respect to the insurance contract *qua* contract and as industrial product. The purview of the *Journal* therefore extends to observations and conclusions about the insurance industry as a whole.

Quite appropriately, the scope of the *Journal* is best gleaned from the articles themselves within this first issue. However, as one might expect, there is much more to come in future issues that will likely expand and refine this scope.

On behalf of all the editors, I would like to thank Professor Robert Googins for his enthusiastic service to the *Journal*. Also, thanks to Dean Hugh Macgill for his outstanding leadership of The University of Connecticut School of Law and his support of our efforts. I would also like to extend gratitude to the following individuals whose support, assistance and encouragement have helped bring this issue to bear: Julia Dunlop, Dean Laurie Werling, Professor Robert Birmingham, Professor Kurt Strasser, Dean Carolyn Jones, Donna Gionfriddo and James Purnell. Special thanks to Leigh Newman for her technical consultation and to the editors of *Connecticut Journal of International Law* and *Connecticut Law Review* for their encouragement, support and advice.

Please enjoy this issue and be assured that *Connecticut Insurance Law Journal* intends to continue, in subsequent volumes, the tradition set forth this year.

Jonathan M. Starble
Editor-in-Chief

INAUGURAL REMARKS

The inauguration of *Connecticut Insurance Law Journal* is a milestone in the evolution of The University of Connecticut School of Law. We were founded in 1921 as the Hartford College of Law, fraternal twin to a Hartford College of Insurance. I do not know if the College of Insurance ever opened its doors at all; it left no trace except for some yellowing papers in a dusty file. By contrast, the College of Law (The University of Connecticut School of Law since 1943), has enjoyed decade after decade of steady growth in its intellectual ambition and achievement, to emerge as one of the leading public law schools in the nation.

Although the law school's horizons have been vastly broadened in areas as diverse as clinical education, jurisprudence, and international law, the study of insurance law has until recently languished on the periphery of the curriculum. Considering the range, complexity, and societal importance of insurance law broadly conceived—and the extraordinary resources Hartford's historic preeminence in the industry gives us—this is a field of inquiry that has long demanded attention.

At long last, under Professor Robert Googins's stewardship, we begin to build an Insurance Law Center which promises to explore and exploit the educational potential of the industry in all its expanding ramifications. *Connecticut Insurance Law Journal* will be a significant component of the Center.

As our third student-edited publication, it will provide valuable experience and specialized knowledge for those who serve on its staff. Its value to the industry itself and to those who study it will be greater still. As a forum for scholarly and professional exploration of problems of insurance law and policy, it will help bridge the widening gap between the academic and practicing branches of our profession.

Congratulations to the founding editors for their vision, energy and resourcefulness. I welcome *Connecticut Insurance Law Journal* to the School of Law and to the great enterprise of inquiry, analysis, reflection and reform which engages us all.

Hugh C. Macgill
Dean, University of Connecticut
School of Law

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In the Fall of 1990, I accepted the position of Director of the Insurance Law Center at The University of Connecticut School of Law. This was the first tangible step in establishing the Center pursuant to a vision of several leaders within the insurance community.

The keystone of the Center was to be an endowed chair. Added to this would be the development of an extensive insurance law curriculum leading to an LL.M. degree, insurance internships, research assistantships, symposia, continuing legal education programs and a student-run law journal. This last piece—the journal—was not slated to begin until the end of the "five-year plan" for completion of the Center.

Although the plan was interrupted by my unexpected sojourn as Insurance Commissioner of Connecticut (1991-1994), the inauguration of the law journal was accelerated by the enthusiasm and dedication of the current editors and their staff who knew that they could launch *Connecticut Insurance Law Journal* before the supporting infrastructure was in place—and they were right!

It has been my distinct privilege to be the *Journal*'s faculty advisor and watch it flourish as the other pieces of the vision are being built around it.

Robert R. Googins
Director, Insurance Law Center
University of Connecticut
School of Law

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Is Insurance a Niche Business? Reflections on Information As an Insurance Product

W. F. Young[*]

For this, the inaugural issue of *Connecticut Insurance Law Journal*, I have supposed it appropriate to write expansively, in a speculative vein, rather than to select the well-defined target of an insuring practice or a legal doctrine. Remembering that the commonest stupidity is to forget what one is trying to do, I appreciate the risks of that choice. Readers who wish the editors well—as I do—will not regard them as underwriters of those risks.

The observations that follow have a serious intent, although a reader might be pardoned for doubting it, given the come-hither quality of my title. The intent is, in part, to characterize the business of insuring, and in part to address the question, "In what sense is insurance a *singular* business?" It is singular, I suggest, in the sense that insuring is a process of exchanging information about specialized projections of loss.

If the loss in question is, for example, collision damage to a car, a policyholder might inquire what premium change would be entailed by a move from Nearville to Farville; and the insurer might respond with a dollar figure derived from a store of banked information about the incidence of reported collision losses in those communities. The insurer would expect to be informed of a change in the principal place of garaging of the policyholder's car. This is an illustration, among countless others, of an exchange of information incident to "insuring."[1]

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* James L. Dohr Professor of Law, Columbia University School of Law. I am grateful to Robert R. Googins and Robert Birmingham, both of the University of Connecticut School of Law, for their serious attention to an earlier draft of this article.

1. The "information" may of course be defective, in one way or another. As providers of information, the insured may be unreliable (possibly leading to the denial of a loss-claim or to invalidation of the contract), and the insurer's rates may be unreliable indicators of risk (owing to market or regulatory compulsions, not to mention incompetence). Defects in the process, though regrettable, need not vitiate its general utility.

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Given that conception, it appears that the function of a market in insurance is subject to constant erosion. It is subject to displacement on one side by schemes of "social insurance" and on the other by fluidity in capital markets. The stocks of information that are the unique products of firms offering insurance have a highly contingent value. Their value depends on decisions made in both the public and the private sectors of the economy; and the long-run tendency in both sectors is to depress their value.

A "niche" enterprise is one that caters to specialized demands, and is easily crowded out.[2] To call insurance a niche business is to say that it exists at the sufferance of others. Governmental disaster relief is one form of encroachment on the potential market for insurance. Another is the proclivity of customers to moderate their risks by diversifying their portfolios. The tendency of these and like encroachments is to make insurance a niche business, catering to an evanescent need. Part II of this paper describes that tendency.

Part I offers some public-choice observations. What conclusions can be drawn from the conception of insuring as an information exchange, with respect to regulation of the insurance business? A measure of success in the regulatory scheme is that it supports privately offered insurance in recording and transmitting widely valued information. Corrections are in order if the performance of that function can be improved. Beyond that, the extensive regulations in place represent a collective decision to place great value on the historicity of information. But that decision should be open, I take it, to reconsideration at any time. It is a constant question, therefore, whether or not reassignments of risk ought to be made, by public choice, without respect to the factor of experience.

The possibilities of displacing privately offered insurance by reassignments of risk, either through acts of government or through market ordering, are especially evident when "insuring" is conceived of as trading in information. These possibilities, taken together and reduced to an epigram, suggest that insurance is a "niche business."

If a group of lawyers were asked why insurance is bought they would be ready, probably, with several excellent answers. It is bought

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2. For a definition of "niche marketing," see MARK N. CLEMENTE, THE MARKETING GLOSSARY 235 (1992): "The marketing strategy to serve a narrow market segment that's unattractive to and unserved by larger competitors . . . . See also *guerilla warfare*."

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because good business judgment requires the pooling of certain risks, some would say.[3] And because trust indentures and other contracts require insuring. And because the law requires it. Each of these answers, among others, is satisfactory in its way, although none of them purports to answer the question comprehensively. To give a comprehensive answer appears to be extraordinarily difficult, owing largely to the multifarious offices performed by what we call "insurance."

In this paper (which is largely intuitive in character) I consider one function of insuring that does not leap to mind as an answer to the question, "Why insure?" The conception of insuring featured here is that of an *exchange of information*—information of a specialized kind. That is an unconventional conception, no doubt, not fully examined so far as I know. But it is not a novel one.[4] The conception is of course quite false in fact to the breadth of functions performed by contemporary insurers. It will prove to be of use only if it suggests answers to some problems of public choice about the insurance business.

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3. The distinctions between risk *transfer*, risk *distribution* and risk *pooling* have attracted a good deal of attention from theorists about insurance. *See* KENNETH S. ABRAHAM, DISTRIBUTING RISK (1986); Donald A. Winslow, *Tax Avoidance and the Definition of Insurance: The Continuing Examination of Captive Insurance Companies*, 40 CASE W. RES. L. REV. 79, 147-48, 151 (1988); Spencer L. Kimball, *Distributing Risk: Insurance Legal Theory and Public Policy*, 19 CONN. L. REV. 311, 319 (1987) (book review). In ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW 5 (student ed. 1988), it is said: "There is no single conception of insurance that is universally applicable for use in disputes involving questions of law." A principal reason offered is that the question, "What is insurance?" arises in a variety of contexts. Compare SPENCER L. KIMBALL, CASES AND MATERIALS ON INSURANCE LAW xxv (1991): "There is no good definition of 'insurance,' for any purpose."

The conception advanced in this paper is an attempt partially to circumvent arguments about the relation between risk and insurance.

4. *See especially* ABRAHAM, *supra* note 3, at 16, 32-33, 176; *see also* Barbara C. Beliveau, *Theoretical and Empirical Aspects of Implicit Information in the Market for Life Insurance*, 51 J. RISK & INS. 286 (1984).

The converse proposition has been examined: that "information-gathering activities are close substitutes for insurance contracts as protection against certain types of risks." Marc Willinger, *Risk Aversion and the Value of Information*, 46 J. RISK & INS. 320, 320 (1989). This paper is part of a literature investigating the conditions in which the willingness to pay for an information search is correlated with risk aversion.

For a contrasting conception see Richard E. Stewart, *The Commodity of Insurance* (Dec. 5, 1977) Insurance Lecture Series (paper on file with *Connecticut Insurance Law Journal*).

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The kind of information that insuring singularly conveys is information about risk factors.[5] In brief, I hold the view, which seems to be quite prevalent, that insurance contracts and insurance prices are grossly inferior sources of information about risks for individual subscribers.[6] Often the particular facts they represent are not especially germane to the interests of the parties, are obscured in transmission, and are overwhelmed by signals on other subjects. So, to take an instance, a policy form for burglary insurance may well be thought to fall short of effectiveness in communicating to a merchant, as an insurance buyer, the issuer's purpose to mark off "inside jobs," remitting claims for employee infidelity to a different brand of insurance. The form says, in expressing that purpose, that the insurer will pay a loss only if there are visible marks of force on all the entry ways—the cashier's office door as well as the door to the safe. A merchant might be pardoned for failing to infer from this provision, couched in the definition of "loss," that its choice and supervision of employees is, in the eyes of the insurer, a powerful determinant of risk. The form is poorly devised to convey that information. Yet I hold the view that insurers function well as purveyors of *general* facts about risk factors to the public at large—as opposed to individual patrons. Among the best known general facts bearing on losses widely insured against are connections (not the particulars, of course) between mortality and smoking, between bodily injury and the use of seat belts, and between road injury and driver's age.[7] From these views it is possible to derive some broad conclusions about the virtues of various official constraints on the insurance market.

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5. Factors of monetary risk are ambiguously related to insuring, in my view. Cash-value life insurance is in demand by "insureds"; and it features a major transfer of monetary risk. So, however, does the purchase of a Treasury note. I follow convention in denying the name "insurance contract" to financial instruments, even though issuers, buyers, and (especially) underwriters of these instruments express important information through their marketing decisions. An intelligible distinction exists, as to the character of the risks concerned. (See further *infra* pp. 20-21, as to cash-value life insurance.)

This is not to say, of course, that monetary risks are uninsurable.

6. *See* ABRAHAM, *supra* note 3, at 32 (Insurers "draft policies in language . . . that is often dense, complex, difficult to understand, and sometimes ambiguous."); *id.* at 79-82 (giving reasons for "slippages"); KEETON & WIDISS, *supra* note 3, § 6.3(4).

7. On the other hand, insurers have incentives to direct bits of information, selectively, to the audiences most likely to find them germane, and have facilities for doing so. Remarks on a draft of this article made by Professor Googins, University of Connecticut School of Law, prompted this observation.

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The demand for insurance-as-information is not neglected by advocates of public-choice decisions. A recent example is a paper by Professor Kent Syverud. He argues that liability insurers have participated in misleading the public about the general facts of liability risks. Writing *On the Demand for Liability Insurance*,[8] Professor Syverud depicts insurers as free-riders on the jitters induced by the successes of plaintiffs and plaintiffs' lawyers. He surmises that the publicity given to immense verdicts, unaccompanied by facts that make them less dreadful, overstimulates the demand. And he prescribes a corrective. That framing of an issue about information is commendable, whether or not his argument is convincing.

The section that follows offers a way of fitting the conception of insurance-as-information together with the dominant object of legislation regulating the business.

I.

[T]he subject matter . . . is safety.[9]

The conception of insurance as an information exchange requires a restatement of the justifications for regulating the business of insurance. The principal immediate object of regulation is to assure the performance by insurers of their obligations by prescribing safeguards against insolvencies.[10] Beyond that, the object is to reinforce the "sense of security" that insurance contracts provide for their holders and beneficiaries. This is the conventional notion.[11]

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8. Kent Syverud, *On the Demand for Liability Insurance*, 72 TEX. L. REV. 1629 (1994).

9. Curtis Nyquist, *A Contract Tale from the Crypt*, 30 HOUSTON L. REV. 1205, 1217 (1993) (quoting Gray v. Gardner, 17 Mass. 188, 189 (1821)).

10. *See* KEETON & WIDISS, *supra* note 3, § 8.2(a) (one of three main objectives).

11. "The primary purpose of insurance regulation, everywhere throughout the world, is to be sure that the insurer (or the reinsurer) can pay claims when called on to do so." KIMBALL, *supra* note 3, at 653. Earlier, Professor Kimball gave this thought both forceful and graceful expression in his article, *The Purpose of Insurance Regulation: A Preliminary Inquiry in the Theory of Insurance Law*, 45 MINN. L. REV. 471 (1961). (But: "It is usually assumed that the purpose of insurance regulation is single and simple. In reality it is neither. There are many purposes, and they are in considerable conflict with one another." *Id.* at 524.) *See also* ABRAHAM, *supra* note 3, at 8-43.

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The notion surfaced in an interesting way in *Gray v. Gardner*,[12] a case featuring an aleatory condition[13] in a contract of sale, in which the seller drew an analogy to marine insurance. In negotiating the price of a quantity of whale oil, the parties had fixed the price by reference to a fortuitous event: that no greater quantity of whale oil arrive at Nantucket and New Bedford, within a specified "term of time" in 1819, than had arrived there in the equivalent period of 1818. The seller, Gray, sued for a price increment. It was important to Gray's case for him to establish that a particular vessel making port in Nantucket had not arrived there at a specified moment. He made the point that, for the purpose of a hypothetical insurance policy, the vessel would not be considered to have "arrived" at the critical juncture. The buyer sought to deflect the point by saying: "the subject matter in one case [that of insurance] is safety, in the other [the case at hand] it is information only."[14]

The supposed distinction between insurance law as a matter of safety and contract law as a matter of information is directly at odds with the conception of insurance presented here: information, I suggest, is just what insuring *is* about. But there is this distinction: experience on which a projection of 1819 arrivals of whale oil, by ton, at Nantucket and New Bedford would not have been a source of information, even in whaling days, having more than idiosyncratic value. In contrast, information about hull risks near Nantucket had been collected and was apparently used in marine insurance rating. That kind of information is the subject of a market worth supporting.

Gray v. Gardner was decided before the business of insuring was subjected to intensive regulation. The element of safety referred to by counsel in that case was presumably the safety of the voyage. Today we should think, rather, of the safety of the *contract* as the special mark of insurance. The public oversight of the business is designed largely to foster that: insurers are regulated so as to guard against their insolvency. But regulation for solvency is not uniquely associated with the business of insuring, and neither is providing a sense of security.

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12. 17 Mass. 188 (1821).

13. "Aleatory" does not signify that the event was altogether beyond influence by either party. See the formulation of the New York definition of insurance: event (or nonevent) "which is, or is assumed by the parties to be, to a substantial event beyond the control of either party." N.Y. Ins. Law § 1101(a)(1), (2) (McKinney 1985).

14. *Gray*, 17 Mass. at 188.

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Possibly the conception of insuring as an exchange of information can help to show what is singular about that object of insurance regulation.

To foster the sense of security is not only an ultimate object of regulation of solvency, in relation to insurance, I suggest, but is also an *intermediate* object. Signals given by an insurer about underwriting risks, in the form of price quotations for insurance, would be seriously contaminated if they were accompanied by signals about the insurer's capacity to honor its commitment. Questions about the credibility of the issuer's promise would generate "noise" in the system. What can be done to maintain, in large measure, the purity of the signals is to remove the matter of credibility from the arena of negotiation. If the solvency of all insurers were assured, by means of official oversight, to the point of market indifference among them, noises about an insurer's reserves and investment policies would be fully abated, by hypothesis; and patronage choices would be the more likely to hinge on the scope and quality of the insurer's information about contingencies particular to the contract in question.[15] Regulation for solvency is, then, an instrument not only for enhancing a sense of security among patrons but also, by that means, for enhancing the value of insurance-like information.[16]

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15. Only a few years ago, that situation could be said to obtain, very nearly: "At present, when a business purchases insurance it may shop for price, terms of coverage, and service reputation; but the purchaser need not worry about the reliability of the insurer's promise to pay, because solvency is virtually assured." Kenneth S. Abraham, *Environmental Liability and the Limits of Insurance*, 88 COLUM. L. REV. 942, 986 (1988).

Professor Abraham went on to say that the reason for prohibiting unlicensed firms from issuing of contracts in the ordinary insurance markets is that "they cannot provide the kind of assurances of solvency and reliability that actually have come to be part of the definition of modern insurance." *Id.*; *see also id.* at 988 ("If the insured could bear the risk of the insurer's insolvency even while transferring the risk of liability . . . insuring environmental liability might become more feasible, though not through 'insurance' as we now know it . . . .").

16. Professor Googins has made the clever point that the intermediate and ultimate objects described here—objects of regulating for solvency—need not coincide. The *appearance* of solvency, contrary to fact, would suffice to remove credibility from the bargaining table. He is of course right. Moreover, occasions arise in which it would be irresponsible for a commissioner of insurance to broadcast an indication of a shortfall in an insurer's accounts. But in general, however one might compare the two states, (i) no official certification about solvency and (ii) accurate official certifications, either state seems preferable to the third: inaccurate certifications. That is, to appreciate insurers as sources of information need not entail the appreciation of government as a source of misinformation.

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Insurers may perceive opportunities in the misuse of information (withholding or falsifying it), as well as in developing, confirming, and transmitting accurate information. Not only conscious misuse, but carelessness about acquiring and deploying information, may lead an insurer into trouble. An insurer relying on degraded information might well gain market share through underpricing its contracts—with disastrous results. That is one error, among others, against which official oversight is meant to guard.[17]

The term "insurance-like information," used above, requires a gloss. The stocks of information on which a successful insuring enterprise depend may be called *underwriting* data. That description has a familiar ring; but it is not a definition. The facts represented are "insurance-like" facts, so to speak. The notion is hard to pin down, however, without relying on vernacular in the business. Examples are easy enough to come by. There are bodies of underwriting data about deaths and disabilities, fire and water damage, and so on. An element of chanciness figures in our understanding of what counts as an insurance-like fact. Beyond that, however, it is not easy to give a definition of underwriting data.

To this point, readers have been invited to conceive of the market for insurance as one in which the essential demand is one for information of a particular kind—underwriting information. In sections to follow, some consequences are derived, first about licensing to offer insurance and then about the language of insurance contracts and its interpretation. In advance of that, however, it is well to confront the question whether or not "underwriting information" is a plausible category, given the fact of moral hazard.

A. *Moral Hazard*

The facts that are classed, generically, under the head *moral hazard* are a conundrum.[18] More broadly understood, it is the expectable mod-

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17. This paragraph was prompted by remarks of Professor Googins, although he would doubtless write in somewhat different terms. He observed, in effect, that insurance buyers may be attracted by over-sanguine risk signals (or, to be exact, the attendant prices) that would not attract them in the absence of regulation for solvency. Just so: imperfect regulation has imperfect results.

18. Moral hazard has been defined as the tendency of a person or firm, upon insuring, thereafter to "underallocate" resources to loss-prevention efforts. ABRAHAM, *supra* note 3, at 14.

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ification of behavior that attends on any reassignment of risk that the actor perceives as relief from the risk, assuming a constant income. One might be of two minds about whether or not information on the subject forms part of the exchange inherent in insuring. According to one view, moral hazard is an affliction of the insurance business, such that a zero level of it would be ideal;[19] but on another view moral hazard is the defining characteristic of the business.[20]

Moral hazard is sometimes discussed as if it were singular to insurance contracts.[21] But that is far from true; moral hazard is a more general phenomenon than that. Professor Curtis Nyquist's investigation into the facts of *Gray v. Gardner*, referred to above, disclosed what seems to have been an attempt on the part of the buyers in that case to divert a cargo of oil to Nantucket, in 1819, so as to depress the price of the oil contracted for. Although the price arrangement in the sale contract evidently subjected the seller to moral hazard, this circumstance did not make the contract one of insurance.

Among the facts that might be disclosed in negotiations for a contract, however, hardly any are more insurance-like than those bearing on moral hazard. Certainly the insurance business is a prime source of public education on the subject.[22] At the same time, a more-than-moderate dose of moral hazard is supposed to make insurance dysfunctional. The education on this subject that is provided by insuring practices comes at a cost: it impairs the utility of information otherwise provided from that source. No doubt this circumstance is the fulcrum of the belief that moral hazard is an affliction of the business.

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19. *See, e.g.*, ABRAHAM, *supra* note 3, at 14-15, 35-36.

20. See Goran Skogh, *The Transaction Cost Theory of Insurance: Contracting Impediments and Costs*, 56 J. RISK & INS. 726, 729 (1989): "[I]n the pool-of-risks theory, moral hazard is treated as a complication. In the transaction-cost theory, moral hazard is the *raison d'être* for insurance." (In Skogh's essay, it should be noted, "transaction-cost theory" is presented not as an alternative, but as a supplement to the "pool-of-risks" theory. Moreover, the transaction costs referred to are not those associated with putting insurance in place, but rather those associated with contracts for goods and services.)

21. *See* C. ARTHUR WILLIAMS, JR. & RICHARD M. HEINS, RISK MANAGEMENT & INSURANCE 51 (3d ed. 1964).

22. *See* Michael Quint, *Bane of Insurers: New Ailments*, N.Y. TIMES, Nov. 28, 1994, at D1, D2 (reporting that the Paul Revere Corporation rejects applications for full-benefit disability insurance, vocation-specific, from physicians in Florida and California, and from certain health professionals country-wide).

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One way to treat the costs associated with moral hazard is to classify them as transaction costs.[23] So regarded, these costs help to justify regulation of the marketing aspects of the insurance business. But it is also plausible to regard the identification and pricing of particular instances of moral hazard as part of the underwriting function.

Here it may be observed that, in large measure, the courts provide regulation of insurance marketing, especially of the responsibility of applicants to provide information to insurers. The background rule (let it not be forgotten) is that of *uberrimae fidei*. As it is put—subject to some qualifications—in the British Marine Insurance Act of 1906, "[T]he assured must disclose to the insurer, before the contract is concluded, every material circumstance which is known to the assured . . . ."[24] This is not the rule applicable to everyday insuring, of course. Although applicants have an obligation of candor, it is sometimes very lightly enforced. Laxity about misrepresentations and concealments by insurance buyers would lead, one might expect, to club-like forms of insurer organizations, in which degrees of candor can be discerned from repeated dealings among the participants, and not only dealings about insurance. Some mutual insurers, risk-retention groups, and other entities that are exclusive about membership fit this description. An object of doing business in that form may be to circumvent rigorous regulation; that object (or a tax-related one) is often in view. But it is also rational to circumvent rules that are not demanding enough, when arranging insurance, so as to form linkages that require little moral-hazard underwriting.

Considered as an element of underwriting, moral hazard provides the sorting system for other information that insurers gather and disseminate. So regarded, it helps to justify regulation of risk classifications, at least in the direction of aggregation.[25]

23. Professor Abraham has treated moral hazard under the heading "Transactions Costs." ABRAHAM, *supra* note 3, at 14-15. But in the same passage he associates it with risk classification. "Perhaps the insurer's most important method of dealing with moral hazard is to create risk classes and to vary the prices charged for coverage, depending on the expected loss of each class of insureds." *Id.* at 15.

24. " . . . and the assured is deemed to know every circumstance which, in the ordinary course of business, ought to be known by him." Marine Insurance Act, 1906 § 18(1) (Eng.), *reprinted in* 2 ARNOULD'S LAW OF MARINE INSURANCE AND AVERAGE 627-28 (16th ed. 1981).

25. Professor Googins has suggested to me that regulation may be deficient in failing to require classifications more refined than those in place. But it is hard to

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The conundrum can be resolved, in part, by observing that insuring practices attract moral hazard in an exceptional measure. This observation does not in itself dictate a particular conception of the insurance business. For if moral hazard is a defining characteristic of the business, it amounts to saying that *the insurance business tends to define itself.* There is a measure of truth in this epigram, I believe. But there are important differences of degree to be noticed. Among contracts officially classified as "insurance," there is marked variation in the degrees of moral hazard they entail. Some of them, more than others, are deliberately devised so as to moderate moral hazard. These include retrospectively rated contracts in particular, but also other types of contracts, some of which are mentioned below. Collectively, these contracts would rank low if scaled according to the function of providing underwriting information.

Some loose correlation seems to exist between the insuring function of a contract and the seriousness of moral hazard associated with it. I conclude that the incidence of moral hazard is one indicator, though an equivocal one, of what should be called underwriting information. At the least, the fact that moral hazard is *absent* from a contract is some reason for denying that the contract is one of insurance.

Is there a better indicator? For present purposes "insurance-like facts" have two main characteristics. One is the element of chanciness—fortuity of event.[26] The other is that they form part of a body of information the value of which depends on an assumption of continuity over time. The future will replicate the past, it is assumed.[27]

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see, *a priori*, why insurers whose credibility is assured would fail to differentiate risks (i.e., deploy their information) efficiently.

26. *See supra* note 13 (provision of New York Insurance Law); KEETON & WIDISS, *supra* note 3, at 475-76 (in relation to risks transferred).

27. Although on an *ex ante* view of history this assumption is demonstrably wrong, it is I believe virtually irresistible. It may lead an insurer to ruin, of course. A notorious instance is the experience during the Great Depression of issuers of non-cancellable disability insurance: the contracts were widely used as surrogates for unemployment insurance. The importance of temporal contingencies is further illustrated by the circumstances leading to the (partial) displacement of "occurrence" based liability insurance by "claims made" insurance—a development alluded to *infra* p. 29.

There is a Learned Hand opinion in which he seems to have made the assumption that the future will be *discontinuous* with the past. Hayat Carpet Cleaning Co. v. Northern Assurance Co., 69 F.2d 805 (2d Cir. 1934). I have always been mystified by it.

To the extent that data are gathered on any other premise, they are not underwriting data. The value of the information peculiar to insurers is, in a word, its historicity. High moral hazard is a sign of that value—but only a sign.

The extent and intensity of official oversight, with respect to "insurance," ought not to be determined in a direct way by considerations of moral hazard.[28] They should be determined chiefly, I think, by reference to the public interest in maintaining stocks of insurance-like information. Broad access to that information is a consideration, naturally; and so is accuracy in gathering and processing the information. Moral hazards are bound to influence judgments about the utility of what insurers, as such, know and can ascertain. But they are a subordinate consideration.

B. Guaranteed Insurance

The perception of insurance as a niche business is hard to maintain against the historical record that appetites emerge for novel and important risk-based contracts. Financial guaranty insurance[29] is a notable instance of new territory that opens up, from time to time, to an extension of the insurance business. This form of insurance is consistent with the conception of insuring as an exchange of information. The fact that issuers of fidelity bonds and contractors' bonds are classified as insurers[30] is a monument to the value ascribed to information on which projections of default and insolvency can be based.

From that platform it is an easy step to conceive of insurance against the default of insurers. Hence the notion of *guaranteed insurance*—financial guaranty insurance with respect to insurance contract obligations. A proposal for authorizing insurance ancillary to insurers' obligations appears to build naturally on provinces already seized for

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The concluding section of this paper—about "the entropy of data"—pursues this topic.

28. By like token, I believe, extraordinary administrative efforts to suppress frauds on insurers are mistaken. Better to let pricing express an insurer's susceptibility to fraud. Insurance departments should look askance at expensive, cooperative measures by insurers to suppress frauds. It is out of fashion, however, to question the "privatizing" of policing functions.

29. For the New York definition, see N.Y. Ins. Law § 6901(a), (b) (McKinney Supp. 1994).

30. *See* N.Y. Ins. Law §§ 1101(a)(3), 1113(a)(16)(A), (B).

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the business. There is an analogy, also, in the guaranty funds that add a measure of credibility to insurance contracts of the most popular types.

The conception of insuring as an information exchange offers a useful perspective on this proposal.[31] By a contract of "guaranteed insurance" I mean one in a set with respect to which the issuer is relieved, by reference to the guaranty, of meeting some standard of financial soundness that would otherwise apply. The term "underlying insurer," though artificial, is convenient for designating that issuer, as opposed to the issuer of the financial guaranty contract.

A bill permitting insurance contract obligations to be insured by financial guaranty firms was put forward in the last session of the New York legislature.[32] Something can be said for the proposal on efficiency grounds.[33] But the proposal cuts against the grain of insurance—"insurance," that is, regarded as a mode of exchanging informa-

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31. More useful, I believe, than the general air of astonishment professed as follows: "[T]here even exists (or has recently existed) insurance against insurance company nonperformance of insurance contracts, though it has not had an enthusiastic reception in the market. Why should it? A double layering of insurance does seem a bit much." KIMBALL, *supra* note 3, at xxviii.

32. N.Y.S.A. 8432, 216th Leg., Reg. Sess., (1993-1994). The bill was not reported out of committee.

According to the supporting memorandum:

> The positive role that financial guaranty insurance has had for corporations and other entities should be made available in connection with policy and contract obligations of insurance corporations. Such action is necessary to enable the insurance industry to compete on a level playing field with banks and other non-insurance entities, which have marketed products which have been enhanced through the use of financial guaranty insurance . . . . As a result, insurers will be able to offer [guaranties to] policyholders and contract holders, in much the same way that access to financial guaranty insurance has provided similar benefits in connection with general corporate obligations.

N.Y.S.A., Mem. in Supp. of Legis. of 1993, 260 (1993).

33. A standard argument would be that the reform would offer easier entree for would-be insurance providers into the insurance market than existing licensing arrangements do. It might also be hoped that, if the introduction of guaranteed insurance of a particular kind were simply to rearrange market shares among the universe of all issuers of contracts of that kind, and if one guarantor, or a set of guarantors, were to attract the patronage of issuers having a large market share, the cost per contract of regulating insurers for solvency would decline. To concentrate examinations on the financial affairs of a single, large guarantor would, in principle, serve the purpose that now requires examinations of the affairs of multiple (unguaranteed) insurers.

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tion. Prospective customers for an underlying contract would find their choices enlarged. There would be, within the scope of the reform, a new choice between guaranteed and unguaranteed contracts. A rational choice would depend, precisely, on calculations of differing expectations of ability to pay: the ability (in the one case) of the underlying insurer and (on the other) the ability, together, of that firm and the guarantor. Actual choices in the market might be skewed by irrational factors. In particular, the associations of the word *guaranteed* might prove to be deceptive for some number of patrons. I lay that aside, however, as speculative. Irrespective of that, the proposal would, if enacted, alter the terms of communication between insurers and their customers. Communications would be enriched, in a sense. If, for example, the underlying insurer were to issue both guaranteed and unguaranteed contracts, otherwise identical, a customer could infer, from the difference in price, something about that insurer's prospect of ruin. But communications would be impoverished in the respect that characterizes insuring as an exchange of information about underwriting factors. That is precisely the thought of statutes proscribing a public communication by an insurer of the fact that its contracts are guaranteed.[34]

Guaranty funds do not have the same demerit, be it noted. The inauguration of a guaranty fund does not introduce a new choice among kinds of contract. Not only so, but it tends to allay concern about insurer insolvency, and so to make all the more prominent the factors of choice that depend on underwriting.

C. *Information and Definitions of Risk*

The use by insurers of standard contract terms contributes immeasurably to their accumulations of underwriting information; but it is also, paradoxically, an impediment to what can be learned from negotiations over insurance.

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34. *See, e.g.*, N.Y. Ins. Law § 1313(d).

Professor Googins reports to me—what one would suspect—that established insurance providers and purveyors instigated legislation of this type. (Established providers opposed the New York bill cited *supra* note 32.) As Connecticut's Commissioner of Insurance, he obtained a relaxation on point-of-sale information that agents can provide.

Compare the requirement that banks advertise themselves as "Member, F.D.I.C." if they can truthfully do so. 12 C.F.R. Part 328.3.

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The courts are notoriously concerned, in relation to standard-form contracts generally, and in relation to insurance contracts in particular, with inequalities of information.[35] That being understood, the terms of mass-marketed insurance are prepared with sensitivity to what has been called the "juridical risk."[36] To that extent the insurance industry itself discounts the value of the stock of underwriting information that is available to it: the claims-adjustment function overrides that of risk-classification.

Some losses covered by homeowners' insurance make a nice illustration. A broad-form homeowners' policy provides coverage for losses produced by rainstorms, under the rubric *all-risk*. But it excludes—loosely speaking—losses produced by landslides. The exclusion (which is actually in terms of "earth movement") is appealing for the reason, presumably, that landslide risks are unevenly distributed geographically. But there is a difficulty: rainstorm and landslide are in some degree covariant causes of loss. That fact has disturbed the courts in the State of Washington, where a "narrow" construction of the exclusion was applied. Some insurers chose to recast their policies. To bracket rainstorm and landslide would have been one way to confront the difficulty. Losses from both causes might have been included, or excluded, from the coverage. So to do would, of course, have suppressed some information that purchasers can derive from the exchange. Rather than do that, the drafters sought to clarify the exclusion as follows: "We do not cover loss caused by [landslide], whether occurring alone or in any sequence with a covered peril." In that form the exclusion came before the Washington Supreme Court in a follow-up case, *Safeco Insurance Co. of America v. Hirschmann.*[37]

Safeco brought the action to confirm its understanding of the exclusion. The defendants, homeowners, had suffered a loss the primary cause of which was—according to their expert—an astonishing day long rainfall; Safeco attributed the loss entirely to landslide. On neither side was it thought, apparently, that the loss might be apportioned. Safeco won a summary judgment in the trial court, but there was a reversal on

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35. *See* ABRAHAM, *supra* note 3, at 103-09, 114-15.

36. *See* Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629, 631 (1943) ("The insurance business probably deserves credit also for having first realized the full importance of the so-called 'juridical risk', the danger that a court or jury may be swayed by 'irrational factors' to decide against a powerful defendant.").

37. 773 P.2d 413 (Wash. 1989).

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appeal. This decision has been understood to install in Washington a notion of "proximate efficient cause," for dealing with concurrent causes of property losses. There was a dissent in *Safeco*, protesting that the doctrine impairs the ability of the insurance industry to segregate and manage risks.[38]

What are the merits of the matter when the contract is considered as an exchange of information? Several observations come to mind. First, as the dissenters in *Safeco* observed, the decision tends to suppress all-risk coverage, and so to constrict the flow of information from that source. ("Insurance purchasers may be required to choose between high premiums or foregoing 'all-risk' coverage entirely.")[39] Conversely, a decision for Safeco would have made the coverage information conveyed by the policy terms more intelligible than the proximate/remote distinction is. It also would have put Safeco's pricing, for the future, on a more reliable footing, and so would have made its price quotations a more credible source of underwriting information. On the other hand, the information conveyed by the terms and pricing of all-risk insurance is relatively inscrutable at best, and is disproportionately debased by the presence of important exclusions.[40]

All the foregoing observations are matters of opinion, of course. For what it is worth, my belief is that the latter observation, about all-risk insurance, dominates the others. I am influenced in that by a well-known episode in the history of "perils of the seas" coverage. This

38. *Id.* at 420 (Callow, C.J., dissenting). The assumption was, of course, that a "clarification" of policy language would not alter the outcome. This assumption has been borne out, in part. See Pluta v. United Servs. Auto. Ass'n, 866 P.2d 690 (Wash. Ct. App. 1994), in which the doctrine of the case was reinforced, overriding the effort of another policy drafter. Note also the comparable, tortuous developments in California (where, however, statutes figure in the problem), recited in Garvey v. State Farm Fire & Casualty Co., 770 P.2d 704 (Cal. 1989).

For unfriendly comments on *Safeco* see Bettigole v. American Employers Ins. Co., 567 N.E.2d 1259 (Mass. App. Ct. 1991); Lawrence A. Wans, Note, *Washington's Judicial Invalidation of Unambiguous Exclusion Clauses in Multiple Causation Insurance Cases*, 67 WASH. L. REV. 215, 227-29 (1992). For a general survey, see Terrence P. Sheehan, Note, *Theories of Concurrent Causation for First-Party Property Damage Insurance: Past Decisions and Present Applications*, 41 DRAKE L. REV. 765 (1992).

39. *Safeco*, 773 P.2d at 420 (Callow, C.J., dissenting).

40. Conversations on the West Coast lead me to believe, however, that coordination with earthquake coverage is a special case. So, also, did the California legislature. *See Garvey*, 770 P.2d at 727 (Mosk, J., dissenting).

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coverage, strongly comparable to all-risk coverage, was supplemented in standard-form marine policies by the inclusion of the so-called Inchmaree Clause. That clause was "first inserted in marine insurance policies to overcome the effects of a decision of the House of Lords which was adverse to the insured. The clause takes its name from the Steamship Inchmaree, which was involved in that case."[41] Occasions of loss encompassed by the clause include "latent defect in the machinery or hull [and] negligence of . . . mariners." Surely those extensions required marine interest-holders to choose—adapting the words of the dissenters in *Safeco*—between high premiums and foregoing perils-of-the-seas coverage entirely. Now, I cannot presume to say that the relation between the Inchmaree ruling and that coverage bears a near resemblance to that between Safeco's exclusions and all-risk coverage. Yet I believe a comparison is instructive.

It is apparent, moreover, that, as compared with hull marine interests, the homeowners that Safeco caters to are poorly situated to bespeak expansions of all-risk coverage.[42] When the crucial decision was made to maintain the rainstorm/landslide distinction, as recited above in the Safeco story, homeowners were of course not consulted. The want of subscribers' voices in the formulation of standard-form insurance contracts puts a powerful spin on issues of application that reach the courts.

The rainfall/landslide distinction is only one of countless coverage terms that generate problems of concurrent causation.[43] I surmise that the mass of insurance buyers do not appreciate the range and difficulty of these problems. Would the demand for insurance be noticeably affected if they did? There is reason to think so. It has been observed that parties bargaining on other subjects make references to insurance as

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41. Russell Mining Co. v. Northwestern Fire & Marine Ins. Co., 322 F.2d 440, 442 n.2 (6th Cir. 1963); *see also* Antilles S.S. v. Members of Am. Hull Ins. Syndicate, 733 F.2d 195, 198 (2d Cir. 1984); WILLIAM H. RODDA, MARINE INSURANCE: OCEAN AND INLAND 39 (3d ed. 1970).

The House of Lords decision referred to was Thames & Mersey Marine Ins. Co. v. Hamilton, Fraser & Co., 12 App. Cas. 484 (1887).

42. See Randall R. Bovbjerg, *Liability and Liability Insurance: Chicken and Egg, Destructive Spiral, or Risk and Reaction?*, 72 TEX. L. REV. 1655, 1666 (1994) (response to Syverud, *supra* note 8): "Producer interests in public actions affecting their bailiwicks are strong, concentrated, and persistent . . . . In contrast, consumer interests are weak, diffuse, and only sporadically asserted . . . ."

43. For a selection see KEETON & WIDISS, *supra* note 3, § 5.5(c).

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a way of economizing on the cost of reaching "complete contingent contracts."[44] Hence, it was suggested, insurance has a commercial utility that is distinct from the function of pooling risks. The instance is given, in support of this thesis, of a decision by a manufacturer and a shipper to arrange a transaction without specifying the effects of various low-probability contingencies, but to require that they be insured against.[45] Similarly, upon the sale of a home, the parties may well spare themselves attention to a host of risks by a term such as "insurance to be kept in force until closing." These economies would hardly be possible if insurance contracts were not themselves ready-made for the situation. It would not be possible, either, if a deficit of underwriting information were sensed, on either side, as a serious disadvantage. The demand for insurance rests, I conclude, on confidence in the degree of determinacy that insurance contracts provide; and there is much evidence—in cases such as *Safeco*—that confidence is misplaced.

II.

Purveyors of insurance might well consider themselves in a dispensable business—a "niche" business—if the market is conceived of as one for exchanges of underwriting information. The conditions required to make it otherwise are, first, that risks are manageable only in private markets and, second, either that patrons of the business cannot succeed as self-insurers by rearranging their ventures, or that insurers are a superior source of information about risk factors.

But those conditions do not certainly obtain. Evidences that they do not are marshaled below, in three parts. In summary, they are (1) that the signals that insurers send and receive about risk factors are thoroughly muddled; (2) that the growth of social insurance undercuts the demand for information of that kind; and (3) that strategies are available to insurance buyers by which to dispense with information of that kind. On the first point, some reasons will be given why one would *not* turn to an insurer as a source of information about risks. On the second

44. Skogh, *supra* note 20, at 727.

45. See Keith N. Hylton & Steven E. Laymon, *The Internalization Paradox and Workers' Compensation*, 21 HOFSTRA L. REV. 109, 155 (following Skogh, *supra* note 20): "[T]he manufacturer and shipper could in many cases arrange their own insurance between themselves. Yet we still see these parties purchasing insurance. The likely reason is that the insurance provides information that the parties are unwilling to trust each other to provide."

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point, the chief observation is that, not only does government-sponsored insurance directly displace privately offered insurance, but it has the exponential effect of suppressing sources of information that would facilitate privately offered coverages cognate to the scope of the former.[46] The third point has both theoretical and empirical support. Theory has it that firms can accomplish, through diversification of their portfolios, as much dispersion of risk as they require. And in fact, fee-for-service arrangements (sometimes in disguise) have come to figure prominently in the business of insurance, at the expense of exchanges of risk information.

A. *Information Exchanges*

> *The traditional notion is that the insurance firm simply pools risks. But the insurance firm is often a source of information for the insured.*[47]

Information flows in both directions in negotiations over insurance contracts. Often each party supplies to the other information about factors of risk that affect the situation of the would-be customer. "My factory is sprinklered," the applicant may say. "Then you are eligible for our lower-cost policy," the insurer may say. "Experience tells us that the reduced prospect of fire loss warrants a differential of *x%*." Well and good. Moreover, news of that differential is sure to spread, so that factory owners at large—and through them a larger public—are the gainers from the collected experience of the insurer. So highly do we prize gains of that sort that we suspend, on behalf of insurers, laws that might otherwise impede them in compiling experience in groups: e.g., the McCarran-Ferguson Act.[48]

The conversation imagined above is loaded with *naiveté*. Who would in fact turn to an insurer for information about risks, given any reasonable alternative? Some reasons one might *not* do so are these:

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46. Government *mandates* that insurance be provided need not have either of these effects. Unhappily, a subsidy of one kind or another is so regularly associated with mandates that they strongly suggest a distortion of the information that insuring provides.

47. Hylton & Laymon, *supra* note 45, at 155.

48. 15 U.S.C. §§ 1012-1014 (1945). For background see KEETON & WIDISS, *supra* note 3, § 8.1(a).

i. *Moral hazard*. A "low" charge for insuring a favored risk includes a component for classification errors; and overall these run in favor of disfavored risks. The "sprinklered" owner must appreciate that the charge might be still lower if the insurer could unerringly identify potential customers as sprinklered or not.

ii. *Self-interested optimism*. The incentive to hold or increase market share may color an insurer's projections of loss toward the shade of rose. Possibly a disinterested observer of fire losses would attribute frequency in recent ones—not to a short-term anomaly, as the insurer does—but to a long-term increase in arson.

iii. *Preference for continuity*. The insurer may be led, by both internal and external constraints, to undervalue the relevance of experience in the recent past, so as to achieve consistency over time at the expense of accuracy in its projections.[49] In contrast, the customer may be a short-term investor who wants accuracy for tomorrow and has no interest in smoothness of premium variations.

More important than any of these entries, it may be, is the circumstance that insurers' rate schedules embody, not "pure" premium, but together with that charges for marketing, for claim-handling, and for other "insuring" functions.[50]

To be sure, one can infer something about the cost of these functions from a rate schedule. With respect to various kinds of insurance—notably life insurance—a schedule of charges reveals that the cost of putting individual policies in place is substantially greater than the cost of providing comparable coverage in group form, and reveals something about the degree of difference. These bits of information are more or less "insurance-like" depending on the extent to which prices and risks are correlated. Prices for term life insurance are insurance-like in large measure, for example, because they are highly correlated with the mortality risks of cohorts of different ages. But prices for single- or

49. A requirement of prior approval of rate changes "limits the ability of each insurer to change rates immediately to reflect new information, positive or negative, on potential claims. The result is a set of rates that are smoother over time and that less closely track underlying costs than would be observed in a truly free or open competition regime." Hylton & Laymon, *supra* note 45, at 152. (As for the comparable effect of licensing requirements, see *id.* at n.175.)

50. Rate filings are another matter, as Professor Googins has pointed out to me; they may well differentiate among the components of enterprise cost. But relatively few customers are so analytical as to consult filings when making decisions about insuring.

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level-premium whole-life policies give comparatively mixed signals, for they are (as it were) contaminated with information about the supposed time-value of money.[51]

These illustrations, though crude, indicate how a firm in the insurance business can be regarded as a purveyor of information about risks, more or less specialized to that function, and how also the information can be contaminated. For a further illustration, consider retrospective rating, as it might be quoted in offering workers' compensation insurance. This is an excellent source of information about the costs of administering a claim-handling system, with relatively little admixture of information about loss projections.

Insurance-like information is of course degraded by various regulatory measures, including, for example, caps on rates. From that fact it might be concluded, hastily, that insurance simply disappears from the screen now in view—insuring as a purchase of risk information—when governments subsidize purchases of coverage. ("Subsidizing" is to be understood broadly here, so as to include not only the dedication of tax revenues but also the appropriation of revenues from lines other than the one subsidized.) But that is far from the right conclusion. The subsidy may well dominate, at the margin, individual decisions about insuring. It is not at all the case, however, that the unsubsidized price must drop from public view. Losses in what is called the residual market for auto insurance sometimes come forcibly to public attention. Not as often, perhaps, as the public interest requires, but now and then. Aside from that, information about risk factors continues to be provided through the private market; only it is more likely to be provided in the form of declinations. To be sure, information in that form does not reach the broad audience that rate information reaches. On the other hand, for those it reaches, news in that form may carry a message with special force, and may be more memorable than mere price information.

There is also, for all popular lines of insurance (as to which, only, subsidization is thinkable), the fact of what might be called "reverse subsidization." Insurers in these lines, not to mention others, must pay the costs of being monitored for solvency, and the costs of complying with the official criteria of solvency. They must, that is, maintain reserves, provide themselves with reinsurance, contribute to a guaranty fund, and the like, to the end that their promises will attain credibility

51. For an explanation of "contaminated," with reference to what count as *insurance* risks, see *supra* note 5.

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at a level that they do not severally choose. These burdens on suppliers are very real; they are a mark of being in a regulated industry; and they contribute to masking the element of loss projections in the supplier's price schedule.

The case against "subsidies" is, on the whole, not strongly founded on the conception of insuring as an information exchange.

B. *Social Insurance*

No data! How are we going to get data unless you issue the insurance?[52]

A social insurance scheme may constrain the private market in several ways. Sometimes the statutory regime includes a simple proscription on marketing a competitive product. Whether or not it does that, government-provided insurance has the direct effect of displacing demand that might otherwise be met from a private source. Professor Michael Rappaport has argued, for example, that insurers might have developed a robust market for unemployment insurance if state initiatives had not diverted the clientele.[53] Steps in that direction were taken in the first third of this century.[54] "[T]he private insurance alternative was abandoned based largely on political considerations and an intellectual environment that was increasingly hostile to market institutions."[55] But the efficient cause for the abortion of this alternative was the advent of Social Security.

The effect of government-sponsored insurance is to "crowd out" the potential for private unemployment insurance. This effect has several aspects. The one I consider most comprehensive is that of suppressing the source of information on which the private market depends. Rappaport—on whose work I draw heavily—alludes to two other aspects. First, the demand for unemployment coverage is sapped by the massive government mandate; the potential for supplementary coverage is marginal. Second, subsidies of various types characterize the official

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52. Speech by Haley Fiske, President of the Metropolitan Life Insurance Company (1926), *in* Michael B. Rappaport, *The Private Provision of Unemployment Insurance*, 1992 WIS. L. REV. 61, 67.

53. Rappaport, *supra* note 52, at 57.

54. *Id.* at 64-71.

55. *Id.* at 62 n.4.

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scheme. These circumstances can be subsumed, I believe, under the general proposition that government-sponsored insurance devalues the information that might be developed in a private market. We cannot know, for example, how seriously competitive offerings of unemployment insurance, across the board, would be threatened by moral hazard, owing to the large-scale preemption of those offerings; and the fact that governments use the insurance for distributional purposes degrades whatever information on that subject can be drawn from the sponsored schemes.[56]

The second session of the 103d Congress floundered in a sea of data about medical-expense insurance as it exists, and as it might exist under various reform proposals. Much of the data was known to be infirm, of course. The infirmities were especially acute with respect to proposals in the mid-range of magnitude. Relatively radical proposals (such as that for single-payor insurance) had something in common with the least-intrusive proposals (such as mandating coverage for the maladies of children): for each of them some reasonably reliable elements of cost could be projected. In this, I believe, the legislative dilemma was in no way exceptional, but was characteristic of moves to intervene in insuring practices. The measures on which political judgments are most likely to converge are the very ones most afflicted with speculation about financial impacts. At the same time, some of those impacts are quite visible. (The Clinton plan would have done much damage to the centers of medical teaching and research.) These circumstances, together with others, led to inanition.

Whether or not the upshot was regrettable, it was a notable recognition of a truth about the private insurance market: although official interventions might, and sometimes do, augment its utility as a producer of useful information, their typical tendency has been subversive of that function. By and large, insurers regard these interventions as a threat to the prosperity they enjoy (such as it is) as bearers of risks. They are fearful of displacement of that role, as any niche enterprise must be. The point made here is that they have equal reason, or more, to fear official administration of risks as encroachments on their role as providers of information.

56. As to government-sponsored insurance in general, see KIMBALL, *supra* note 3, at 694-95. For papers on federal insuring programs, especially those embracing financial risks, see GOVERNMENT RISK BEARING (Mark S. Sniderman ed., 1993).

C. Risk Retention

[I]nsurance is not a necessary tool in managing corporate risk.[57]

For at least some firms insurance contracts are dispensable. That is a thesis commonly advanced, with various qualifications, by theorists of corporate finance. The point is glancingly recognized in treatments of the law of insurance. In the Keeton & Widiss text on insurance law, for example, a section on risk retention contains this passage: "If one entity, such as a corporation or a governmental agency, engages in a sufficient volume of ventures of a given type, the risks of all the ventures can be spread by the enterprise acting on its own."[58] Two supplements to this proposition are required to arrive at the generalization that insurance has little utility for an enterprise in corporate form. First, arranging insurance contracts is a costly way of spreading risks. Second, an efficient firm will adapt its activities so as to minimize costs. The firm will, that is, alter its commitment to "ventures of a given type"—abandoning some and taking up others—to the point where it can, "acting on its own," spread the risks of all its ventures and need not enlist the aid of an insurer.

The conception of insuring as an information exchange reinforces the thesis of dispensability. One would not pay for information that is ready to hand through an examination of one's own experience. There is eloquent testimony to this fact in the practices of large firms. They retain immense quantities of what would, in relation to a small firm, be characterized as "risk."[59] The claim has been made that retrospectively rated policies are the "predominant form of unrelated insurer coverage for large businesses."[60] The following paragraphs refer to this and some other well-known arrangements that, although they are called by the name "insuring," largely feature services by an insurer other than giving signals about loss projections.

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57. Richard D. MacMinn, *Insurance and Corporate Risk Management*, 54 J. RISK & INS. 658, 658 (1987).

58. KEETON & WIDISS, *supra* note 3, at 13.

59. Another way of expressing that fact would be to say that non-catastrophic fortuitous losses are simply not *risk*.

60. Winslow, *supra* note 3, at 138.

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Theorists of corporate finance believe that insurance serves, in spite of the thesis described above, to moderate a kind of moral hazard associated with debt obligations. The bondholders of a corporation have reason to fear the attitude of risk neutrality on the part of the firm's managers; correspondingly, the managers do not want it to be seen that they have that attitude. By arranging insurance, the managers give a signal—which redounds to the benefit of shareholders—that they are risk averse. This is in crude form a qualification on the broad thesis stated above (crudely) as the thesis of dispensability.

A judgment about the thesis depends a good deal on what is understood to be a contract of "insurance." That can be shown by reference to an investment contract drawn from a recent case.[61] The contract addressed the concern of the investors about the attitudes of the firm's managers toward risk; yet it was not one of insurance in any standard sense.[62] The managers enticed outsiders to invest by underwriting the firm's profitability. More exactly, they contracted that, for a time, the firm would maintain a specified level of earnings; and the managers were to make an investment of their own to the extent that the firm fell short of a defined break-even point during that period. (Let this contract be called, for convenience, the "triggered-investment contract.")

The making of this contract gave no signals particular to the facts that count in underwriting. To be sure, the managers' obligation to invest would doubtless be triggered by an uninsured casualty loss (one of a certain magnitude). But the parties bundled that kind of risk together with the simple risk of the misfortune of unprofitable operations. The information that the outside investors can have derived from the negotiations was about nothing more than the insiders' expectations.

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61. National Tax Credit Partners, L.P. v. Havlik, 20 F.3d 705 (7th Cir. 1994).

62. Apparently it was one, however, on a view taken by some economists. *See* Isaac Ehrlich & Gary S. Becker, *Market Insurance, Self-Insurance and Self-Protection*, 80 J. POL. ECON. 623 (1972). Adapting their diction, the position was as follows: For the firm to achieve the specified earnings level, or to fall short of it, represented "mutually exclusive and jointly exhaustive 'states of the world'"—one more "well-endowed" and the other less so. The promisor-managers faced diverse consumption opportunities contingent on the occurrence of these states; and they chose to redistribute income toward the one less well-endowed. Of course, in the law's eye the managers required no license to make this contract, for it was simply a financing contract. Any number of other financing contracts (doubtless including letters of credit) would seem to fit the authors' conception of insurance, but not that of the law.

Further comment on this view is presented *infra*.

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The other side of the coin is that contracts called "insurance contracts" sometimes convey little or nothing about expectations. Firms offering insurance are under steady pressure to slough off the function of providing information. That is the general conclusion to be drawn from industry moves toward retrospective rating, which has been called "quasi self-insurance," with respect to workers' compensation insurance.[63] "Retrospective rating . . . assesses premiums not on the basis of expected losses over the policy period ahead, but according to the actual losses incurred in the period just passed."[64] A subscriber to a retrospectively rated contract does, of course, pay the insurer for services; and often a floor and a ceiling are set on a charge to which the employer commits itself. (Hence, *quasi* self-insurance.) But the premium arrangements sought by large firms are so variable, it is said, that "no real risk is shifted."[65]

Experience rating tends toward the same conclusion,[66] though less obviously. "Under experience rating [of workers' compensation insurance], an employer's class premium[67] is modified to reflect the firm's

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63. Hylton & Laymon, *supra* note 45, at 145. On rating plans for this insurance, see generally CURRENT ISSUES IN WORKERS' COMPENSATION (James Chelius ed., 1986).

64. Hylton & Laymon, *supra* note 45, at 145. For a somewhat more fine-grained account see *id.*

65. Winslow, *supra* note 3, at 138.

66. "The main difference between experience rating and retrospective rating is that the former uses the employer's experience from previous periods to modify the current policy period rate, whereas the retrospective plan uses experience from the current policy period to determine the current premium, on an *ex post facto* basis." CURRENT ISSUES IN WORKERS' COMPENSATION, *supra* note 63, at 133.

Compare Hylton & Laymon, *supra* note 45, at 148: "It is important to remember that experience rating schemes emphasize a forward-looking calculation, that is, insurers wish to predict losses and costs in the year ahead, not to penalize for losses in the years passed."

Moreover, experience rating is offset by the introduction of a "credibility factor," which reflects the magnitude of the subscriber's operations. The loss experience of small firms is more variable than that of large firms, year-by-year. (Compare the "law of large numbers.") Firms of a certain magnitude are therefore assigned a percentage of adjustment to the otherwise determined charge; and the percentage varies inversely with size. "[T]he premiums of very large firms are almost wholly determined by their experience rating, without the meaningful intervention of a credibility component." *Id.*

67. As to class rating, see Hylton & Laymon, *supra* note 45, at 146.

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specific injury experience . . . ."[68] "If there is a common argument concerning experience rating, it is that there is too little of it. The typical complaint is that the insurance industry, for some reason, does not use experience rating as much as it should."[69] Using the conception of "insuring" as gathering, processing, and disclosing of information, I take this argument to be one against insuring.[70]

Both retrospective rating and experience rating represent a diminution in the significance attached to the insurer's assessment of the riskiness of employment according to the subscriber's line of business and to the composition, by work assignments, of its work force. Of the two, retrospective rating is the more independent of the insurer's contribution of information—via class rating—but only in degree.[71]

Contracts issued by a captive insurer are also dubious candidates, sometimes, for the characterization "insurance." The point has arisen chiefly in relation to issues of taxation. In that connection, it has been suggested that the capacity of a firm to disperse risks internally makes it ineligible to be an "insured" even when it participates in the standard insurance market. That thought is directly cognate with the conception of insuring as an exchange of information.

Not only do gainful opportunities for risk retention, open to corporations of a certain size, dampen the demand for insurance, but also extreme inequalities of individual wealth do so. Along with wealth, in general, comes decreasing risk aversion; so the preference curve runs. It follows that, the larger a person's wealth, the lesser is the optimal amount of insurance for that person.[72] The implication is that, if insur-

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68. *Id.* at 147.

69. *Id.* at 153.

70. *But see* ABRAHAM, *supra* note 3, at 80-81. See also Abraham, *supra* note 15, at 980-85, proposing a system of "retroactive indexing" of premiums for insurance against environmental liabilities.

71. The advice of an insurer, bought and paid for, may determine a firm's choice as among these and other rating plans—not excluding the employment of an insurer as a claims administrator. My view is that an insurer providing underwriting information in this transaction steps out of the role of insurer, and into that of an "outside" risk manager.

72. *See* Jan Mossin, *Aspects of Rational Insurance Purchasing*, 76 J. POL. ECON. 553, 564 (1970). "If the individual has decreasing risk aversion, then the optimal coverage is lower the larger his wealth." *Id.* at 558. (There are, however, problems about discerning this from observations of decisions actually made. One of the problems is that, even with respect to an individual decision-maker, the "slope of the risk aversion function" must take account of both present and future consumption oppor-

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ance is not already a niche business, it will become so at some point on the path toward the extreme of wealth disparities.

CONCLUSION: THE ENTROPY OF DATA

Is insuring—considered as an exchange of information—a flourishing enterprise? Or is it moving toward the margin, where niche enterprises operate under the threat of extinction?[73] Possibly a rough index could be constructed, subject to some restrictions, by reference to what might be called the entropy of data. Some types of insurance exhibit relatively high sensitivity to entropy, others not. A prime illustration, drawn from the sector of vocational liability insurance, is the contrast

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tunities. *Id.* at 564.)

Studies, by group, of choices made in insurance-like contexts are summarized in Paul J. H. Shoemaker & Howard C. Kunreuther, *An Experimental Study of Insurance Decisions*, 46 J. RISK & INS. 603 (1979). The variable "wealth" may be less significant than *expected* wealth, and both may be less significant than expected income. It should be noted that a set of undergraduate students—presumably impecunious—appeared, in the study reported above, to be more risk-acquisitive than a set of clients of an insurance agency. *Id.* at 608.

73. The extinction of the business as generally conceived is not imminent. Some statistics are considered obligatory in a paper such as this. Those given in the following paragraph are derived from data, with respect to life insurance, as reported in the AMERICAN COUNCIL OF LIFE INSURANCE, LIFE INSURANCE FACT BOOK with respect to property and casualty insurance, as reported in INTERNATIONAL TRADE ADMINISTRATION, U.S. DEPARTMENT OF COMMERCE, U.S. INDUSTRIAL OUTLOOK, 1994 and with respect to health insurance, as reported in HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA—all reproduced in the U.S. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE UNITED STATES (114th ed. 1994) as Tables 828-830 (pp. 534-35).

Over the four-year period 1987-1991, life insurance in force, issued by U.S. insurers, increased by 34%. (This increase is the more significant in that the proportion of group insurance to the whole decreased slightly.) For the same period the *premium income* of insurers from providing health insurance increased by 38.41%. Comparable income from providing property and casualty insurance increased by 15.42%. (But it must be noted that the underwriting loss of these insurers more than doubled during this period.) Even after applying a deflator drawn from the Consumer Price Index, all these ratios were in double digits.

See also KIMBALL, *supra* note 3, at 682-83 ("The world's gross premiums in the direct insurance market (life and nonlife) reached $1,210 billion in 1989, compared to $498 billion in 1984."). Statistics of liability insurance are reported in Syverud, *supra* note 8, at 1629-30, especially nn.1-4. "From 1965 to 1986, the amount we spent on liability insurance grew in real terms by 8.7% annually." *Id.* at 1629-30.

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between coverages written on the "occurrence" basis and those written on the "claims made" basis. The former has what is inelegantly called a *long tail*: it extends to liabilities that may transpire in a relatively distant future. Claims-made coverage does not. The two are roughly equivalent, so long as the enterprise insured throws off claims that are even over time in frequency and magnitude.

But a major discontinuity in claims experience will throw off any calculation. (Experience with asbestosis claims is the standard example.) The data of past experience suffers entropy. If, however, the contract insures against claims transpiring in the near future, and only those, comparatively good projections of loss can be drawn from recent claims experience. Hence: claims-made coverage.

Occurrence-based contracts feature references by the underwriter to events of considerable age; the charges are relatively insensitive to events of the recent past. In contrast, the underwriting of claims-made contracts is especially attentive to the incidence of recent events.[74] For this reason (among others), rates for occurrence-based coverage are more informative than rates for claims-made coverage, with respect to projections from accumulated experience. In recent years insurance offerings have shifted away from the former, and toward the latter. That shift signifies a move of insurance toward the periphery of product-liability and related coverages. It has been officially discouraged.[75]

The difference is, however, one of degree. Time lags are built into insuring, considered as an exchange of information. In particular, data from a more or less distant past enter into the signals that prices convey. Claims-made coverage is not an exception to this proposition, in principle.

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74. *See* ABRAHAM, *supra* note 3, at 49-51, 58-59; KEETON & WIDISS, *supra* note 3, § 5.10(d)(1), (3); Abraham, *supra* note 15, at 980, 982; Steven Pottier & Robert C. Witt, *On the Demand for Liability Insurance: An Insurance Economics Perspective*, 72 TEX. L. REV. 1681, 1690-91 (1994).

75. Minimum standards for approval by the New York Insurance Department of claims-made policy forms, for specific types of commercial-liability coverage, were established by Regulation No. 121, N.Y. COMP. CODES R. & REGS. tit. 11, § 73 (1993); *see* Press Release from N.Y.S. Ins. Dept. (July 16, 1986) ("[W]idespread use of the claims-made policy approach would be inappropriate as well as unnecessary for most Commercial General Liability (CGL) risks.").

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The conception of insurance depicted here is directly opposed by one that assumes the complete entropy of data. That conception is espoused by the economists Gary Becker and Isaac Ehrlich.[76] They make the claim, implicitly, that regulation of the market for insurance is unrelated to the function of conveying underwriting information. In their view, insurance contracts are simply a specialized form of financial contracts—"derivatives" as we might now say.

Ehrlich and Becker put forward this case: Lightning may strike a home, causing damage. The prospect (probability) of the strike is beyond human control, but the prospect of damage can be moderated by installing a lightning rod. Is it the former or the latter prospect (they ask) that is "relevant" for deciding on the optimal response by the homeowner to his risk? According to the Becker-Ehrlich analysis, the homeowner must consider his consumption opportunities with a view to the opposing "states of the world" *damage* and *no damage*—not the states *lightning strike* and *no strike*. "It has been claimed (they say) that states can always be defined to guarantee the independence of their probabilities from human actions, but we deny that this can be done in a meaningful way . . . . [A] search for state probabilities that are independent of human actions would be self-defeating."[77] There is, in other words, no such thing as a pure fortuity, when attention is paid to losses insured against as opposed to occasions of loss.

Economists and lawyers do not differ, I daresay, on the latter proposition. Ehrlich and Becker have tilted at a straw man. It is not that the law identifies insured events with "state probabilities" that are *wholly* independent of human action; rather, the legal conception of insurance assumes a *relative* independence. Just as we see, among differing forms of insurance, differences in the degrees of data entropy, so also we must acknowledge that fortuity is a matter of degree. There are border-

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76. *See* Ehrlich & Becker, *supra* note 62. This was in response to Arrow, writing as follows:

> Insurance is not a material good . . . . [I]ts value to the buyer is clearly different in kind from the satisfaction of consumers' desires for medical treatment or transportation. Indeed, unlike goods and services, transactions involving insurance are an exchange of money for money, not money for something which directly meets needs.

KENNETH J. ARROW, ASPECTS OF THE THEORY OF RISK BEARING 45 (1965).

As it seems to me, this passage discounts unduly the content of information in the exchange.

77. Ehrlich & Becker, *supra* note 62, at 638.

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line cases. But the case of damage to structures by lightning is not among them. On the probability of damage by lightning, recorded history is revealing. (The more so, of course, on the probability of lightning strikes.) Indeed, relatively ancient history is revealing on this subject: the data are not subject to anything near instant entropy.

The point needs to be insisted on, simple as it is. The justification for regulating insurance contracts depends heavily upon it. We do not accept it that the "products" of insurers are determined optimally by competition. In this matter (as in others) the law is at odds with Hayek, the prophet of competition for this century. He preached the merit of "competition as process."[78] Following him, we should expect insurers to cultivate ever-new sources of information, to reconfigure it continuously, and to convey it in idiosyncratic codes. To the extent that they do not, we should regard them as a dead weight on enterprise.

The case is of course otherwise. We insist on conventions of communication from insurers (e.g., standard-form contracts). We authorize them to build compatibility into their systems and programs, and indeed compel them to do so in various ways. We require that their prices reflect accumulated experience. These modes of regulation require justification, naturally. In my view the best form of justification is a claim about the particular stocks of information that insurers command—a claim that unconstrained competition would impair the ongoing utility of that information. A public good resides in the durability of institutional memories.

That being allowed, it must be added that regulation of the business may have lost something of its one-time justification. My impression is that those who engage in it, and those who patronize it, do not regard exchanges of information as a function so central to the enterprise as it once was. The entropy of data accelerates; and as it does the business of insuring appears increasingly to be a niche business.

78. F. A. HAYEK, NEW STUDIES IN PHILOSOPHY, POLITICS, ECONOMY AND THE HISTORY OF IDEAS 179-90 (1978).

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ALLOWING MOTORISTS A CHOICE TO BE LEGALLY UNINSURED BY SURRENDERING TORT CLAIMS FOR NONECONOMIC LOSS

(WITH SOME FURTHER THOUGHTS ON CHOICES BETWEEN PIP AND TORT COVERAGE)

*Jeffrey O'Connell**

This Article presents some of my latest thoughts on auto insurance reform, particularly with regard to problems of less affluent individuals. Part I presents a proposal for the legalization of uninsured drivers, with comments on the likely constitutional status of such a proposal. Part II suggests more general improvements to no-fault insurance in the form of a choice between personal injury protection (PIP) and tort liability payments. The interactions of these proposals are summarized in part III of the Article.

I. A CHOICE TO BE LEGALLY UNINSURED

Uninsured motorists have long been a bane of American motorists. In 1968, at least 4% of drivers in every state were uninsured, tallying a minimum of 5 million uninsured motorists in the United States.[1] As time passed, the problem snowballed. By 1981, 8% of all car owners were not covered by automobile insurance, according to a study by the Insurance Information Institute.[2] In 1991, the most reliable estimate of the number of uninsured motorists in the United States had risen to 17 million. Industry officials estimated that uninsured motorists cause one of every eight accidents—a 40% increase over the last decade.[3] That

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1. ALAN I. WIDISS, A GUIDE TO UNINSURED MOTORIST COVERAGE v (1969).

2. ALAN I. WIDISS, UNINSURED AND UNDERINSURED MOTORIST INSURANCE § 1.12, at 15 (2d ed. 1992).

3. Fannie Weinstein, *Bane of the Highways*, 52 INS. REV. 32, 34 (1991).

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same year, it was reported that in Los Angeles 52% of the population was uninsured.[4]

Corresponding to the increase in numbers of uninsured motorists was an increase in first-party claims for uninsured motorist coverage. (Under uninsured motorist (UM) coverage, one buys first-party coverage from one's own automobile liability insurer. In the event of an accident, the insurer pays as though it were insuring the liability of the uninsured motorist who tortiously injured the motorist with UM coverage.) During a two-week period in 1977, twenty-nine insurance companies—who provide over 60% of all private passenger insurance in the United States—were polled as to the amount of insurance claims that were paid. The results indicated that 5% of the claims were paid with uninsured motorist coverage.[5] Three years later, an All-Industry Research Advisory Council (later entitled the Insurance Research Council) study of uninsured and hit-and-run drivers found that about 10% of all motor vehicle liability insurance claims resulted from accidents involving uninsured motorists.[6] A report by the Insurance Research Council stated that uninsured motorist claims nationwide rose by 20% between 1976 and 1986.[7] According to the National Association of Independent Insurers, the number of uninsured motorist claims for private passenger nonfleet vehicles increased 62% between 1983 and 1987. Over the same period, the average size of uninsured motorist claims also rose dramatically: 58% in Pennsylvania, 78% in New Jersey, and 149% in New Mexico.[8]

What makes these statistics even more ominous is a 1981 California report stating that "in terms of mean number of prior accidents, the uninsured motorists had 72% more accident involvements than the average of their counterparts in the general population."[9] Thus, uninsured motorists seem disproportionately to cause accidents.

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4. Gerald D. Stephens, *Please, No More Complaints*, BEST'S REV., Jan. 1991, at 61, 63 (1991). For a statistical study on the rising rate of uninsured motorists, see ALL-INDUSTRY RESEARCH ADVISORY COUNCIL, UNINSURED MOTORISTS (Oct. 1989) [hereinafter AIRAC].

5. WIDISS, *supra* note 2, § 1.12, at 15.

6. *Id.* at 16.

7. Weinstein, *supra* note 3, at 32.

8. *Id.*

9. WIDISS, *supra* note 2, at 16 (citing Jensen Kuan & Raymond C. Peck, *A Profile of Uninsured Motorists in California*, Department of Motor Vehicles, Business, Transportation and Housing Agency, St. of Cal., Feb. 1981, at 1).

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The vast increase in the numbers of uninsured motorists is caused, in part, by the high expense of even low limits for personal injury automobile liability coverage. Because claims for pain and suffering lead to such relatively high payouts in smaller cases (for, say, "whiplash" claims, entailing soft tissue injuries not manifesting themselves by objective measurement, such as by x-rays), the cost of even low compulsory limits for such coverage—especially in inner cities—can be astronomical, upwards of $1000 per year, further leading the poor to be unable to pay for even minimum limits. As a result, many less affluent people are driven from the insurance pool.

It was the growing problem of uninsured motorists nationwide that led to uninsured motorist coverage not only being available in state after state, but required—or at least required to be offered.[10] Naturally enough, the increasing numbers of uninsured motorists have caused the cost of uninsured motorist coverage to escalate rapidly in recent years.

But here we reach a "Catch 22" situation. Increased numbers of uninsured motorists directly cause an increase in the cost of uninsured motorist coverage, and the increased cost of uninsured motorist coverage contributes to the increasing number of uninsured motorists. One cannot underestimate the increasing resentment of insured motorists at this situation.[11] Not only must they pay ever larger amounts for uninsured motorist coverage, but those same uninsured motorists, while illegally avoiding their fair contribution to the auto insurance pool, withdraw amounts from that pool by virtue of their claims against insured motorists—claims that are totally undiminished by their own uninsured status. That many uninsured motorists are from minority groups adds an ugly element to all this resentment.

Furthering the numbers of uninsured drivers, and the resentment toward them, is the low possibility of detection or apprehension of uninsured drivers. Even those uninsured motorists whose drivers' licenses or car registrations are suspended or revoked continue to drive with relatively little possibility of detection or apprehension—or even punishment upon apprehension.[12] As Professor Jennifer Arlen has written,

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10. For a concise listing of each state's law in this regard, see AMERICAN INSURANCE ASSOCIATION, SUMMARY OF SELECTED STATE LAWS AND REGULATIONS RELATING TO AUTOMOBILE INSURANCE (1994).

11. *See* INSURANCE RESEARCH COUNCIL, PUBLIC ATTITUDE MONITOR, fig. 4-2, at 24 (1993) (reporting on a survey of Roper-Starch Worldwide Inc.; 57% of respondents reported more uninsured motorists as a major factor contributing to rising auto insurance premiums).

12. *See* Steven L. Myers, *Suspensions Don't Slow Drivers: And Many Get Behind*

criminal laws regulating the misconduct of motorists are simply not adequately enforced. "[D]espite stringent drunk driving laws," she tells us, "Georgia has tens of thousands of repeat offenders, and . . . judges do not take away drivers' licenses even when a driver has 15 drunk-driving convictions."[13] If those charged with law enforcement ignore egregious conduct such as chronic drunk driving, they certainly will not—and do not—punish the relatively innocuous offense of driving without insurance.

But if the threat of punishment does little to force less affluent motorists back to the insurance pool, neither may lowering the cost of auto insurance, as an experience in Florida indicates. In 1982, Florida amended its compulsory auto insurance law to enable a motorist without assets to buy only $10,000 dollars of no-fault auto insurance, eliminating the requirement that one also buy bodily injury liability insurance with at least a $10,000 limit. But the resulting drop in the costs of basic compulsory coverage had minimal effects on the number of insureds.[14]

When one thinks about it, the decision of poor people, with few or no assets to protect, to drive uninsured for tort liability makes eminently good economic sense. Facing large unmet needs for essentials for themselves and their families,[15] why should they annually spend many hundreds of dollars to buy an arcane piece of paper providing a highly

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the Wheel with Suspended Licenses or None at All, N.Y. TIMES, Apr. 25, 1993, at 43.

13. Jennifer H. Arlen, *Compensation Systems and Efficient Deterrence*, 52 MD. L. REV. 1093, 1114 n.79 (1993) (citing Adam Gelb, *Georgia's Drunk Driving Scandal: The State Can't Get Drunks off the Road*, ATLANTA J. & CONST., Nov. 3, 1991, at A1).

14. *See* AIRAC, *supra* note 4, tbl. 4, at 7. When Michigan passed its no-fault auto insurance law requiring both liability and no-fault coverage, it provided that uninsured motorists (but not members of their family) would be ineligible for payment from either PIP or tort (below the threshold). As a result, the totally blameless uninsured motorists can be without any remedy when injured by even a grossly negligent motorist. To some this has seemed a very harsh provision indeed. At least Michigan does not similarly penalize the uninsured's family members; they can claim no-fault benefits from a car in or by which they are injured. The provision later suggested herein seems fairer all around than the Michigan one. *See infra* notes 17-18 and accompanying text.

15. *See infra* note 24 and accompanying text.

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contingent, long-delayed transfer payment to strangers probably far more affluent than themselves?[16]

This whole sad tale should point us to taking another look at the phenomenon of uninsured motorists. If luring them into the insurance pool by substantially lowering the cost of coverage, along with the draconian threat of punishment with the loss of a driver's license and car registration, will not work, what can be done?

Motorists should be allowed to go uninsured with the only penalty that one's uninsured status disallows one—and also one's dependent family members—from tort claims for noneconomic losses (principally pain and suffering), unless one is tortiously injured by a motorist guilty of illegally driving under the influence of alcohol or drugs or of intentionally inflicting injury.[17] In other words, let those who cannot (or will not) pay cash for automobile insurance pay for it, in effect, with their uncompensated pain and suffering. But because payment for pain and suffering is that component of damages normally tapped to pay plaintiffs' lawyers' fees,[18] uninsured motorists should also be entitled to reasonable attorneys' expenses in addition to payment for their economic losses.

A. *The Advantages of Legalizing Uninsured Motorists*

1. Advantages to the Insureds

Under this plan, those who remain insured for bodily injury will be rewarded by lowering the costs of their liability insurance because they will now no longer be exposed to claims for noneconomic loss from the uninsured. This equation ought to assuage the outrage of insured motorists who are liable for full common law damages to the uninsured but unable as a practical matter to recover any losses, economic or noneconomic, from such motorists. The reason the proposal allows the uninsured to still recover economic losses is that it would seem to be inequitable in the extreme to allow, say, a very affluent motorist with

16. *See infra* note 26 and accompanying text.

17. This concept could also be applied in a no-fault state, applicable to tort claims preserved above the threshold. *See* Jeffrey O'Connell et al., *The Costs of Consumer Choice for Auto Insurance in States Without No-Fault Auto Insurance*, 54 MD. L. REV. 281 app. B (1995). For further variations, see *infra* part III.

18. CHARLES WOLFRAM, MODERN LEGAL ETHICS 528 n.21 (1986).

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huge assets to negligently damage an impecunious motorist or pedestrian and escape scot-free without paying any losses.[19] Professor Stephen D. Sugarman of the Berkeley law faculty has written as follows:

> This proposed restriction on recovery is analogous to the norm now applied to auto accident victims whose own negligence contributes to their injuries. For example, if there is a crash between someone who runs a stop sign and a speeder and the speeder is hurt, then his fault is compared with the fault of the other driver, and the amount of money the speeder recovers is reduced proportionately. Under O'Connell's reform the motorist who is at fault for not carrying insurance would have his legal award cut down as well—by losing the pain and suffering damages he might otherwise have obtained.[20]

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19. As an alternative proposal, when a claim is made by anyone classified as an uninsured motorist, if the defendant provides the victim, within ninety days after the filing of the claim, a written commitment to pay the claimant's economic loss in excess of any other available coverage, plus a reasonable attorney's fee, the claimant would be foreclosed from pursuing the tort claim any further. However, under one version of this "early offers" approach, the claimant could pursue the claim if it could be proven beyond a reasonable doubt that the defendant, either himself or vicariously, was guilty of intentional, drunken or drugged misconduct in causing the accident. An alternative provision could allow only actions for economic loss and punitive damages to survive the early offer.

For the origins of this approach, whereby full-scale tort liability can only be avoided by such early offers, see Jeffrey O'Connell, *Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses*, 77 NW. U. L. REV. 589 (1982). Under this approach, defendants are encouraged, but not required, to provide expeditiously an offer to pay benefits covering only net economic loss above collateral sources, rather than spending precious resources litigating fault and the value of noneconomic loss, as well as paying for the latter.

This "early offers" approach might be deemed better, for example, than just allowing an injury victim to claim in tort for only economic loss. Under the latter approach, a defending insurer might well be under a strong incentive to resist and delay payment of a tort claim for economic loss, knowing that its exposure is thus limited. This is a common complaint under tort claims for property damage against some insurers when they similarly face no exposure to payment of noneconomic loss. Under the "early offers" approach, an insurer must earn the right to pay an uninsured motorist only economic loss, by promptly (within ninety days) offering to do so. On the other hand, a defendant with either no, or very doubtful, liability would not be inclined to make an early offer to evade full-scale tort liability.

20. Stephen D. Sugarman, *Put a Limit on Uninsured Motorists' Right to Sue*, SACRAMENTO BEE, Apr. 26, 1995, at B7.

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2. Advantages to the Less Affluent

Lest it be thought the proposal is unfair to those unable to afford auto insurance,[21] one must consider the adverse consequences of the

21. An analogous (and indeed also arguably "politically incorrect") solution to a different but related problem concerns appeals of criminal convictions by the indigent whereby those who have violated the law also gain an undue advantage compared to the law-abiding.

> The problem [of the hopeless appeal] is the product of the worthy effort to assure equal justice to indigent persons accused of crime. Despite its entirely meritorious sources, it is nevertheless a serious problem which is too easily discounted by some observers. . . . [H]opeless appeals can clog the judicial system and cause an erosion of the process which results in less adequate justice for those appellants who do have substantial questions to raise . . . [An] alternative . . . appears to be to provide some counter-incentive [sic] which might influence the decision of the defendant to initiate an appeal. Much of the problem lies in the fact that the indigent is in a no-lose situation, which provides every inducement to appeal, however forlorn the hope.
>
> Creating valid counter-incentives [sic] under our Constitution is not easy. As the due process and equal protection clauses have been construed, indigents cannot be subjected to handicaps that are not laid on non-indigents. Courts cannot deal with indigents' cases in ways that are less favorable than the ways in which they deal with non-indigents' cases. But from this constitutional development, sound enough in principle, a reverse inequality has in fact emerged. Indigents now are not treated equally; they are given preferred treatment.
>
> The indigent's preferential treatment derives from the no-lose position; non-indigents are in no such position. A non-indigent convicted of crime must pay the expenses of his appeal—transcript preparation costs, court costs, and counsel fees. And he must bear these expenses, win or lose. Before taking an appeal, a non-indigent must weigh the likelihood of success and the value of success against the monetary cost. . . . In making this decision he will, of course, be influenced to a large extent by his attorney's appraisal of the case. Thus, to advise his client, a non-indigent's lawyer must think hard about the substantiality of the issues and form a judgment about whether an appeal would be worthwhile. Such decisions do not have to be made by an indigent and his counsel. In short, the non-indigent and the indigent do not stand on level ground. The non-indigent alone has incentives not to appeal; he must balance benefit against cost.
>
> While the Constitution prohibits treating indigents less favorably, the Constitution has not been construed to prevent measures designed to put indigents and non-indigents on equal footing. Nor should it be. . . . The key to our proposal for equalizing all criminal appellants is to give the indigent defendant something to lose in the appeal similar to that which the

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present system for the poor. A Fall 1994 editorial in an African American Philadelphia newspaper read as follows:

> If you just listened to the candidates [jockeying] for election in November, you would easily think that the only *issue* of importance is crime because all the candidates talk about is who will be the "toughest" on criminals.
>
> There is one issue that impacts more Philadelphians than all of the crimes committed in any given month and that is the (criminal) auto insurance rates Philadelphians are FORCED to pay simply because they live within the city.
>
> Because state law mandates that all motor vehicle owners must have insurance to drive those vehicles and because many Philadelphians are required to pay auto insurance rates far in excess of the value of the vehicles they drive, many Philadelphians are committing a crime because they are driving without the legally required auto insurance.

> non-indigent has. The following scheme aims to do that by creating a monetary stake that will cause the defendant to appraise his case, with the aid of counsel, and decide whether there are any appealable issues that make the appeal worthwhile when balanced against the economic loss that will be involved.
>
> A monetary stake can be created by establishing a fund that might be called the Criminal Defense and Rehabilitation Fund. This fund, supplied out of tax money, would be used to defray the expenses of appeals for indigents who do take appeals. However, the defendant would be given an option: he could pursue his appeal at public expense (as he can now) or he could elect instead to take a specified amount of money from the fund, either for himself or to be paid to persons he would designate. . . .
>
> This plan would force the defendant to think about his case as a non-indigent must. The plan would not treat indigents less favorably. Indeed it would afford them a financial benefit not now available. If the defendant elected to take the money, he would forever forego his right to take an appeal or to pursue collateral procedures at public expense. Of course he would remain free to pursue such litigation thereafter at his own expense.
>
> The plan makes sense in that often a sum of money would be more useful to a defendant or his family, as well as to society, than the pursuit of a fruitless appeal. Indigents and their families are by definition not affluent. This arrangement would be an indirect means of affording financial assistance to needy persons while at the same time providing salutary counterincentives to filing meritless appeals.

PAUL D. CARRINGTON ET AL., JUSTICE ON APPEAL 91-94 (1976).

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> Curiously, none of these tough on crime candidates is addressing the issue of . . . auto insurance rates which [have] turned thousands of otherwise law abiding Philadelphians into criminals. Many city residents see a better option in becoming petty criminals than impoverishing themselves by paying the highest auto insurance rates in the nation.
>
> Candidates need to get real and use their clout to assist reforming auto insurance laws which force decent citizens to become criminals.[22]

This situation exists to a substantial degree in every American community, large and small. Currently, less affluent motorists (if they insure at all)[23] can pay over 30% of their annual household income on auto insurance, impeding their buying such necessities as food or shelter. A recent study of low-income insured motorists in Maricopa County, Arizona, found that 44% were forced at some point to postpone buying food in order to pay their auto insurance premium.[24]

Furthermore, as pointed out in part II, the poor may also pay substantially more in absolute terms because so many of them live in urban areas where typical personal auto insurance premiums are much higher than in suburban and rural areas. In 1994, the average annual premium charged by one California insurer for minimum liability coverage in Los Angeles was $811; the same coverage in Northridge came to only $578. For Wisconsin the 1994 average was $367 in Milwaukee, but $213 in Waukesha.[25]

Note also that under the tort system an insurance company, in rating its own insureds, only considers whether they are likely to be involved in an accident, not what they would be paid once an accident occurs. A liability insurance company, in setting premiums, knows it will not pay its own insured but rather the unknown persons its insureds may tortiously injure in a future accident. The poor therefore pay very high premiums even though by definition they surely incur less wage loss (and probably less medical expenses) compared to oth-

22. *Candidates Should Address High Auto Insurance Rates*, PHIL. TRIB., Oct. 21, 1994, at A6.

23. *See supra* notes 1-16 and accompanying text.

24. Robert Lee Maril, *The Impact of Mandatory Auto Insurance Upon Low Income Residents of Maricopa County, Arizona* 8-9 (1993) (on file with *Connecticut Insurance Law Journal*).

25. Data supplied by State Farm Insurance Company (on file with author).

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ers. It is as though one was charged for fire insurance based only on the likelihood of fire but not on the value of one's house. Under auto insurance, then, at a given level of coverage, the poor must pay into the insurance pool the same as the rich even though they will extract much less from the pool. Keep in mind, too, that the poor are less likely to pursue a tort claim. According to legal sociologist H. Lawrence Ross:

> [T]ort law in action may . . . be termed inequitable. It is responsive to a wide variety of influences that are not defined as legitimate by common standards of equity. The interviews and observations I conducted convinced me that the negotiated settlement rewards the sophisticated claimant and penalizes the inexperienced, the naive, the simple, and the indifferent. Translating these terms into social statuses, I believe that the settlement produces relatively more for the affluent, the educated, the white, and the city-dweller. It penalizes the poor, the uneducated, [the African American and the rural dweller] . . . .[26]

26. H. LAWRENCE ROSS, SETTLED OUT OF COURT: THE SOCIAL PROCESS OF INSURANCE CLAIMS ADJUSTMENTS 241-42 (1970). Consider the following table from the largest study of payment to auto accident victims, done in the 1960s:

Table 1
Relationship of Family Income to Serious Injury and [Automobile] Fatality Cases, to Retention of Counsel, and to Reparations [Compensation] Received.

Family income (1)	Percent retaining counsel (2)	Ratio of net reparations to economic loss (3)
Under $5,000	30.0	0.38
$5,000-9,999	36.7	0.52
$10,000 and over	41.9	0.61
Total	35.0	0.49

Reprinted from U.S. DEP'T OF TRANSP., ECONOMIC CONSEQUENCES OF AUTOMOBILE INJURIES 54, tbl. 3.25 (1970) (Automobile Insurance and Compensation Study). The "compensation received" figures included both tort and nontort sources, with "[a]bout one-third of recovery [for bodily injury and property damage] from tort." *Id.* at 2.

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Tort law's adversarial basis also disadvantages lower income drivers in another sense: such drivers are often without resources to temporarily tide themselves over after an accident and are thus often compelled under tort law to accept low settlements because of their need for immediate payment. When the poor are involved in a suit, however, there is reason to believe that they are especially vulnerable to the schemes of illicit lawyers, doctors, and chiropractors to pad claims and even stage accidents.[27]

Thus, community leaders of minority and low-income groups are likely to favor this proposal. In 1989, when a proposal was made to allow such groups to buy a low-benefit first-party auto insurance policy, eliminating payment for pain and suffering, the *Los Angeles Times* described the situation as follows:

> For the first time since he intervened in California's "war of initiatives" over auto insurance [in 1988], consumer advocate Ralph Nader is having his views questioned by some of the consumer, minority and low-income groups that are most committed to lowering insurance prices.
>
> At an unannounced meeting with Nader in Sacramento . . . , representatives of a coalition of these groups who are backing a proposal for a no-frills . . . insurance policy to be sold across the state for $160 to $200 challenged his opposition to [such] insurance.
>
> People who described the meeting said it was a polite but spirited exchange during which Nader and [his ally] Harvey Rosenfield . . . were criticized for aligning themselves with the California Trial Lawyers Assn. . . .
>
> Those present at the meeting from the minority and consumer side—including Mario Obledo, national chairman of the Rainbow Coalition, John Gamboa, executive director of the Latino Issues Forum, George Dean, president of the California Council of Urban Leagues, and Harry Snyder, West Coast director of the Consumer [sic] Union—declared that they saw no [other] way of making auto insurance affordable to the poor . . . .

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27. *See, e.g.*, Alfred Haggerty, *Insurer Gears Up to Brake Phony Auto Accident Scams*, NAT'L UNDERWRITER (Prop. & Cas. ed.) July 27, 1984, at 2; *The Accident Swindlers*, CHI. SUN-TIMES, Feb. 10-24, 1980, *passim.*

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Nader responded that by giving up rights to file lawsuits and seek pain and suffering compensation, people insured under the no-fault proposal would become victims of a "two-class auto insurance system" under which rich policy holders would have more ability to recover damages from accidents than the poor.

"Why should we give up pain and suffering awards?" Nader asked in a subsequent interview. "The trouble with the minority groups is that . . . [t]hey accepted the principle that if they were poor, they'd have to get compensated for just medical benefits and wage losses, not pain and suffering . . . ."

Dean of the Urban League told The Times . . . "We estimate there are 5 million drivers who can't afford and don't have insurance now . . . . I remember saying to Ralph myself that I know he has been a hero for the consumer in many instances, but I think he is wrong on this particular issue," said Dean. "We're trying to come up with something affordable that will allow the people who are our constituency—the low-income people in this state—to drive legally and not break the state's mandatory insurance law. That's our bottom line."

Obledo said he had told Nader that 5 or 6 million Californians cannot afford auto insurance. "Some of his points . . . are meritorious," he said of Nader, "but we're in a situation here that we had to come up with a plan that provides insurance for the lowest cost."

Edith Adame, counsel to the Latino Issues Forum, said . . . "We understand [Nader's] a man of principle, but in this case about 6 million people are going to be sacrificed for the principle. If he were in our boat, he would probably do the same thing we're doing (proposing a no-frills policy)."

The Consumer [sic] Union's Snyder said he felt the meeting had succeeded in making Nader and Rosenfield "realize that if they are going to kill a low-income solution, they have to come up with one that's at least as good." So far, he said, "Nader's theology makes each accident a meal ticket for the trial lawyer."[28]

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28. Kenneth Reich, *Nader Draws Criticism by Consumer for No-Fault View*, L.A. TIMES, May 29, 1989, at A3.

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Other important segments of the consumer movement have broken with Nader and the trial bar in calling for systemic reform of the auto tort system, based on what they see as tort law's *anti*-consumer character. A report by the National Insurance Consumer Organization, an organization closely associated with Ralph Nader that generally defends the tort system, breaks with Nader in describing the pain and suffering component of automobile tort law as a "dream of a huge reward . . . [that] is, for almost all, only a dream. And whatever large sums are awarded are heavily taxed by the lawyers. . . . On economic grounds it's a bad buy . . . ."[29] Indeed, "damages [for] . . . pain and suffering are . . . a rough measure of the plaintiff's attorney fees,"[30] thereby greatly lessening the adverse impact of eliminating such damages, especially since the proposal advanced here provides for payment of an uninsured's attorney's fees in addition to economic loss.[31]

3. Advantages to Administrators and Law Enforcers

Another appeal of this proposed scheme is that it is self-executing. There is no need for cumbersome means of identifying motorists who are or become uninsured; no need for diverting vital police and judicial efforts to the mundane—and often futile task—of enforcing penalties for being uninsured.[32] (Our experience with Prohibition should have taught us the dangers of unenforceable laws.) Rather, when an uninsured motorist is in an accident and makes a tort claim, the defending insurer has an incentive to establish routinely and inexpensively the claimant's uninsured status at that time—and to assess the penalty of refusing to honor any claim for noneconomic damages.[33]

29. Pay-At-The-Pump: Private No-Fault Auto Insurance ii (a proposal by the National Insurance Consumer Organization, on file with *Connecticut Insurance Law Journal*); *see also* ANDREW TOBIAS, AUTO INSURANCE ALERT! 57-58 (1993). For a study emphasizing the necessity of eliminating claims for pain and suffering as a means of controlling auto insurance costs, see J. David Cummins & Sharon Tennyson, *Controlling Automobile Insurance Costs*, 6 J. ECON. PERSP. 95 (1992). *See also* STEPHEN CARROLL ET AL., THE COSTS OF EXCESS MEDICAL CLAIMS FOR AUTOMOBILE PERSONAL INJURIES (RAND 1995).

30. WOLFRAM, *supra* note 18, at 528 n.21.

31. *See supra* text accompanying note 18; *see also supra* note 19.

32. *See supra* notes 12-13 and accompanying text.

33. Bills incorporating the concept proposed herein have been introduced in Arkansas, California, Colorado, Delaware and Virginia. But they foreclose claims only by owners or operators, not dependents. *Cf. supra* text accompanying note 17.

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Doing away with the requirement that all motorists must buy auto insurance would also seem to make it feasible to do away with the need for assigned risk plans. (Under assigned risk plans, those unable to get insurance in the normal market are arbitrarily assigned to insurers on a rotating basis, dependent on an insurer's percentage of business written in the state.) In other words, because failing to procure automobile liability coverage no longer need entail any other state imposed sanction, criminal or otherwise, no need will exist to guarantee, by the elaborate and expensive bureaucratic means employed today, the availability of auto insurance to those the insurance market sees fit to reject.

. . . .

All of the above discussion pertains only to liability for personal injury. As to liability for property damage, the law could retain compulsory property damage liability insurance. But such a requirement ignores that many among the poor will simply not be able to afford such coverage either. Two reform possibilities arise, neither of them entailing any requirement that one insure for property damage liability.

First, the new law could provide that failure to purchase minimum limits, including for property damage, is "paid for" by the surrender of one's right to claim for pain and suffering. In other words, the requirement of liability insurance for both personal injury and property damage would be negated by the surrender of the right to claim for pain and suffering. (But as a further means of making it easier for the poor to buy minimum limits, the law could provide that to the extent the other motorist's car is covered by collision insurance, there is no liability to such motorist for property damage. Given that more affluent drivers are more likely to carry collision insurance, such a provision will entail some redistribution of income to the poor.) Second—either as an alternative or as a supplement to the above provision as to property damage—a motorist not carrying property damage liability insurance could not claim property damage against third persons

Hawaii's new "pure" no-fault auto insurance legislation allows motorists to be legally uninsured. *See* Haw. S.B. 1762, 18th Leg., Reg. Sess. (1995). It abolishes all personal injury tort claims except for intentional, drunken, or drugged misconduct. *Id.* (The bill was passed by the legislature and is awaiting signature by the governor as this Article goes to press.)

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(unless, here also, the other motorist was guilty of intentional, drunken, or drugged misconduct).

B. Responding to Constitutional Concerns

State legislatures considering adopting the foregoing proposal to allow motorists to be legally uninsured may need assurance that the proposal is likely to withstand an attack under the Fourteenth Amendment of the United States Constitution. Although I do not undertake here an extensive discussion of the issue, the proposal would arguably be constitutional. For such a law—neutral on its face—to be unconstitutional, there must be proof of an intent to discriminate; disparate impact may be evidence of intent, but is insufficient by itself.[34] "Disproportionate impact is not irrelevant, but it is not the sole touchstone of an invidious racial discrimination forbidden by the Constitution."[35] This applies not only to any racial impact of the proposal (because race is the paradigm equal protection case), but also to its wealth component. Even if disparate impact on the poor is inevitable, wealth—by itself—is not sufficient to rate strict scrutiny.

In *James v. Valtierra*,[36] the Court declined to invalidate a California law providing for a mandatory local referendum on installation of low-income housing despite that law's use of explicit wealth classifications. Indeed, the Court has stated that *prima facie* wealth classifications, unlike *prima facie* racial classifications, do not warrant strict scrutiny. In *Dandridge v. Williams*,[37] the Court declined to apply strict scrutiny to legislation involving the curtailing of welfare benefits. The Court expressed hesitation towards resuscitating rigorous review of legislative regulation of social and economic fields. Even though "the administration of public welfare assistance involves the most basic economic needs of impoverished human beings," the Court could "find no basis for applying a different [i.e., a strict scrutiny] Constitutional standard."[38]

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34. Washington v. Davis, 426 U.S. 229, 242 (1976).
35. *Id.*
36. 402 U.S. 137 (1971).
37. 397 U.S. 471 (1970).
38. *Id.* at 485.

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Lindsey v. Normet[39] again presented a housing and wealth issue. This case involved a law making it possible for a landlord to evict a tenant who had not paid the rent in fifteen days. The appellants argued for a more stringent standard of constitutional review because the need for decent shelter is a fundamental interest particularly important to the poor.[40] The Court refused to apply strict scrutiny: "The Constitution does not provide judicial remedies for every social and economic ill."[41]

In *San Antonio Independent School District v. Rodriguez*,[42] the Court denied strict scrutiny to the wealth classification involved in school funding. This time the Court attempted to leave itself some maneuvering room for the future. The Court refused to apply strict scrutiny due to "the absence of any evidence that the financing system discriminates against any definable category of 'poor' people or that it results in the absolute deprivation of education. The disadvantaged class is not susceptible of identification in traditional terms."[43] Admittedly, the Supreme Court has used wealth to invalidate laws in the past,[44] but language in *Rodriguez* indicates that the Court will only apply strict scrutiny to wealth classifications if a fundamental right is involved:

> [I]n recognition of the fact that this Court has never heretofore held that wealth discrimination alone provides an adequate basis for involving strict scrutiny, appellees have not relied solely on

39. 405 U.S. 56 (1972).

40. *Id.* at 74.

41. *Id.*

42. 411 U.S. 1 (1973).

43. *Id.* at 25.

44. *See* Griffin v. Illinois, 351 U.S. 12 (1956) (invalidating state laws that prevented an indigent criminal defendant from acquiring a transcript, or an adequate substitute for a transcript, for use at several stages of the trial and appeal process); Douglas v. California, 372 U.S. 353 (1963) (Establishing an indigent defendant's right to court-appointed counsel on direct appeal, the Court dealt only with defendants who could not pay for counsel from their own resources and who had no other way of gaining representation.); Williams v. Illinois, 399 U.S. 235 (1970), and Tate v. Short, 401 U.S. 395 (1971) (striking down criminal penalties that subjected indigents to incarceration simply because of their inability to pay a fine) (Again, the disadvantaged class consisted only of those persons totally unable to pay the requisite fine.); Bullock v. Carter, 405 U.S. 134 (1972) (invalidating the Texas filing-fee requirements for primary elections). The Court claims that these decisions are based on the monopoly of the state and the absolute deprivation involved. *Rodriguez*, 411 U.S. at 22. It is possible that this is another way of saying that these rights are "fundamental."

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> this contention. They also assert that the State's system impermissibly interferes with the exercise of a "fundamental" right . . . .[45]

However, the Supreme Court has never held that insurance coverage is a "fundamental" right; if it had, state laws forbidding persons from driving for lack of insurance would be unconstitutional. Even more pertinently, there are explicit holdings that there is no constitutional right to payment for pain and suffering under personal injury law.[46] Finally—and most importantly—that the proposed reform has an advantageous—not an adverse—impact on the poor[47] should effectively blunt constitutional attacks at both the federal and the state levels.

How the proposal will fare under state constitutions may, though, be less clear, at least in a few instances. Very few state constitutions have explicit equal protection clauses, but many have language which has been interpreted like an equal protection clause. As to the issue of disproportionate impact on the poor, three states can be cited as making wealth a suspect classification: California in *Serrano v. Priest*,[48] Montana in *Oberg v. City of Billings*,[49] and Wyoming in *Washakie County School District No. One v. Herschler*.[50] However, quite apart from an advantage to the poor under the proposed reform, states seem to require the addition of a fundamental right to invalidate laws. In *Serrano*, for instance, California found that education was a fundamental right before invalidating the funding system. And, Wyoming, a state in which wealth is a suspect classification, has ruled explicitly that insurance is not a fundamental right.[51]

Other types of state constitutional provisions, such as provisions in Arizona and other states prohibiting limitations on amounts recovered in personal injury cases, may come into play but extensive discussion of such is beyond the scope of this Article. Suffice it to say, earlier dis-

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45. *Rodriguez*, 411 U.S. at 29.

46. *See, e.g.*, Montgomery v. Daniels, 340 N.E.2d 444 (N.Y. 1975); New York Cent. R.R. v. White, 243 U.S. 188 (1917).

47. *See supra* part I.A.2.; *see also* CARRINGTON ET AL., *supra* note 21.

48. 487 P.2d 1241 (Cal. 1971), *cert. denied sub nom.* Clowes v. Serrano, 432 U.S. 907 (1977).

49. 674 P.2d 494 (Mont. 1983).

50. 606 P.2d 310 (Wyo.), *cert. denied sub nom.* Hot Springs Cty. Sch. Dist. No. One v. Washakie Cty. Sch. Dist. No. One, 449 U.S. 824 (1980).

51. Mills v. Reynolds, 837 P.2d 48 (Wyo. 1992).

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cussion by the author of the constitutionality of elective no-fault laws seems pertinent.[52]

II. A Choice for Insured Motorists Between PIP and Tort[53]

In addition to allowing motorists to be legally uninsured, what else should be done to further auto insurance reform? This section of the Article focuses on the problems of no-fault insurance and suggests improvements. Where possible, I emphasize Connecticut's experience as a tribute to this first issue of *Connecticut Insurance Law Journal.*

Originally the proponents of no-fault auto insurance argued that no-fault could provide compensation to many more auto accident victims than are paid under the tort liability system, with faster payments and far lower transaction costs (i.e., attorneys' and adjusters' fees). In 1992, however, the Connecticut legislature voted to repeal the state's twenty-year-old threshold no-fault law. The voting margin on this measure was large enough in both houses to foreclose the possibility of veto by the Governor. The Connecticut no-fault law had been the weakest in the country with the lowest level of no-fault benefits ($5000), and a very low medical expenses threshold ($400). Above these limits, any accident victim could sue for tort damages while also collecting no-fault benefits. Since Connecticut's law did not sufficiently balance even its low no-fault benefits with limitations on victims' rights to sue in tort, its unsatisfactory results should have come as no surprise.[54]

Connecticut had originally followed the lead of Massachusetts in passing no-fault legislation, but surpassed its neighboring state in the degree to which it watered down the no-fault terms of the law. As a result, under Connecticut's no-fault law, premiums soared in price. In 1990, the average liability premium in the state was $522, the fourth highest of 51 jurisdictions. Given these statistics, it was understandable

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52. *See* Jeffrey O'Connell & James Souk, *Is It Constitutional?*, *in* JEFFREY O'CONNELL, ENDING INSULT TO INJURY: NO-FAULT INSURANCE FOR PRODUCTS AND SERVICES 204 (1975).

53. Portions of part II unrelated specifically to Connecticut are adapted from a study by principal authors O'Connell et al., *supra* note 17, and from Jeffrey O'Connell, *No-Fault by Choice*, *in* AGENDA FOR LEADERSHIP 169 (James Peyser ed., 1994).

54. ROBERT JOOST, AUTOMOBILE INSURANCE AND NO-FAULT LAW, § 6:16 (3d ed. 1995). The verbal threshold was also low, including a fracture of any bone. *Id.*

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that the legislature was unhappy with the no-fault approach it had adopted.

A. *Fissures in the No-Fault System*

Although the track record of watered-down no-fault auto insurance in Massachusetts has been much less adverse than the record in Connecticut, the experience of Massachusetts and other states outlined below, especially New York's, sheds light on what went wrong in Connecticut and what should be done about it.

Massachusetts was the first state to enact a no-fault insurance law, albeit a very modest one providing only $2000 of no-fault benefits and allowing an injured motorist to sue another party with fault-based claims when medical expenses exceeded $500. Even with such a modest law, the results in Massachusetts led to dramatic premium reductions, a success which then led other states, including Connecticut, to follow suit. In 1977, Robert Keeton, co-author along with the present writer of the principal proposal of no-fault auto insurance, wrote the following:

> The most dramatic effect of a no-fault law on costs occurred in Massachusetts, where in 1976 the rates for compulsory bodily injury coverage (including $5,000 of liability insurance and $2,000 of no-fault insurance) were still well below the rates in the tenth preceding year, 1967, for compulsory bodily injury coverage ($5,000 of liability insurance only). The accompanying exhibits [see Exhibit 1 and Exhibit 2] show the movement of the average compulsory bodily injury rate for Massachusetts motorists from 1951 through 1976. These exhibits show rates for compulsory bodily injury coverage only (which, in 1971-76, includes $2,000 of no-fault coverage as well as $5,000/$10,000 of liability coverage). For the years 1968-70, rates were frozen at 1967 levels, first by administrative order and later by statute, while legislative consideration of no-fault and other reform proposals proceeded. The bodily injury no-fault law was enacted in 1970 and became effective January 1, 1971.[55]

55. W. PAGE KEETON & ROBERT E. KEETON, CASES AND MATERIALS ON THE LAW OF TORTS 804-05 (2d ed. 1977).

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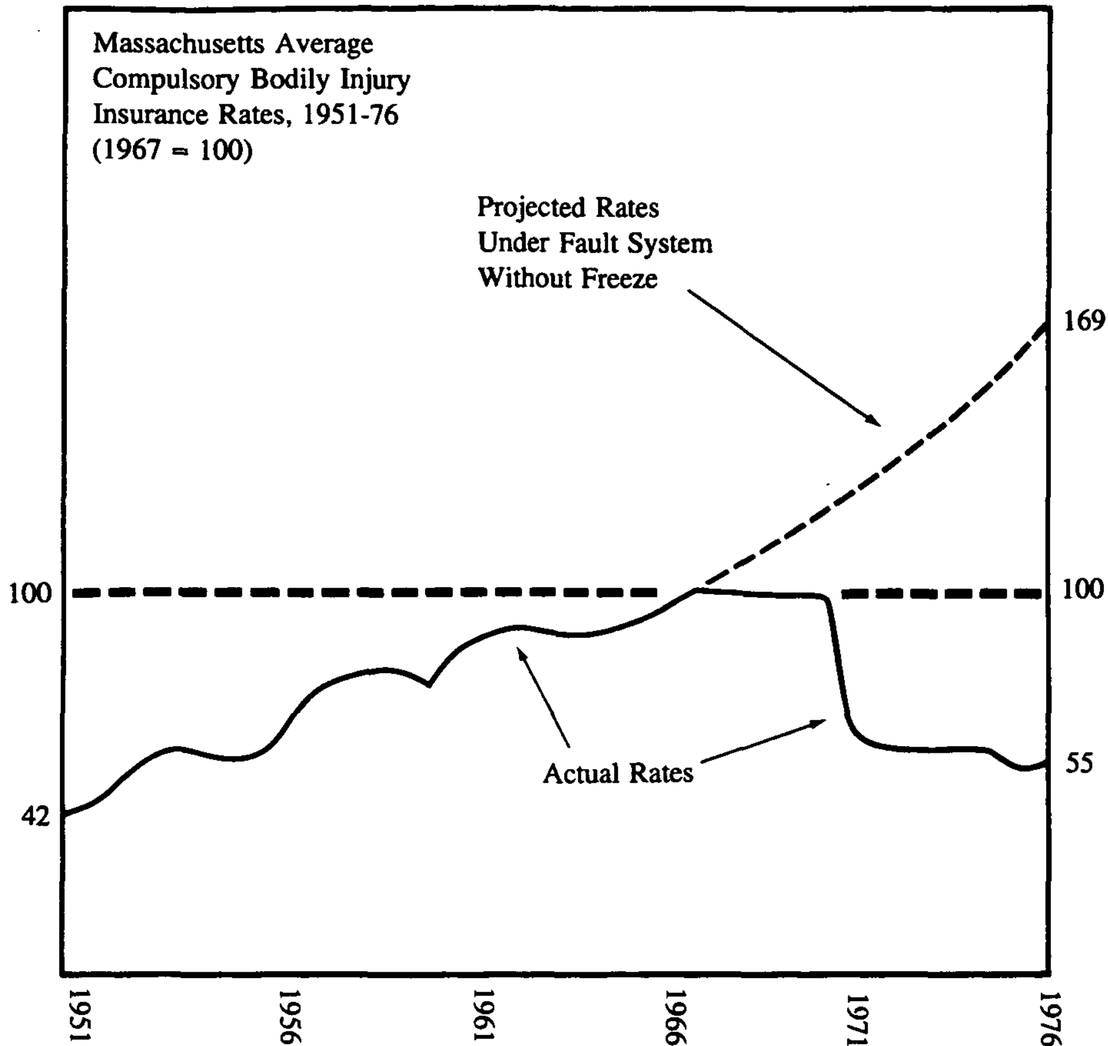
Exhibit 1



These figures compare insurance rates in Massachusetts under the no-fault plan with rates that would have hypothetically been obtained had the pre-existing fault-based system continued in place without a rate freeze.

Taking 1967 as the base year (assuming 1967's Bodily Injury (BI) Insurance Rates = 100), compare actual Insurance Rates under the Massachusetts No-Fault plan (adopted in 1971) with projected Fault-Based rates in the absence of a rate freeze, with an assumed continuing average rate increase of 6% per year. The result: BI rates in 1978 of $55.00 versus projected rates of $169.00.

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Exhibit 2

Massachusetts Average Compulsory Bodily Injury Rates,
1951-76
(1967 = 100)

		Projection of Rates Under Fault Law, Without Rate Freeze (Continuing Average increase of 6% per year)
1951	42	
1952	46	
1953	54	
1954	59	
1955	56	
1956	58	
1957	70	
1958	76	
1959	79	
1960	76	
1961	85	
1962	89	
1963	90	
1964	88	
1965	90	
1966	94	
1967	100	
1968	100	up 6% = 106
1969	100	up 6% = 112
1970	100	up 6% = 119
1971*	85 initially, 63 after rebate	up 6% = 126
1972	60	up 6% = 134
1973	59	up 6% = 142
1974	59	up 6% = 150
1975	54	up 6% = 159
1976	55**	up 6% = 169**

* First year under no-fault law

** Compare these figures with consumer prices generally. By January 1, 1976, the Consumer Price Index, on the base of the 1967 average of 100 had risen to 166.3.

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Gradually, however, the efficacy of thresholds prohibiting suits based on fault began to erode in Massachusetts, Connecticut and elsewhere. Although no-fault auto laws were designed to eliminate many tort claims, they have been doing so with decreasing effectiveness, thus sabotaging no-fault states' attempts to avoid the disadvantages of the tort system. According to an insurance industry study in the late 1980s conducted by the All-Industry Research Advisory Council (later entitled the Insurance Research Council):

> Tort thresholds in the no-fault states, designed to reduce costs and legal complexities for the less serious injuries, appear to have eliminated about 21% of the potential [tort] liability claims among persons collecting no-fault PIP [personal injury protection] benefits in 1987. This is only half as many as were eliminated in 1977 . . . . This decrease is one measure of how much the effect of the tort thresholds has been eroded by inflation and by [broadening] legal interpretations over the intervening 10 years.
>
> A surprisingly high percentage of PIP claimants were judged to be eligible for a tort (fault-based) claim in some of the no-fault states despite the thresholds . . . . [For example] [m]ore than half (53.5%) of PIP claimants in Massachusetts . . . were judged to be eligible for a tort claim . . . .[56]

For many years there were futile attempts to increase both the PIP benefits and the tort threshold in Massachusetts by legislative amendments. While similar efforts in Connecticut never succeeded, in 1988 the Massachusetts legislature finally passed a bill ordaining a new level of $8000 in PIP benefits with a new tort threshold of $2000 in medical expenses.

But even if Connecticut had been successful in no-fault reform, proliferating tort claims may not have been controlled. Take the case of Massachusetts. After the Massachusetts no-fault law was amended in 1988, the median number of treatment visits per automobile injury-related claim rose radically in 1989—from 13 to 30 median visits per

56. ALL-INDUSTRY RESEARCH ADVISORY COUNCIL, COMPENSATION FOR AUTOMOBILE INJURIES IN THE UNITED STATES 13-14 (1989).

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claim, which amounts to a 131% increase.[57] Even for fracture treatments, health care visits increased in 1989 by 50% following the higher no-fault threshold law. Obviously the increased number of treatment visits in 1989 reflected not new medical treatment techniques but rather attorney-driven conduct designed to escalate unnecessary medical expenses to a level sufficient to overcome the new thresholds.[58]

Chiropractors in particular were a large beneficiary of an increase in soft-type tissue injury claims. Once again focusing on the year after Massachusetts raised its no-fault threshold, visits to chiropractors shot up by a factor of three, from 10 to 30 per bodily injury claim.[59] In that same year, 1990, chiropractors were paid $71.9 million by insurance companies in Massachusetts for treatments to victims of automobile accidents, an increase of 320% between 1986 and 1990.[60] Even Anthony Tarricone, president of the Massachusetts Academy of Trial Attorneys and a leading plaintiffs' lawyer, acknowledges widespread abuse in chiropractic billing since Massachusetts raised its tort threshold.[61]

Indeed, with or without changes in tort thresholds, tort payments continued to dominate insurance rates in both Connecticut and Massachusetts. In 1987, only 13.7% of the total payments made to auto accident victims in Massachusetts were made under no-fault coverage; for the same year, only 18.2% of the total payments to victims in Connecticut were no-fault payments. Both percentages are much lower than the 31.7% of total payments made under no-fault insurance in the average state with a no-fault law.[62] In other words, other states' no-fault laws had higher tort thresholds in relation to their no-fault benefits. (But as will shortly be demonstrated even the best of these laws are inadequate.)

57. Sarah S. Marter & Herbert I. Weisberg, *Medical Expenses and the Massachusetts Automobile Tort Reform Law, A First Review of 1898 Bodily Injury Liability Claims*, 10 J. INS. REG. 462, 488, tbl. 12 (1992).

58. LESTER BRICKMAN ET AL., RETHINKING CONTINGENCY FEES 32-33 (1994).

59. Efrain Hernandez Jr., *Ring in Somerville Indicted for Filing False Auto Claims*, BOSTON GLOBE, July 3, 1992, at 58.

60. *Id.*

61. James Andrews, *No-Fault Insurance Faulted As Some States Move to Drop It*, CHRISTIAN SCI. MONITOR, May 26, 1994, at 3.

62. *See* JOOST, *supra* note 54, § 6:16.

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A good measure of the propensity of bodily injury claims to rise in our society is the change in recent years in the ratio of bodily injury claims to property damage claims (BI-PD ratio). In Connecticut, with its low threshold, the ratio increased from 10 bodily injury claims per 100 property damage claims in 1980 to 24.2 per 100 in 1992. (See Table 2 below.) In Massachusetts, also with a low threshold, the ratio rose from 14.5 per 100 in 1980 to 33.6 per 100 in 1992.[63] In California, without any no-fault law, the ratio rose steadily from 31.1 per 100 in 1980 to 67.2 per 100 in 1992.[64] In New York, on the other hand, with its no-fault law's relatively high threshold the ratio remained very constant from 1980-89 at about 11 per 100.[65]

Widespread and significant increases in frequency of claims for bodily injury are all the more dramatic for having occurred while injuries and deaths from auto accidents have themselves decreased. Both technical advances and public policy initiatives have resulted in a decrease in the frequency and severity of auto accidents. Examples include safer cars containing collapsible steering wheels, padded dashboards, energy-absorbing fronts, and air bags; massive education and law enforcement campaigns against drunk driving; and state laws mandating (and achieving much higher rates of) use of seat belts and child-restraint devices. According to the Insurance Research Council, a majority of the additional automobile bodily injury claims made during the period 1987 to 1992 were for soft-tissue injuries (e.g., sprains and strains to necks and back, including the legendary "whiplash" syndrome),[66] which not so coincidentally are difficult to diagnose objectively (and hence are easy to allege and difficult to disprove). Yet during the same period, the number of automobile injuries that could be

63. INSURANCE RESEARCH COUNCIL, INC., TRENDS IN AUTO INJURY CLAIMS app. A, tbl. A-23 (2d ed. 1995) [hereinafter TRENDS].

64. *Id.* tbl. A-6.

65. *Id.* tbl. A-34. Under New York law, tort recovery is allowed only if the injury results in death, dismemberment, significant disfigurement, or significant limitation of use of a body function or system. This is a verbal threshold, as opposed to a monetary threshold.

66. INSURANCE RESEARCH COUNCIL, INC., AUTO INJURIES: CLAIMING BEHAVIOR AND ITS IMPACT ON INSURANCE COSTS 17-29 (1994); *see also* Lawrence K. Altman, *Whiplash Treatments Found to Be Ineffective*, N.Y. TIMES, May 2, 1995, at C1.

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Table 2

Claim Frequency, Claim Severity and Average Loss Cost
Bodily Injury (BI) and Property Damage (PD)

Connecticut

Year	Earned Car Years	BI Claim Frequency	BI Claim Severity	BI Average Loss Cost	PD Claim Frequency	PD Claim Severity	PD Average Loss Cost	Number of BI Claims Per 100 PD Claims
1993	1,006,686	1.02	$21,062	$215.65	4.11	$1,706	$70.02	24.9
1992	905,687	1.03	20,885	215.86	4.26	1,610	68.59	24.2
1991	842,094	1.00	20,338	202.44	4.51	1,589	71.71	22.2
1990	891,725	1.00	19,811	198.13	5.09	1,621	82.58	19.6
1989	898,687	0.88	18,951	166.70	5.08	1,575	79.96	17.3
1988	864,183	0.79	19,420	154.07	5.34	1,500	80.14	14.8
1987	860,127	0.70	17,198	119.93	5.39	1,355	73.10	13.0
1986	828,102	0.68	16,615	133.80	5.25	1,192	62.61	13.0
1985	774,782	0.65	15,918	103.38	5.40	1,048	56.58	12.0
1984	730,558	0.69	14,421	100.18	5.62	979	55.04	12.3
1983	859,086	0.74	12,318	91.48	5.62	896	50.38	13.2
1982	886,610	0.68	12,579	86.07	5.97	838	50.03	11.4
1981	905,933	0.59	12,278	72.52	5.87	766	44.96	10.1
1980	885,681	0.57	10,721	60.75	5.69	665	37.83	10.0
Percent Change '80-'93	13.7%	79.6%	96.5%	255.0%	-27.9%	156.5%	85.1%	149.4%

Notes:
(1) Claim frequency is the number of claims per 100 insured cars.
(2) Claim severity is the average loss paid per claim.
(3) Average loss cost is the average amount of loss per year per insured car, including cars not involved in accidents.

Source: Fast Track Monitoring System, 1993 Fourth Quarter Report for Year 1993, 1992 Fourth Quarter Report for Year 1992, 1991 Fourth Quarter Report for Year 1991, 1990 Fourth Quarter Report for Year 1990, 1989 Fourth Quarter Report for Year 1989, 1989 Second Quarter Report for Years 1988 through 1984, and 1985 Second Quarter Report for Years 1983 through 1980.

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objectively diagnosed (e.g., broken bones) went down, as did the number of hospital admissions and disabilities caused by automobile accidents.[67] Finally, during the 1980s, fatality frequency dropped by 38%, from 3.35 deaths per 100 million miles driven in 1980 to 2.07 in 1990.[68] The numerous decreases occurring in closely related incidents make the dramatic contemporaneous increases in bodily injury claims extremely anomalous and troublesome.

Further illustrating the ill effects of BI tort claims, New York's experience also shows the relatively low cost of even high PIP benefits, compared to total bodily injury costs, even in a state with a strong verbal threshold barring tort claims. New York's $50,000 of PIP benefits contributes only 24.6% of the total pure premium for bodily injury claims. In other words, the relatively few tort claims preserved over New York's strong verbal threshold contribute disproportionately to total costs.[69] The RAND Corporation estimates that on a nationwide basis almost half the bodily injury premiums go for noneconomic loss in a state like New York with high PIP benefits and a high threshold.[70] All this indicates that even New York's no-fault law, which has prompted many reformers to urge enactment of similar no-fault laws in other states, is not a good enough model for reform. *A fortiori*, a proposed 1992 Connecticut reform, removing its modest verbal threshold and putting in place a $3000 threshold (with limited coverage for physical therapy and negative tests) would have been inadequate in leaving so many large tort claims intact. Even in New York the possibility of suing in tort above the relatively high (verbal) threshold is being exploited by increasingly experienced plaintiffs' lawyers. This activity led to a recent rise in New York's BI-PD ratio of almost 50% by 1992, from 11 to about 15 per 100.[71]

Even a state like New York, then, while long dealing relatively effectively with the problem of higher costs for smaller claims (an effectiveness, though undercut by recent developments) has long dealt insufficiently with the problem of larger tort claims. The only way to deal with the latter—while also dealing with the former—would seem

67. Jeffrey O'Connell et al., *Consumer Choice in the Auto Insurance Market*, 52 MD. L. REV. 1016, 1023 (1993).

68. *Id.*

69. *Id.* at 1019-20.

70. *Id.* at 1020.

71. TRENDS, *supra* note 63, tbl. A-34.

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to be the elimination of claims for noneconomic damages in cases both large and small.

But rigorous opposition in state after state to enactment of proposals mirroring New York's law suggests that an even more ambitious plan to eliminate both large and small claims for pain and suffering would not likely pass,[72] particularly over the objections of the trial bar. In other words, the power of opponents of no-fault laws (including consumer advocates such as Ralph Nader who, as pointed out above, have allied themselves with the trial bar) is such that mandating even an arguably inadequate New York-type law does not seem politically feasible. Indeed, given the size of the margin by which the Connecticut no-fault law was repealed, the legislative route to any mandatory no-fault reform promises very little in Connecticut.

An answer may be ambitious reform beyond even New York's law but which does not force relatively radical change on everybody.

B. The Proposed Choice System

Choice reform could give motorists the option of foregoing claims for noneconomic loss, without requiring them to do so.[73] Connecticut motorists thus could be given the alternative of purchasing PIP coverage, payable without reference to fault at the $20,000 compulsory insurance level currently required for liability for bodily injury in Connecticut.[74] Persons electing such PIP coverage could neither sue nor be sued for pain and suffering if involved in accidents with either those who had elected PIP or otherwise. Such PIP motorists would only be allowed to claim in tort against other motorists, whether covered by PIP or otherwise, for economic loss in excess of their PIP coverage. (But, if an injury was caused by a tortfeasor's alcohol or drug abuse, there would be no restriction on the right to sue in tort.) As to accidents between PIP insureds and those electing to stay under the tort system, tort insureds would make a claim against their own insurer for both economic and noneconomic loss (under coverage termed "tort

72. *But see supra* note 33 (concerning Hawaii's new no-fault legislation).

73. *See* Jeffrey O'Connell & Robert Joost, *Giving Motorists a Choice Between Fault and No-Fault Insurance*, 72 VA. L. REV. 61, 70-72 (1986).

74. CONN. GEN. STAT. § 14-112(a) (1995). Note that just as one can opt to buy more liability insurance than financial responsibility limits mandate, so one could opt to buy more PIP coverage than financial responsibility limits mandate.

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maintenance coverage"),[75] just as they do today under uninsured motorist coverage. Claims for economic loss in excess of one's own tort maintenance coverage would be allowed against PIP insureds. In accidents between two tort liability insureds, the current common law tort system would apply without change.

Some further details:[76] PIP coverage would be in excess of all collateral sources and payable periodically. When claims for economic loss above either PIP or tort maintenance coverages are paid, a reasonable attorney's fee would also be payable.[77] The law applicable to property damage is unchanged by the proposal.

Note that in a state that already has no-fault insurance, the plan could be implemented such that the state's no-fault law could be retained except that, pursuant to the foregoing description, rights to claim for noneconomic loss above the threshold could be waived, with corollary reliance on tort maintenance coverage by those who stay in the tort system.

C. *Estimating the Cost of the Choice Plan*

Forthcoming estimates of the effects of such an elective PIP no-fault plan have been done by the RAND Corporation. Being based on data collected while Connecticut's repealed no-fault law was in effect, the study cannot tell us about the precise effect of this reform on current Connecticut insurance rates.[78] But RAND estimates savings of 75.2% of bodily injury costs under elective PIP compared to what costs would be under Connecticut's (now repealed) no-fault law. (On the other hand, costs for motorists who elect to remain in tort will be re-

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75. On the controversial philosophical question of whether it is necessary for tort payments to be made by, or even on behalf of, tortfeasors (by their insurers, for example), see Symposium, *Corrective Justice and Formalism: The Care One Gives One's Neighbors*, 77 IOWA L. REV. 443-44, 445, 672-74, 677, 698-99, 703-04. *See also* JULES COLEMAN, RISKS AND WRONGS 303-28, 361-406 (1992).

76. For the terms of a draft bill implementing this proposal, see O'Connell et al., *supra* note 17, app. B. For a further feature, see *supra* note 19.

77. *See* WOLFRAM, *supra* note 18 and accompanying text.

78. Alan F. Abrahamse & Stephen J. Carroll, *The Effects of a Choice Auto Insurance Plan on Insurance Costs* (forthcoming, 1995, as RAND publication DRU-848-ICJ); *see also* O'Connell et al., *supra* note 17. For earlier cost studies of non-no-fault states, applicable generally nationwide and specifically to California, Illinois, North Carolina and Ohio, see O'Connell et al., *supra* note 67. A cost study by the same authors for no-fault states appears in O'Connell et al., *supra* note 17.

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duced by only 2%.)[79] The 75.2% bodily injury premium savings would probably translate into a savings of about 37% in total premiums, including property damage liability and physical damage (i.e. collision and comprehensive) coverages.[80] (The savings for New York and Massachusetts are estimated at 71.1% and 73.1% respectively for bodily injury premiums, with about half that as savings in total premiums.)[81] Although these estimated savings seem high, they are arguably conservative. They do not reflect that no-fault coverage applies above and beyond collateral sources such as private health insurance, Medicare, Medicaid, workers' compensation, and private sick leave or disability coverage for lost wages. Moreover, the RAND estimates do not include reductions resulting from reduced incentives for motorists covered by no-fault plans to exaggerate their medical bills and lost wages in order to inflate their pain and suffering claims.

Note also that the choice plan results in a premium structure mirroring progressive taxation; the less affluent will have the most substantial savings. Total premium savings for those who buy only minimum coverage in the form of PIP and PD liability (with no collision or comprehensive coverage) would be much higher—probably in the 50-60% range for total premiums.[82]

All this means that, while all motorists who choose PIP are likely to experience significant savings on their auto insurance premiums, the savings could most significantly impact the fragile financial status of low-income motorists. Granted that even drastic reductions in premium costs may leave many of the poor still unable to afford coverage, at the margin such reductions will be of great advantage to those among the poor who want to be insured.

Keep in mind, as pointed out earlier, the less affluent not only pay a staggering percentage of household income for auto insurance, they

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79. Abrahamse & Carroll, *supra* note 78, tbl. 6. Savings vary very little depending on the percentage switching to PIP. *Id.* tbl. 7; *see also* O'Connell et al., *supra* note 67, at 1032-33.

80. O'Connell et. al., *supra* note 17, tbl. 1 at 287, tbl. 2 at 296. Collision and comprehensive are complementary first-party no-fault car damage coverages. Collision covers damage to the insured's car due to collision with any other object or due to upset. Comprehensive is a catch-all provision affording coverage for damage caused by a variety of perils other than collision or upset, e.g., theft, falling objects, fire, wind, hail, glass breakage, vandalism, etc.

81. Abrahamse & Carroll, *supra* note 78, tbl. 6.

82. O'Connell et al., *supra* note 67, tbl. 1, at 27.

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also may pay significantly more in absolute terms because many reside in urban settings. Auto insurance costs in Connecticut's urban areas are often much higher than other areas. (For data in this regard, see Table 3 below, comparing, for example, Bridgeport with other less urban or non-urban areas.) Therefore, premium savings in the 50% range could have beneficial effects on the less affluent desiring to be insured in terms of both percentage of household income and absolute dollars saved.

D. Whither Choice?

The attraction of a choice bill is that it undercuts the opposition of no-fault's opponents. It is one thing to oppose everyone being required to abandon full-scale tort liability in favor of no-fault insurance; it is quite another to oppose anyone being given such a choice. Furthermore, the advantage of the choice bill discussed herein is that, unlike a 1993 choice bill defeated in Connecticut,[83] it removes claims for pain and suffering both large and small—arguably an essential feature for effective automobile insurance reform, as the data from New York suggests.[84] In sum, the merits of allowing all motorists—rich and poor and neither—to opt out of claiming for noneconomic loss, in return for lower costs and prompt and sure receipt of benefits for economic loss,[85] are worthy of intense consideration in Connecticut and other states.[86]

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83. Conn. H.B. 5176, Reg. Sess. (1993).

84. *See supra* notes 69-71 and accompanying text.

85. That substitution of PIP coverage for traditional tort liability will arguably not likely lessen deterrence of unsafe conduct and thereby increase costs, see Richard Epstein, *Automobile No-Fault Plans,* 13 CREIGHTON L. REV. 769, 785 (1980). On empirical studies on tort law's deterrent effect (or lack thereof), see O'Connell & Joost, *supra* note 73, at 87 n.72. *But see* Gary Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?,* 42 U.C.L.A. L. REV. 377, 393-97 (1994).

86. For a study echoing points made here, emphasizing PIP payments which concomitantly eliminate tort claims for pain and suffering as the best means of controlling auto insurance costs, see Cummins & Tennyson, *supra* note 29, at 95. For a statistical study documenting the pernicious effects of a threshold permitting PIP payees to pursue tort claims for pain and suffering, see Richard A. Derig et al., *Behavioral Factors and Lotteries Under No-Fault with a Monetary Threshold: A Study of Massachusetts Automobile Claims,* 61 J. RISK & INS. 245 (1994). *See also* CARROLL ET AL., *supra* note 29.

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Table 3

Territorial Claim Frequency, Claim Severity and Average Loss Cost
Bodily Injury (BI) and Property Damage (PD)

Connecticut

Territory	Earned Car Years	BI Claim Frequency	BI Claim Severity	BI Average Loss Cost	PD Claim Frequency	PD Claim Severity	PD Average Loss Cost	Number of BI Claims Per 100 PD Claims
11	55,454	3.08	$12,116	$373.62	10.09	$1,618	$163.23	30.6
14	84,837	1.70	16,077	273.27	5.63	1,630	91.83	30.2
15	37,696	1.40	14,918	208.16	5.95	1,525	90.75	23.4
17	186,443	0.91	19,416	176.00	4.53	1,774	80.42	20.0
18	30,173	1.01	18,067	183.23	4.08	1,756	71.60	24.9
19	108,331	1.25	16,180	202.98	5.27	1,635	86.08	23.8
20	237,811	1.02	16,916	173.14	4.79	1,597	76.46	21.4
21	149,780	1.21	19,049	230.07	4.37	1,746	76.34	27.6
23	94,802	0.94	14,698	138.14	4.72	1,570	74.05	19.9
24	347,315	0.84	17,720	148.01	3.95	1,664	65.74	21.1
25	57,862	2.20	13,544	297.74	6.39	1,728	110.35	34.4
26	60,653	1.13	18,549	209.49	4.64	1,747	81.02	24.4
27	48,473	1.11	15,369	170.27	5.41	1,649	89.25	20.5
28	14,383	0.92	21,183	194.40	5.71	1,787	102.00	16.1
30	41,333	0.62	19,873	122.61	4.79	1,639	78.44	12.9
31	67,232	1.04	17,940	185.72	5.54	1,703	94.35	18.7
32	51,304	2.87	13,836	397.57	5.70	1,780	101.39	50.4
33	134,050	1.66	16,355	270.86	4.65	1,758	81.69	35.6
State	1,807,932	1.24	$16,449	$203.25	4.92	$1,676	$82.44	25.1

Definition of Territories:

11	Hartford	24	Remainder of State
14	Waterbury	25	Bridgeport
15	New Britain	26	Fairfield and Stratford
17	Remainder of Fairfield County	27	Norwalk
18	Waterbury Suburban	28	Westport
19	Hartford Suburban	30	Darien and Greenwich
20	Remainder of Hartford County	31	Stamford
21	Remainder of New Haven County	32	New Haven
23	Norwich, New London and Torrington	33	New Haven Suburban

Notes:
(1) Claim frequency is the number of claims per 100 insured cars.
(2) Claim severity is the average loss paid per claim.
(3) Average loss cost is the average amount of loss per year per insured car, including cars not involved in accidents.
(4) Data are for 1989-1991 combined.

Source: NAII Automobile Compilation (1993).

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III. COMBINING THE LEGALIZATION OF UNINSURED MOTORISTS WITH A FURTHER CHOICE PLAN

What about the potential interaction between the proposal to allow motorists to be legally uninsured and the proposal to make optional PIP coverage an alternative to requiring purchase of bodily injury liability insurance? In addition to two choices for bodily injury coverage (tort or PIP), motorists will have available the third choice of meeting the law's demands by surrender of their claims for noneconomic loss, insuring neither for PIP nor tort liability coverage. In this connection, a further feature could enable relatively affluent motorists with adequate collateral sources to even forego PIP coverage and to insure only for tort liability along with abandonment of claims for pain and suffering both by and against themselves.[87] This might be an attractive alternative, for example, for retired individuals with adequate pension coverage for their wage loss and adequate health insurance from their retirement plans and/or Medicare.[88]

Thus, one would have the following categories for motorists' complying with financial responsibility law so far as it pertains to personal injury: (1) motorists buying tort maintenance coverage for personal injury; (2) motorists buying PIP coverage and tort liability insurance (mostly to cover economic loss); (3) motorists buying only tort liability coverage, but eliminating claims for pain and suffering; (4) motorists buying neither tort nor PIP coverage.

Consider further the consequences of each choice:

(1) Motorists buying at least the minimum of either tort liability or PIP coverage.

Motorists buying liability insurance colliding with other motorists so choosing would have their rights to claim, and to be claimed against, remain as they were at common law. Such motorists colliding with PIP motorists would claim against their own insurer for common law damages, including noneconomic losses, with the right to claim further against their own insurer under inverse liability coverage (called "tort maintenance") for common law damages, with the further right to claim

87. For a further feature which could be applicable to everyone waiving claims for noneconomic loss, see *supra* note 19.

88. Note that the more that motorists of varying incomes can be expected to forego claims for pain and suffering, the more the constitutionality of the proposal is strengthened. *See supra* part I.B.

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against PIP motorists for economic loss,[89] plus attorney's fees, above their own first-party inverse liability coverage.

PIP motorists colliding with other PIP or tort motorists would receive PIP benefits without reference to fault to the extent of the PIP coverage purchased, and could claim in tort against PIP or tort motorists for economic loss above their own PIP coverage.[90]

In any of the above instances, any tort right against a motorist insured only for PIP would be relatively worthless. This leads to the following:

(2) For motorists who purchased either PIP or tort maintenance insurance, their right to claim in tort for economic loss above their own first-party coverage (whether tort or PIP) would be redeemable as a practical matter only to the extent of the other motorist's third-party tort liability coverage.[91]

(3) Motorists buying only tort liability insurance but waiving their right to claim for noneconomic loss would be solely dependent on their own collateral sources for payment of economic loss, but, to the extent that such sources were inadequate, could claim in tort for excess economic loss[92]—with that right also, as a practical matter, only redeemable to the extent of the other motorist's third-party liability insurance.

(4) As to motorists buying neither liability insurance nor PIP, they could only claim in tort for economic loss against any other motorist.[93]

In all of the above situations, motorists, no matter how or whether insured, would retain claims for both economic and noneconomic losses against any motorist guilty of intentional, drunken, or illegally drugged misconduct.

IV. CONCLUSION

Part III concerns itself with relatively ultimate choices for auto insurance. The author concedes that interim steps—such as those outlined in parts I and II—may have more immediate appeal. But the direction society should be pursuing is clear: less and less dominance of the increasingly discredited state-mandated monopoly of tort liability

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89. For a further feature, see *supra* note 19.
90. *Id.*
91. *Id.*
92. *Id.*
93. *Id.*

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insurance, with its pain and suffering component and all its concomitant transaction costs, delay, fortuity and even corruption, replaced by more and more allowance of consumer access to sensible alternatives to tort law.

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OBLIGATING INSURERS TO INFORM INSUREDS ABOUT THE EXISTENCE OF RIGHTS AND DUTIES REGARDING COVERAGE FOR LOSSES

Alan I. Widiss[*]

I. INTRODUCTION

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

Judicial decisions—as well as instances reported by attorneys—describe situations in which insureds are not aware that an insurance policy entitles them to indemnification for significant losses.[1] In addition, sometimes there are situations in which insureds are unaware of provisions that afford associated rights (such as the use of arbitration

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Mr. J. Bryan Schulte and Ms. Mary Ann Brown—assisted by Ms. Amy Warren, Legal Assistant—represented the claimants in the lawsuit which was the catalyst for the analysis set forth in this Article. Discussions with Mr. Schulte, Ms. Brown, and Ms. Warren helped to refine some of the views set forth in this Article.

Finally, I am especially indebted to several colleagues—Professors Eric Anderson, Steve Burton, and Michael Green—for their comments, questions, and suggestions.

1. *See infra* notes 2, 13-14, 18, 26-31, 37, 44, 47, 62-64.

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to resolve a disputed matter) or that coverage for a loss may be forfeited if the insured fails to take certain actions specified in the contract.

In most circumstances, the insurance policy under which benefits will be provided is not in doubt for either the insured or the insurer. However, when more than one type of coverage is included in a single insurance policy, an insured may not be aware that more than one of the coverages provides benefits. Several types of coverage commonly are included in the insurance policies purchased by the owners of automobiles, homes, and businesses.

The lawsuit that was the catalyst for the analysis in this Article, *Weber v. State Farm Mutual Automobile Insurance*,[2] resulted from an accident involving the Weber family. The parents and one child were killed, and two sons, ages thirteen and seventeen, were injured.[3] Following the accident, the children's grandmother was appointed as a guardian and conservator.[4] The insurer which had issued the family's automobile insurance was notified about the accident. An investigation was initiated and the insurance benefits afforded by several of the first-party coverages in the family's automobile insurance policy were promptly disbursed.[5] Payments were made by the insurer under the medical payments coverage, the personal property coverage, the funeral benefits coverage, and the collision coverage in the Weber family's automobile insurance policy.[6] The adjuster, as well as his supervisor in the insurer's claims department,[7] recognized at the time those insurance benefits were paid that the insurance policy also provided uninsured motorist insurance coverage,[8] and reserves were established for the

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2. 873 F. Supp. 201 (S.D. Iowa 1994). The author was retained by the claimants as a consultant in this case.

3. The description of the facts in *Weber* is based on materials that were provided by the claimants, the insurance company, and the "Background" statement in *Weber*. *See id.* at 202-04.

4. *Id.* at 202.

5. *Id.* at 205.

6. *Id.*

7. Employees in the insurer's claims department acknowledged that "there was never any doubt that the uninsured motorist coverage applied to the Weber claim." *Id.* at 203.

8. *Id.* at 205.

> State Farm does not argue its obligation to pay the uninsured motorist benefits to the Webers was fairly debatable. By State Farm's own admission, no questions on coverage existed for denying or failing to process the Weber's claims. State Farm admits it "knew the Weber passengers were

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anticipated claims.[9] However, the insurer's employees did not advise anyone about the uninsured motorist insurance coverage that was included in the family's automobile insurance policy. No information was provided by the insurer's claims department to individuals representing the estates of the decedents, the surviving children, or anyone representing the surviving children, regarding the uninsured motorist coverage for injuries sustained by the children, for claims that could be made by the surviving children for loss of consortium as a result of the deaths of family members, and for wrongful death claims that might be made. The actions of the insurer in paying claims under several of the first-party coverages without also disclosing those benefits provided by the uninsured motorist coverage ultimately resulted in a claim against the insurer for punitive damages.[10]

The thesis set forth in this Article is that insurers are obligated to inform insureds about (1) all coverages that may afford an insured a right to indemnification, (2) actions which need to be taken to preserve an insured's right to insurance benefits, and (3) collateral rights related to applicable insurance coverages. The Article first focuses on the legal principles and doctrines that provide the basis for this duty. This is

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entitled to uninsured motorist coverage benefits under the insurance policy." (Defendant's Brief p. 6).

Id.

9. A document entitled "Investigation . . . Summary" (prepared on December 12, 1988, and initialed by the claims representative in Missouri handling the liability insurance claim on "12-13-88") specifies that the percentage of negligence of Mr. Richard Weber was 100% and identifies the claimants *and* the coverages involved for members of the Weber family as:

Richard Weber	C (Medical Payments)
	G (Collision Coverage)
Mary Weber	U (Uninsured Motorist)
	C (Medical Payments)
Tommy Weber	U (Uninsured Motorist)
	C (Medical Payments)
Patrick Weber	U (Uninsured Motorist)
	C (Medical Payments)
Kelly Joe Weber	U (Uninsured Motorist)
	C (Medical Payments).

10. Several months after the payments were made, the children's grandmother retained an attorney to investigate whether additional insurance claims could be pursued. *Weber*, 873 F. Supp. at 203. Following inquiries by the attorney, the insurer initiated steps to disclose the applicability of the uninsured motorist coverage included in the Weber family automobile insurance policy. *Id.*

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followed by a discussion of rationales which could mitigate the obligation to disclose information, as, for example, when an insured is assisted by legal counsel. The final section considers the scope or nature of the obligation to disclose information to insureds.

II. Justification for Obligating Insurers to Disclose Information About Insurance Coverages

In virtually all situations, until and unless an insurer receives notification that an insured has sustained or may have sustained a loss as a result of a covered occurrence or event, the insurer has no basis for any action. Thus, insurance policies typically condition the insurer's obligations upon being notified of an occurrence. After being informed of an occurrence, insurers generally respond by providing forms to be used for filing a claim. And, in some instances, employees or agents of the insurer undertake an active role in assisting claimants, or even act on behalf of claimants, in completing the papers necessary for submitting a claim. Following notification of an occurrence, I believe an insurer is obligated to disclose all applicable benefits, or to clearly inform insureds about the existence of rights and duties regarding all coverages, or to explain why the insurance benefits will not be paid in order to (a) fulfill the insurer's contractual commitment, (b) comply with the obligation—implied as a matter of law in all contracts—to deal fairly and in good faith, (c) protect the insured's reasonable expectations, and (d) avoid omissions that could constitute fraudulent misrepresentation.

A. *Fulfilling the Insurer's Basic Contractual Commitment to Provide Coverage*

The contractual arrangement for insurance is consummated when an insurance policy is issued. Thereafter, an insurance contract obligates the insurance company to provide benefits upon the occurrence of an event covered by the contractual arrangement. The nature and scope of an insurance coverage is typically set forth in terms which may not be readily understood by insureds. In uninsured motorist insurance policies, for example, basic descriptions of the insurance state that insurers

> will pay all sums which the insured or his legal representative shall be legally entitled to recover as damages from the owner or operator of an uninsured highway vehicle because of bodily

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> injury sustained by the insured, caused by accident and arising out of the ownership, maintenance or use of such uninsured highway vehicle; provided, for the purposes of this coverage, determination as to whether the insured or such representative is legally entitled to recover such damages, and if so the amount thereof, shall be made by agreement between the insured or such representative and the company or, if they fail to agree, by arbitration.[11]

This type of provision is a complicated formulation which is not easily comprehended by a layperson.[12] Virtually all insurance coverages acquired by individual consumers have comparably complicated coverage statements specifying the circumstances in which the insurer is obligated to provide benefits if a described event occurs.

After an insurance company has received notice of an event that may be covered by an insurance arrangement, the insurer is obligated to fulfill the contractual commitment by making an appropriate investigation of the event and then either disbursing the insurance benefits or explaining to the insured why benefits are not being paid. As enumerated by the authors of one article:

> When insureds suffer losses and present claims, insurers are required to make initial determinations of the extent of their liabilities, if any. This includes verifying the existence of the losses, determining sufficient facts about the nature and circumstances of the losses *to ascertain whether and to what extent there is coverage,* interpreting the applicable policies to decide what coverage is available on the facts found, and determining the amount payable for any covered losses.[13]

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11. See the policy forms compiled in the appendices of 2 ALAN I. WIDISS, UNINSURED AND UNDERINSURED MOTORIST INSURANCE app. at 25 (1992).

12. In essence, the provision specifies that an insured is to be indemnified when bodily injuries are caused by an accident arising from the ownership, maintenance or use of an uninsured highway vehicle. Although an insurance policy commonly includes clauses specifying that the insured must provide information to the insurer *and* must cooperate with the insurer's investigation of the claim, the insurer's obligation to the insured—which is the essence of the transaction after the coverage is issued and the premium paid—typically is defined only in the basic coverage statement.

13. William T. Barker et al., *Is an Insurer a Fiduciary to Its Insureds?*, 25 TORT & INS. L.J. 1, 7 (1989) (emphasis added). Similarly, the Utah Supreme Court concluded: "[T]he implied obligation of good faith performance contemplates, at the very least, that the insurer will diligently investigate the facts to enable it to

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In other words, an insurer must undertake an investigation that is sufficient to determine "to what extent there is coverage" and the benefits payable, because the insurer is obligated to disburse the benefits specified in the applicable insurance policy whenever there is—in the words of the California Appellate Court—"enough evidence of whatever form and however acquired that it would be unreasonable for the insurance company to refuse to pay the claim."[14]

Investigation, fair evaluation, and prompt rejection or settlement constitute "performances" that are "the essence of what the insured has bargained and paid for . . . ."[15] Each of these actions is essential in order for an insurance company to fulfill its explicit contractual obligation to the insured.[16] Obviously, if the investigation and evaluation result in the payment of all applicable insurance benefits, no disclosures of information by the insurer are necessary. However, when an insurer decides not to disburse benefits, I believe disclosures are required in order to discharge the implied obligation to deal fairly and in good

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determine whether a claim is valid, will fairly evaluate the claim, and will thereafter act promptly and reasonably in rejecting or settling the claim." Beck v. Farmers Ins. Exch., 701 P.2d 795, 801 (Utah 1985); *see also* MFA Mut. Ins. Co. v. Flint, 574 S.W.2d 718, 720 (Tenn. 1980) (quoting Merchants Indem. Corp. v. Eggleston, 179 A.2d 505, 509 (N.J. 1962)); Bowler v. Fidelity & Casualty Co., 250 A.2d 580, 587 (N.J. 1969).

14. McCormick v. Sentinel Life Ins. Co., 200 Cal. Rptr. 732, 741 (Cal. Ct. App. 1984).

15. *Beck*, 701 P.2d at 801.

16. *Cf.* Egan v. Mutual of Omaha Ins. Co., 620 P.2d 141, 145 (Cal. 1979) ("*For the insurer to fulfill its obligation not to impair the right of the insured to receive the benefits of the agreement*, [the insurer] must give at least as much consideration to the latter's interest as it does to its own.") (emphasis added), *appeal dismissed, cert. denied*, 445 U.S. 912 (1980); *Bowler*, 250 A.2d at 588 ("In situations where a layman might give the controlling language of the policy a more restrictive interpretation than the insurer knows the courts have given it and as a result the uninformed insured might be inclined to be quiescent about the disregard or nonpayment of his claim and not to press it in timely fashion, the company cannot ignore its obligation. It cannot hide behind the insider's ignorance of the law; it cannot conceal its liability. In these circumstances it has the duty to speak and disclose, and *to act in accordance with its contractual undertaking*. The slightest evidence of deception or overreaching will bar reliance upon time limitations for prosecution of the claim.") (emphasis added); Barker, *supra* note 13, at 9 ("[T]he insurer may not use its superior size, sophistication, and bargaining power or the insured's special dependence on it to deprive the insureds of the promised benefits of the insurance policy.").

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faith, to protect the insured's reasonable expectations, and to avoid omissions that could constitute fraudulent misrepresentation.[17]

B. *Complying with the Obligation to Deal Fairly and in Good Faith*

Courts in states throughout the nation have concluded that all contracts—including insurance policies—impose on each party an implied obligation to act fairly and in good faith.[18] For example, in 1930, the

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17. Mr. William Barker, the co-author of the first article examining judicial decisions sustaining claims that an insurer breached the obligation to deal fairly and in good faith, graciously agreed after reviewing this Article, to set out a short statement of his "philosophical position."

> Anglo-American law generally does not impose a duty to rescue another from risks which the potential rescuer did not create. Likewise, there is usually no liability for mere failure to disclose (as opposed to misrepresentation or concealment) in the absence of a special duty to disclose. While an insurer's duty of good faith creates some duty to inform, the normal rule is also relevant to determination of the scope of the duty. Thus, those arguing for a broader duty have the burden of justifying the additional breadth for which they contend. And, because it is generally accepted that an insurer is not a fiduciary, one would expect that its duty to inform is less extensive than a fiduciary's. A fiduciary has a duty to inform the principal of all things touching the relationship which it would or might be useful for the principal to know, so asserting a similar duty for an insurer seeks to impose a form of fiduciary duty on a non-fiduciary.

Letter from William T. Barker, Professor, Dickinson School of Law, to the author (Mar. 1, 1995).

18. *See, e.g.,* Darlow v. Farmers Ins. Exch., 822 P.2d 820, 828 (Wyo. 1991) ("The law has clearly advanced beyond arm's length dealings when considering first-party obligations such as medical payment provisions."); *id.* at 827 ("The insurer's duty is to 'exercise intelligence, good faith, and honest and conscientious fidelity to the common interest' of the insured as well as the insurer and give at least equal consideration to the interest of the insured, and if it fails to do so, the insurer acts in bad faith.") (citation omitted); Dercoli v. Pennsylvania Nat'l Mut. Ins. Co., 554 A.2d 906, 909 (Pa. 1989) ("We have long recognized that: 'The utmost fair dealing should characterize the transactions between an insurance company and the insured.'") (quoting Fedas v. Insurance Co. of Pa., 151 A. 285 (N.J. 1930)); Rawlings v. Apodaca, 726 P.2d 565, 570 (Ariz. 1986) ("[F]irmly established law indicates that the insurance contract between plaintiffs and Farmers included a covenant of good faith and fair dealing, implied in law, whereby each of the parties was bound to refrain from any action which would impair the benefits which the other had the right to expect from the contract or the contractual relationship."); *Beck,* 701 P.2d at 801 ("We further hold that as parties to a contract, the insured and the insurer have

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Wisconsin Supreme Court stated that the rights of the insured "go deeper than the mere surface of the contract written for him by the defendant" and implied obligations are imposed "based upon those principles of fair dealing which enter into every contract."[19] The New Jersey Supreme Court's decision in *Bowler v. Fidelity & Casualty Co.*

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parallel obligations to perform the contract in good faith, obligations that inhere in every contractual relationship.") (citing State Auto. & Casualty Underwriters v. Salisbury, 494 P.2d 529, 531 (Utah 1972) and Leigh Furniture & Carpet Co. v. Isom, 657 P.2d 293, 306 (Utah 1982)); *Egan*, 620 P.2d at 145 ("In addition to the duties imposed on contracting parties by the express terms of their agreement, the law implies in every contract a covenant of good faith and fair dealing."); *Bowler*, 250 A.2d at 587 ("Insurance policies are contracts of the utmost good faith and must be administered and performed as such by the insurer. Good faith 'demands that the insurer deal with laymen as laymen and not as experts in the subtleties of law and underwriting.'") (citing Merchants Ind. Corp. v. Eggleston, 179 A.2d 505, 509 (N.J. 1962) and Gallagher v. New England Mut. Life Ins. Co., 114 A.2d 857, 861 (N.J. 1955)); Comunale v. Traders & Gen. Ins. Co., 328 P.2d 198, 200 (Cal. 1958) ("There is an implied covenant of good faith and fair dealing in every contract that neither party will do anything which will injure the right of the other to receive the benefits of the agreement. This principle is applicable to policies of insurance.") (citation omitted); Hilker v. Western Auto. Ins. Co., 231 N.W. 257, 258 (Wis. 1930) ("[T]he rights of the insured 'go deeper than the mere surface of the contract written for him by the defendant [and implied obligations are imposed] based upon those principles of fair dealing which enter into every contract.'") (citation omitted), *aff'd on reh'g*, 235 N.W. 413 (Wis. 1931); *Fedas*, 151 A. at 286-87 ("The utmost fair dealing should characterize the transactions between an insurance company and the insured. If the insurer, having knowledge of a loss, by any act throws the insured off his guard as to the necessity of performing some duty enjoined by the policy, the insurer should not be permitted to take advantage of the failure to act."); *see also* RESTATEMENT (SECOND) OF CONTRACTS § 205 (1981) ("Every contract imposes on each party a duty of good faith and fair dealing in its performance and its enforcement."); 5 WILLISTON ON CONTRACTS § 670 (3d ed. 1961). *See generally* STEPHEN S. ASHLEY, BAD FAITH ACTIONS: LIABILITY AND DAMAGES (1984-1990 & Supp. 1991); WILLIAM M. SHERNOFF ET AL., INSURANCE BAD FAITH LITIGATION (1984); ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES AND COMMERCIAL PRACTICES §§ 6.2, 7.8-7.9 (1988); *Symposium on the Law of Bad Faith in Contract and Insurance*, 72 TEX. L. REV. 1203 (1994).

The special public interest in insurance contracts helps explain why "good faith" has come to mean something different in this context than in contract law generally. *Cf.* STEVE J. BURTON & ERIC G. ANDERSEN, CONTRACTUAL GOOD FAITH: FORMATION, PERFORMANCE, BREACH AND ENFORCEMENT § 9.2 (Little, Brown & Co., forthcoming 1995).

19. *Hilker*, 231 N.W. at 258.

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of New York,[20] which involved a time limitation on the right to sue under a disability insurance contract, provides an excellent summary of how some courts view this duty:

> Insurance policies are contracts of the utmost good faith and must be administered and performed as such by the insurer. Good faith "demands that the insurer deal with laymen as laymen and not as experts in the subtleties of law and underwriting." In all insurance contracts, particularly where the language expressing the extent of the coverage may be deceptive to the ordinary layman, there is an implied covenant of good faith and fair dealing that the insurer will not do anything to injure the right of its policyholder to receive the benefits of his contract.[21]

Courts in other states have adopted formulations of the good faith doctrine in terms that are comparable to the New Jersey Supreme Court's statement. For example, in a 1978 case involving uninsured motorist coverage, the Tennessee Supreme Court concluded that the duty to deal "fairly and in good faith" required a claims adjuster to inform the insureds about "the extent of coverage afforded them under the MFA [insurance] policy *before* negotiating a settlement, especially since it was apparent to [the adjuster] that respondents did not know the coverage."[22] In *MFA Mutual Insurance Co. v. Flint*,[23] the duty was violated when the adjuster "took advantage of [the insureds'] ignorance to negotiate a settlement for a grossly inadequate consideration."[24]

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20. 250 A.2d 580 (N.J. 1969).

21. *Id.* at 587-88 (citations omitted). In *Bowler*, the court concluded:

> In situations where a layman might give the controlling language of the policy a more restrictive interpretation than the insurer knows the courts have given it and as a result the uninformed insured might be inclined to be quiescent about the disregard or non-payment of his claim and not to press it in timely fashion, the company cannot ignore its obligation. It cannot hide behind the insured's ignorance of the law; it cannot conceal its liability. In these circumstances it has the duty to speak and disclose, and to act in accordance with its contractual undertaking. The slightest evidence of deception or overreaching will bar reliance upon time limitations for prosecution of the claim.

Id. at 588.

22. MFA Mut. Ins. Co. v. Flint, 574 S.W.2d 718, 722 (Tenn. 1980) (emphasis added).

23. 574 S.W.2d 718 (Tenn. 1980).

24. *Id.* at 722; *see also* Craft v. Economy Fire & Casualty Co., 572 F.2d 565 (7th

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The Tennessee Supreme Court concluded in the *MFA* decision that the duty of good faith and fair dealing encompasses obligating insurers to inform insureds about the scope of coverage when it is apparent to the insurer's employees that the insured is not aware that indemnification is available from the insurer.[25] A decade later, the California Supreme Court articulated a more stringent duty: "[T]he duty of good faith does not permit the insurer passively to assume that its insured is aware of his rights under the policy. *The insurer must instead take affirmative steps to make sure that the insured is informed of his remedial rights.*"[26] Distilling the significance of several California Supreme

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Cir. 1978); Richardson v. Employer Liab. Assurance Corp., 102 Cal. Rptr. 547 (Cal. Ct. App. 1972), *overruled by* Gruenberg v. Aetna Ins. Co., 510 P.2d 1032 (Cal. 1973).

25. *MFA*, 574 S.W.2d at 722.

26. Sarchett v. Blue Shield, 729 P.2d 267, 276-77 (Cal. 1987) (emphasis added).

Most states have adopted legislative provisions designed to discourage unfair claim settlement practices by insurance companies. The model for many of these statutes—developed by the National Association of Insurance Commissioners—provides that an insurer is subject to administrative sanctions for not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims in which liability has become reasonably clear. *See* MODEL UNFAIR CLAIMS SETTLEMENT PRACTICES ACT § 4.D (National Ass'n of Ins. Comm'rs 1991). Thus, insurers are required to effectuate a prompt, fair, and equitable settlement when liability has become clear.

Several states include requirements that clearly and explicitly require disclosures by insurers. For example, see the requirements in Minnesota, Ohio, and Utah:

Section 72A.20-12a(d) of the Minnesota Statutes states:

> STANDARDS FOR CLAIM FILING AND HANDLING. The following acts by an insurer, an adjuster, a self-insured, or a self-insurance administrator constitute unfair settlement practices: . . .
>
> (5) *failing to notify an insured* who has made a notification of claim *of all available benefits or coverages which the insured may be eligible to receive* under the terms of a policy and of the documentation which the insured must supply in order to ascertain eligibility.

MINN. STAT. ANN. § 72A.20-12a(d) (West 1986) (emphasis added).

Section 3901-1-54 of the Ohio Administrative Code states:

> UNFAIR PROPERTY/CASUALTY CLAIMS SETTLEMENT PRACTICES . . .
>
> (E) Misrepresentation of policy provisions.
>
> (1) *An insurer shall fully disclose to first party claimants all pertinent benefits, coverages* or other provisions of an insurance contract under which a claim is presented.
>
> (2) No agent shall willfully conceal from first party claimants benefits, coverages or other provisions of any insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

OHIO ADMIN. CODE § 3901-1-54 (1994) (emphasis added).

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Court precedents, Judge Carr observed very simply: "It is basic that an insurer has a duty to disclose policy terms to its insureds."[27]

In many states, judicial decisions hold that the duty of good faith and fair dealing obligates insurers to inform insureds about rights and duties regarding coverages in a variety of circumstances.[28]

Section 31A-26-303 of the Utah Code provides:

UNFAIR CLAIM SETTLEMENT PRACTICES

(1) No insurer or person representing an insurer may engage in any unfair claim settlement practice under Subsections (2), (3), and (4).

(2) Each of the following acts is an unfair claim settlement practice: . . .

(c) *failing to settle a claim promptly under one portion of the insurance policy coverage*, where liability and the amount of loss are reasonably clear, in order to influence settlements under other portions of the insurance policy coverage, but this Subsection (2)(c) applies only to claims made by person[s] in direct privity of contract with the insurer.

UTAH CODE ANN. § 31A-26-303 (1986) (emphasis added).

However, in most states, violation of the state's unfair claims practices act does not provide the basis for a cause of action by an insured. For example, see Morris v. American Family Mutual Insurance Co., 386 N.W.2d 233, 233 (Minn. 1986) ("[*Syllabus by the Court*:] A private party does not have a cause of action for a violation of the Unfair Claims Practices Act.").

27. Ramirez v. USAA Casualty Ins. Co., 285 Cal. Rptr. 757, 761 (Cal. Ct. App. 1991).

28. *See* Darlow v. Farmers Ins. Exch., 822 P.2d 820, 827 (Wyo. 1991) ("[T]he Darlows argue that inherent in this duty is the requirement that the insurer inform the insured of the extent of the coverage afforded under their policy before negotiating a settlement, especially when it is apparent that the insured did not know the coverage . . . . [T]he duty of good faith and fair dealing includes informing an insured as to coverage and policy requirements when (1) it is apparent to the insurer that there is a strong likelihood that its insured only can be compensated fully under her own policy and (2) the insured has no basis to believe that she must rely upon her policy for coverage."); Dercoli v. Pennsylvania Nat'l Mut. Ins. Co., 554 A.2d 906, 909 (Pa. 1989) ("The appellees' agents in this case voluntarily undertook to provide assistance and advice to appellant and in the process advised her against retaining independent legal counsel. The appellees were bound to deal with the appellant on a fair and frank basis, and at all times to act in good faith. The duty of an insurance company to deal with the insured fairly and in good faith includes the duty of full and complete disclosure as to all of the benefits and every coverage that is provided by the applicable policy or policies along with all requirements, including any time limitations for making a claim."). The *Dercoli* court also commented:

The appellant argues that as the spouse of David R. Dercoli and as a resident of the same household with him she is a "named insured" under

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> the terms of the relevant insurance policies. She argues that by virtue of the relationship that existed between her and the appellee-insurers, the appellees were charged with a duty of fair dealing and good faith with respect to the determination of the benefits that appellant may reasonably be entitled to claim. Thus appellant argues that when *Hack v. Hack, supra,* was decided [abolishing the defense of inter-spousal immunity], the appellees had a duty to inform her of the decision and of her apparent right to benefits under the liability provisions of the applicable policies as a result of that decision.
>
> In spite of the fact that appellant was assured by appellees' agents that they would see to it that appellant received all benefits to which she was entitled, appellees' agents failed to advise her of her right to seek liability damages. The appellant argues that this failure was a breach of appellees' duty of fair dealing and good faith. In addition, appellant argues that when *Hack* abolished the bar of inter-spousal immunity, a conflict of interest arose with the appellees' agents who were advising the appellant . . . . Considering all of the well pleaded material facts in appellant's complaint and the reasonably deducible inferences therefrom, we believe that the appellant's arguments have merit.

Id. at 908-09. (Note: In Miller v. Keystone Insurance Co., 636 A.2d 1109, 1113 (Pa. 1994), the court stated: "Because the *Dercoli* opinion in support of overturning *Taglianetti* commanded the allegiance of only two members of this Court, this view is without precedential authority.").

See also Miller v. Keystone Ins. Co., 586 A.2d 936, 941 (Pa. Super. 1991) ("The imposition of the duty in *Dercoli* was premised on three factors: (1) the insurer had assumed the responsibility for processing its insured's claim; (2) the insurer knew that the insured was relying exclusively on its advice and counsel; and (3) the insurer had knowledge regarding an additional claim for benefits to which Mrs. Dercoli was entitled and it failed to disclose such information."), *rev'd,* 636 A.2d 1109 (Pa. 1994); *Sarchett*, 729 P.2d at 276-77 (Cal. 1987) ("[T]he duty of good faith does not permit the insurer passively to assume that its insured is aware of his rights under the policy. The insurer must instead take affirmative steps to make sure that the insured is informed of his remedial rights.") (citing Davis v. Blue Cross, 600 P.2d 1060 (Cal. 1979)); Gatlin v. Tennessee Farmers Mut. Ins. Co., 741 S.W.2d 324, 326 (Tenn. 1987) ("As pointed out in *MFA Mutual Insurance Co. v. Flint*, . . . an insurer has the duty to deal with its insured 'fairly and in good faith.' This includes informing an insured as to coverage and policy requirements when (1) it is apparent to the insurer that there is a strong likelihood that its insured only can be compensated fully under her own policy and (2) that the insured has no basis to believe that she must rely upon her policy for coverage. This was the situation in this case. By having insured both automobiles, Mr. Turner knew that Mr. Williams had only $10,000.00 in liability insurance coverage. He also knew that Ms. Gatlin had uninsured motorist coverage in excess of Mr. Williams' policy limits. He kept in almost constant contact with Ms. Gatlin for approximately a year after the accident. He informed her that Mr. Williams also was insured by Farmers Mutual, but never informed her that she probably would have to look to her own policy for full

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compensation. In our opinion this was not acting 'fairly and in good faith.'"); Rawlings v. Apodaca, 726 P.2d 565, 571 (Ariz. 1986) ("We hold . . . that one of the benefits that flow from the insurance contract is the insured's expectation that his insurance company will not wrongfully deprive him of the very security for which he bargained or expose him to the catastrophe from which he sought protection. Conduct by the insurer which does destroy the security or impair the protection purchased breaches the implied covenant of good faith and fair dealing implied in the contract."); *MFA*, 574 S.W.2d at 722 ("Keeping in mind the fact that there was never any question but that the uninsured motorist was solely responsible for the accident and that MFA was liable to respondents under the uninsured motorist provision of the policy, the duty of MFA to deal with its insured 'fairly and in good faith' required Mr. Carpenter to inform respondents as to the extent of coverage afforded them under the MFA policy before negotiating a settlement, especially since it was apparent to Mr. Carpenter that respondents did not know the coverage. This Mr. Carpenter did not do. Instead, he took advantage of respondents' ignorance to negotiate a settlement for a grossly inadequate consideration. He was able to do this by leaving out of the negotiation damages due to be paid respondents for personal injuries. Under the circumstances of this case, this action by Carpenter is clearly bad faith and overreaching and breaches the duty MFA owed respondents to deal with them fairly and in good faith."); *id.* at 721 ("We hold . . . that an insurer is under the duty of dealing with its insured 'fairly and in good faith' in settling a claim by its insured under the uninsured motorist provision of an automobile liability insurance contract."); *Davis*, 600 P.2d at 1063 ("[W]e have concluded that the trial court properly denied the insurer's petitions on the ground that the insurer breached its duty of good faith and fair dealing to its insureds by failing timely or adequately to apprise them of the availability of the arbitration procedure."); *id.* at 1065-66 ("In particular, in a situation in which an insured's lack of knowledge may potentially result in a loss of benefits or a forfeiture of rights, an insurer has been required to bring to the insured's attention relevant information so as to enable the insured to take action to secure rights afforded by the policy.").

Cf. Palombo v. Broussard, 370 So. 2d 216, 220 (La. Ct. App. 1979) ("State Farm knew the extent of injuries suffered by the parties, and had a good estimate of the amount of compensation required. It knew the amount of coverage it had available to each individual, yet it did not convey to its insured this information (that all four persons were 'insureds' under the express provisions of the Buick policy and the Lachaussees under the Chevrolet policy also). It stalled negotiations with the plaintiffs while requesting plaintiffs not file suit. After the judgment of the Louisiana Supreme Court in *Seaton v. Kelly* where it was established that a passenger (such as the Palombos) could not 'stack' the UM coverage of a second automobile owned by the owner of the occupied automobile, State Farm knew that the maximum it would have to pay plaintiffs was $50,000 while the Lachaussees were still entitled to stack both of their policies to have a total of $100,000 available. Knowing this, State Farm, on November 22, 1976, settled with the Lachaussees, who the State Farm adjuster knew to be the less seriously injured couple, for seventy percent of the only policy available to the plaintiffs. For this Court to call State Farm's action 'good faith' would be a mockery of those

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words . . . . Obviously State Farm engaged in practices which amount to 'bad faith.'") (citation omitted); Bowler v. Fidelity & Casualty Co. of N.Y., 250 A.2d 580, 588 (N.J. 1969) ("In situations where a layman might give the controlling language of the policy a more restrictive interpretation than the insurer knows the courts have given it and as a result the uninformed insured might be inclined to be quiescent about the disregard or non-payment of his claim and not to press it in timely fashion, the company cannot ignore its obligation. It cannot hide behind the insured's ignorance of the law; it cannot conceal its liability. In these circumstances it has the duty to speak and disclose, and to act in accordance with its contractual undertaking. The slightest evidence of deception or overreaching will bar reliance upon time limitations for prosecution of the claim.") ("When a loss occurs which because of its expertise the insurer knows or should know is within the coverage, and the dealings between the parties reasonably put the company on notice that the insured relies upon its integrity, fairness and honesty of purpose, and expects his right to payment to be considered, the obligation to deal with him takes on the highest burden of good faith."); Cody v. Insurance Co. of Or., 454 P.2d 859, 862 (Or. 1969) ("Defendant contends it had no obligation to disclose its coverage, that the complaint alleges no positive conduct by it misleading plaintiff to his detriment, and that it was not responsible for the delay by plaintiff in filing his action. We disagree because we believe defendant did have an obligation to disclose its coverage and because defendant did take positive action to mislead plaintiff when its agent told plaintiff there was no coverage of any kind."); Ramirez v. USAA Casualty Ins. Co., 285 Cal. Rptr. 757, 763 (Cal. Ct. App. 1991) ("It is basic that an insurer has a duty to disclose policy terms to its insureds . . . . This rule is equally applicable to an action for bad faith breach of the insurer's duty to disclose to an insured the existence and amounts of underinsurance. An insurer is not entitled to delay disclosure of policy existence and terms of underinsurance on the ground the insured must first resolve any actions against third parties.").

See also Walker v. Occidental Life Ins. Co., 432 P.2d 741, 743-44 (Cal. 1967) ("[T]he primary problem we must decide is whether the insurer is required to give an employee notice of the termination of his employment either directly or through its employer agent. We answer this question in the affirmative. There is no controlling authority on the issue in California, but the majority of jurisdictions hold, under similar policy provisions, that the employee is entitled to receive notice that the employer has terminated their relationship. The rationale of these decisions is that the privilege of converting the policy regardless of an employee's physical condition is a valuable property right, that it would be inequitable to hold that an employee may be deprived of the right without his knowledge at the whim of the employer, and that the inclusion of such a clause in the policy implies an intention that the employee should have knowledge of the precise date of the termination of his employment.") (citations omitted).

But see Wedzeb Enters. v. Aetna Life & Casualty Co., 570 N.E.2d 60, 64 (Ind. Ct. App. 1991) ("Wedzeb has presented no facts to us upon which we can conclude Aetna acted in bad faith by failing to inform Wedzeb of potential coverage under Section II of the insurance policy prior to the signing of the release."); Advanced Methods, Inc. v. Grain Dealers Mut. Ins. Co., 274 F.2d 634, 637 (7th Cir. 1960)

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C. *Protecting Reasonable Expectations*[29]

Courts throughout the country have concluded it is appropriate to protect the "reasonable expectations" of policyholders.[30] Expectations about what services will be provided by an insurer are the result of many factors, including the sense of confidence which both insurers and sales representatives endeavor to create.[31] Advertisements—including television commercials, magazine advertisements, and the advertisements

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("Advanced argues that there is a *positive duty* implied by law on insurance companies to take the initiative in informing the insured of the existence of agreed forfeiture conditions such as a twelve months limitation clause. Failure to fulfill that duty, under Advanced's theory, would preclude the insurer from defending suit on one of the forfeiture conditions. Under the facts of the instant case, we hold that no such duty exists. Where Advanced retained attorneys who threatened suit, Grain Dealers is not under a duty, *upon its own initiation*, to forward a copy of such agreed forfeiture conditions to the insured.").

29. The principle of honoring the reasonable expectations of insureds, which has been applied in hundreds of judicial decisions, recognizes the indisputable fact that when an insurance policy is purchased, both parties clearly intended to create a contract obligating the insurer to provide insurance. *See* KEETON & WIDISS, *supra* note 18, § 6.3; ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW § 25D (1987); KENNETH S. ABRAHAM, DISTRIBUTING RISK 101-32 (1986).

30. In 1947, Judge Learned Hand commented:

> An underwriter might so understand the phrase, when read in its context, but the application was not to be submitted to underwriters; it was to go to persons utterly unacquainted with the niceties of life insurance, who would read it colloquially. *It is the understanding of such persons that counts;* and not one in a hundred would suppose that he would be covered, not "as of the date of completion of Part B," as the defendant promised, but only as of the date of approval.

Gaunt v. John Hancock Mut. Life Ins. Co., 160 F.2d 599, 601 (2d Cir.) (emphasis added) (citation omitted), *cert. denied*, 331 U.S. 849 (1947).

When there is a dispute about whether coverage exists, the doctrine of protecting reasonable expectations of insureds can appropriately be stated in the following way:

> In general, courts will protect the reasonable expectations of applicants and insureds regarding the coverage afforded by insurance contracts even though a careful examination of the policy provisions indicates that such expectations are contrary to the unambiguously expressed intention of the insurer.

KEETON & WIDISS, *supra* note 18, § 6.3.

31. Miller v. Keystone Ins. Co., 586 A.2d 936, 941 (Pa. Super. 1991), *rev'd*, 636 A.2d 1109 (Pa. 1994). Judge Ford Elliott then added: "And failing to do so, may not an insurer be held to have breached an affirmative duty imposed by its contract of insurance of good faith and fair dealing." *Id.*

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in the telephone Yellow Pages[32]—are filled with slogans and statements carefully crafted to foster trust and faith in insurance companies:

AMERICA CAN DEPEND ON FARMERS

AMERICAN FAMILY INSURANCE . . . .
All Your Family Protection Under One Roof

FARM BUREAU . . . .
Where Belonging Makes a Difference

IMT INSURANCE CO . . . .
Be Worry Free With . . . .

STATE FARM INSURANCE . . . .
Like a good neighbor, State Farm is there.

Such advertising—by both individual companies and the industry collectively—creates expectations that persons who are insured will be treated fairly and justly by an insurer's employees when there is an occurrence which is covered by an insurance policy. For example, the Arizona Supreme Court observed: "We hold . . . that one of the benefits that flow from the insurance contract is *the insured's expectation* that his insurance company will not wrongfully deprive him of the very security for which he bargained . . . ."[33]

Advertising by insurers fosters a sense that insureds can rely on assistance from the persons who are responsible for processing claims. Moreover, the trust that insurers seek to engender among purchasers creates a relationship in which individuals can reasonably expect that when insurers are notified of an occurrence, the insurance company will

32. The following slogans and statements appeared in the Yellow Pages for Iowa City. Similar statements can be found in the Yellow Pages for cities throughout the United States, as well as on television and in the print media (such as newspapers and magazines). Courts sometimes hold that consumers should discount statements made by advertisers.

33. Rawlings v. Apodaca, 726 P.2d 565, 571 (Ariz. 1986) (emphasis added). In *Miller*, Judge Ford Elliott observed:

> It should be stated that most insurance agents and brokers approach their relationship with their insured in this spirit of cooperation and trust. Therefore, is it so great a duty to impose on an insurer that if the potential for an adversarial relationship exists, it is under an obligation to so advise its own insured.

Miller, 586 A.2d at 941.

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respond by clearly specifying what the insured must do to initiate a claim and, when those actions are taken, will then either pay those benefits or explain why insurance benefits will not be paid. If an insurer avoids paying insurance benefits by not providing relevant information to an insured, the company does not fulfill those reasonable expectations.

D. Avoiding Omissions That Could Constitute Fraudulent Misrepresentations

Fraudulent misrepresentations can result from a failure to disclose information,[34] as well as from incorrect statements. Provisions from the Restatement (Second) of Torts are of particular significance in providing a basis for assessing what an insurer is obligated to do in order to avoid an omission that would constitute a misrepresentation. Section 551(1) states:

> One who *fails to disclose* to another a fact that he knows may justifiably induce the other to . . . refrain from acting in a business transaction *is subject to the same liability to the other as though he had represented the nonexistence of the matter that he has failed to disclose*, if but only if, he is under a duty to the other to exercise reasonable care to disclose the matter in question.[35]

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34. *See* KEETON & WIDISS, *supra* note 18, § 5.8.

Also, consider the comments of the New Jersey Supreme Court:

> [I]f the insurer has factual information in its possession substantially supporting the policyholder's right to benefits, but it has a reasonable doubt as to whether the evidence is sufficient to require payment, *the obligation to exercise good faith*, upon which it knows or should know the insured is relying, *cannot be satisfied by silence or inaction*. It must notify the insured of its decision not to pay his claim. But mere naked rejection would not be sufficient. The giving of such notice should be accompanied by a full and fair statement of the reasons for its decision not to pay the benefits, and by a clear statement that if the insured wishes to enforce his claim it will be necessary for him to obtain the services of an attorney and institute a court action . . . .

Bowler v. Fidelity & Casualty Co. of N.Y., 250 A.2d 580, 588 (N.J. 1969) (emphasis added).

35. RESTATEMENT (SECOND) OF TORTS § 551 (1977) (emphasis added); *see also* Sinnard v. Roach, 414 N.W.2d 100, 105 (Iowa 1987) ("A representation need not be an affirmative misstatement; it can arise as easily from a failure to disclose material

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The widespread recognition of a special relationship between an insured and an insurer (sometimes viewed as a quasi "fiduciary" relationship),[36] as well as the requirement that an insurer act in good faith, provides substantial support for the existence of the "duty" contemplated by the authors of the Restatement.

Information about the applicability of an insurance coverage for a loss is undoubtedly "material." Ignorance of information that results in an insured's failure to take some action which, in turn, results in a loss of coverage, is also certainly "material." Furthermore, individuals in an insurer's claims department are in a position to know that a failure to disclose the coverage is likely to result in an insured's not pursuing benefits which are available under the coverage afforded by the applicable insurance. As Justice Tobriner, speaking for the majority of the California Supreme Court in the *Davis* case, observed:

> In particular, in situations in which an insured's lack of knowledge may potentially result in a loss of benefits or a forfeiture of rights, *an insurer has been required to bring to the insured's attention relevant information* so as to enable the insured to take action to secure rights afforded by the policy.[37]

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facts."); Cornell v. Wunschel, 408 N.W.2d 369, 374 (Iowa 1987) ("Concealment of or failure to disclose a material fact can constitute fraud in Iowa.").

Also consider RESTATEMENT (SECOND) OF TORTS § 551(2)(a), stating that a party to a business transaction has "a duty to exercise reasonable care to disclose . . . matters known to him that the other is entitled to know because of a fiduciary or other similar relation of trust and confidence between them" before the transactions are consummated.

36. Judges have commented: "[I]n essence, the contract [between an insurer and an insured] *itself creates a fiduciary relationship* because of the trust and reliance placed in the insurer by the insured." Beck v. Farmers Ins. Exch., 701 P.2d 795, 799 (Utah 1985) (emphasis added); *see also Rawlings*, 726 P.2d at 571 ("[W]e do not go so far as to hold that the insurer is a fiduciary, *but do hold that it has some duties of a fiduciary nature*. Equal consideration, fairness and honesty are among them.") (emphasis added) (citations omitted); *cf.* Barker, *supra* note 13, at 7.

37. Davis v. Blue Cross, 600 P.2d 1060, 1065 (Cal. 1979) (emphasis added); *see also Rawlings*, 726 P.2d at 571 ("Conduct by the insurer which does destroy the security or impair the protection purchased breaches the implied covenant of good faith and fair dealing."); Dercoli v. Pennsylvania Nat'l Mut. Ins. Co., 554 A.2d 906, 909 (Pa. 1989) ("The duty of an insurance company to deal with the insured fairly and in good faith includes the duty of full and complete disclosure as to all of the benefits and every coverage that is provided by the applicable policy or policies along with all requirements, including any time limitations for making a claim."). (Note: In Miller v. Keystone Insurance Co., 535 Pa. 531, 636 A.2d 1109 at 1113

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If an insurer fails to exercise reasonable care in disclosing information about either an insured's right to coverage for a loss *or* actions that need to be taken to preserve the right to those benefits, the omission may be an actionable misrepresentation. In the *Weber* case,[38] the insurer made payments under several of the coverages in the family's automobile insurance policy—including the medical payments coverage, the collision coverage, and the funeral benefits coverage—but did not disburse payments under the uninsured motorist coverage. When questions were subsequently raised about the insurer's actions and inaction, United States District Judge Longstaff concluded:

> Plaintiffs' motion for summary judgment is also granted to the extent that in connection with the fraudulent nondisclosure claim the defendant was under a duty to exercise reasonable care to disclose the uninsured motorist coverage provisions of the policy.[39]

The *Weber* case well illustrates the risk that inaction by the employees or agents responsible for administering an insurer's claims department may be judged by a court to be a misrepresentation.

(Pa. 1994), the court stated: "Because the *Dercoli* opinion in support of overturning *Taglianetti* commanded the allegiance of only two members of this Court, this view is without precedential authority."); *cf.* Barker, *supra* note 13, at 14 ("Insureds seeking benefits for losses that they have suffered have a special dependence on their insurers.").

38. See the description of the *Weber* case in the Introduction, *supra* part I.

39. Weber v. State Farm Mut. Auto. Ins. Co., 873 F. Supp. 201, 209 (S.D. Iowa 1994). In this opinion, Judge Longstaff stated:

> In claims for fraudulent misrepresentation the Iowa Supreme Court has held that "a representation need not be an affirmative misstatement; it can arise as easily from a failure to disclose material facts." *Sinnard v. Roach*, 414 N.W.2d 100, 105 (Iowa 1987). *See also Cornell v. Wunschel*, 408 N.W.2d 369, 374 (Iowa 1987) (stating concealment of or failure to disclose a material fact can constitute fraud). The Iowa Civil Jury Instructions 810.2 set forth the elements a party must prove to recover on a claim for fraudulent nondisclosure. For the misrepresentation or concealment to be actionable, the party charged with fraud must have a legal duty to communicate the matter to the other party. *Id.* The Iowa Civil Jury Instructions 810.2 cite as authority RESTATEMENT (SECOND) OF TORTS § 551.6.

Id. at 208.

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E. Heightening the Insurer's Obligation When an Applicable Insurance Coverage is Mandated by Legislative Requirements

Legislation in many states creates mandates for one or more types of insurance, including uninsured motorist insurance,[40] underinsured motorist insurance,[41] automobile liability insurance,[42] and no-fault automobile insurance.[43] The various state insurance laws establishing requirements for such coverages are clearly intended to benefit insureds who are injured in motor vehicle accidents. When a coverage is provided as a result of a statutory mandate,[44] if an insurer does not inform an insured about benefits that are available following receipt of notification that any injury has occurred, it frustrates the public policy manifested by the statutes mandating coverage.[45] Accordingly, the

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40. *See* 1 ALAN I. WIDISS, UNINSURED AND UNDERINSURED MOTORIST INSURANCE 3-50 (1992).

41. *See* 3 ALAN I. WIDISS, UNINSURED AND UNDERINSURED MOTORIST INSURANCE 3-60 (1995).

42. *See* SUMMARY OF SELECTED STATE LAWS AND REGULATIONS RELATING TO AUTOMOBILE INSURANCE (American Ins. Ass'n (AIA) Law Publications, 1994); *see also* IRVIN E. SCHERMER, AUTOMOBILE LIABILITY INSURANCE 15-1 to 15-34 (1990).

43. *See* WIDISS, *supra* note 40, at 3-19.

44. Several of the instances in which insurers have not provided information to insureds have involved uninsured or underinsured motorist insurance. *See, e.g.*, Gatlin v. Tennessee Farmers Mut. Ins. Co., 741 S.W.2d 324, 326 (Tenn. 1987); MFA Mut. Ins. Co. v. Flint, 574 S.W.2d 718, 721 (Tenn. 1980); Ramirez v. USAA Casualty Ins. Co., 285 Cal. Rptr. 757, 761 (Cal. Ct. App. 1991); Palombo v. Broussard, 370 So. 2d 216, 220 (La. Ct. App. 1979).

45. For example, in a dispute that involved no-fault automobile insurance, Judge Ford Elliott commented:

> It is very significant that one of the primary purposes of the No-fault Act was to insure that a claimant would not need an attorney to secure basic benefits, and to this end, the burden was placed on the insurer to investigate and pay claims. The scheme of the Act encouraged claimants to place their trust and reliance in their insurance companies to see to it that their claims would be handled properly, and that they would receive *all to which they were entitled under the Act. A necessary corollary of this reliance was that insurers would handle and process claims in good faith and in the best interests of the claimant* in a nonadversarial relationship.

Miller v. Keystone Ins. Co., 586 A.2d 936, 942 (Pa. Super. 1991) (emphasis added), *rev'd*, 636 A.2d 1109 (Pa. 1994). Judge Ford Elliott also observed: "Additionally, there is at least some evidence in the instant case that Keystone voluntarily assumed the processing of Mrs. Miller's claim in that it is alleged that the statement of benefits which was submitted by Mrs. Miller actually was prepared by an agent of

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public's interest in assuring indemnification for persons injured in motor vehicle accidents provides substantial support for the proposition that the standard of conduct for an insurer's employees and agents is heightened when such statutory mandates have been adopted for a particular type of insurance coverage.

III. Possible Limitations on Obligating Disclosure by Insurers

A. *Lack of Awareness of an Insured's Ignorance*

Some of the judicial opinions that address whether an insurer is obligated to disclose the existence of coverage or conditions that could result in a loss of rights related to insurance benefits have emphasized that the insurers were on notice that the insureds were not aware of their rights.[46] William T. Barker and Donna J. Vobornik analyzed these decisions and postulated—based particularly on statements in two decisions by the California Supreme Court and, to some extent, on two decisions by the Pennsylvania Supreme Court—that "the duty to inform arises only where the insurer is on notice of the insured's ignorance of

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Keystone." *Id.*

In the subsequent appeal to the Pennsylvania Supreme Court, Justice Cappy stated in a dissenting opinion:

> I would hold that, pursuant to its duty of good faith and fair dealing, Keystone had an affirmative obligation to disclose to this insured: that it had knowledge of the possibility of a claim for recovery; that the potential for an adversarial relationship existed; and that it was no longer acting in the interests of its unrepresented insured in this matter. In my opinion, *this requirement would be a minor obligation given the alleged relationship of the parties that had theretofore involved a spirit of cooperation and trust.*

Miller v. Keystone Ins. Co., 636 A.2d 1109, 1116 (Pa. 1994) (Cappy & Papadakos, JJ., dissenting) (emphasis added). However, the majority opinion reversed the superior court, holding that the insurer had no duty to inform the estate of the potential availability of benefits. Speaking for the majority, Justice Zappala stated: "[I]n the absence of evidence of fraud, intentional deception, or the making of misleading statements, the employer has no affirmative duty to apprise a compensation claimant of any or all available benefits." *Id.* at 1113.

46. In particular, two California cases—which involved the insured's right to employ arbitration for a determination about whether the insurer appropriately denied the insurance benefits that were sought—included such statements. *See* Sarchett v. Blue Shield, 729 P.2d 267, 276-77 (Cal. 1987); Davis v. Blue Cross, 600 P.2d 1060, 1066-67 (Cal. 1979); *see also* Dercoli v. Pennsylvania Nat'l Mut. Ins. Co., 554 A.2d 906 (Pa. 1989).

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the rights in question."[47] I believe that such a limitation is neither warranted by the comments in the aforementioned California judicial decisions nor appropriate in this context.

The statements in the California Supreme Court decisions do not indicate that "awareness" of the insured's ignorance was central to the insurer's responsibility to act fairly and in good faith. In the first case, *Davis v. Blue Cross*,[48] decided in 1979, the court stated: "In particular, in situations in which an insured's lack of knowledge may potentially result in a loss of benefits or a forfeiture of rights . . ."[49] The court's use of the term "In particular" as a preface to the statement suggests that the point the court was making was an additional reason, not a condition for all cases.

Eight years later, the court addressed a similar problem in *Sarchett v. Blue Shield*.[50] Barker's and Vobornik's analysis of the significance of *Sarchett* was predicated on the statement in the opinion that the duty to advise the insured of the availability of arbitration arises "*[o]nce* it becomes clear to the insurer that the insured disputes its denial of coverage."[51] However, speaking for a majority of the court,[52] Justice Broussard also stated: "[T]he duty of good faith *does not permit the insurer passively to assume* that its insured is aware of his rights under the policy. The insurer must instead take affirmative steps to make sure that the insured is informed of his remedial rights."[53] The observation

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47. William T. Barker & Donna J. Vobornik, *The Scope of the Emerging Duty of First-Party Insurers to Inform Their Insureds of Rights Under the Policy*, 25 TORT & INS. L.J. 749, 758 (1989). Barker and Vobornik also considered statements in Taglianetti v. Workmen's Compensation Appeal Board, 469 A.2d 548, 550 (1983), and *Dercoli*, 554 A.2d 906. Their view is clearly supported by a subsequent application of *Dercoli* in Pennsylvania. *See Miller*, 586 A.2d at 941 ("The imposition of the duty in *Dercoli* was premised on three factors: (1) the insurer had assumed the responsibility for processing its insured's claim; (2) the insurer knew that the insured was relying exclusively on its advice and counsel; and (3) the insurer had knowledge regarding an additional claim for benefits to which Mrs. Dercoli was entitled and it failed to disclose such information.").

48. 600 P.2d 1060 (Cal. 1979).

49. *Id.* at 1065-66.

50. 729 P.2d 267 (Cal. 1987).

51. *Id.* at 276 (emphasis added).

52. Justice Mosk dissented in an opinion to which Chief Justice Bird and Justice Reynoso concurred. Justice Lucas filed an opinion, in part concurring with the majority and in part dissenting.

53. *Sarchett*, 729 P.2d at 276-77 (emphasis added).

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that an insurer is not permitted "passively to assume that its insured is aware of his rights under the policy" seems to make clear that knowledge of an insured's ignorance is not a condition on the insurer's responsibility "to make sure that the insured is informed of his remedial rights."

Frequently, the relative expertise of insurers and insureds contributes significantly to the inclination of judges to protect the interests of insureds. For example, Judge Ford Elliott observed:

> It is implicit . . . that an insurer in counseling an unrepresented insured recognize that its level of information is most likely greater than that of the insured. Not only are insurers at an advantage in terms of differing legal interpretations on coverage issues, but insurers have the additional benefit of their own legal counsel when processing claims.[54]

In most instances, the failure of an insured to act clearly indicates the ignorance of the relevant information.

In most situations the individual's inaction speaks for itself. Imposition of a requirement that an insurer must actually be aware of the insured's ignorance would be an invitation to litigation about both what the insurer *and* what the insured knew or should have known—matters that are inherently difficult, if not impossible, to prove.

Once an insurer has received notice of an occurrence, there is no reason to restrict the obligation to disclose relevant information about the insured's rights and duties. *If* the insurer's employees or claims representatives process the claim without additional input from the claimants, full responsibility rests on those individuals. *If* additional actions by claimants or beneficiaries are necessary, the insurer should be obligated to provide complete information about the coverages that may provide benefits, what has to be done to initiate a claim for the insurance benefit, the period within which those actions must be done, and all ancillary rights. Anything less falls short of the insurer's contractual obligations.

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54. Miller v. Keystone Ins. Co., 586 A.2d 936, 942 (Pa. Super. 1991) (referring to *Dercoli*, 554 A.2d 906), *rev'd*, 636 A.2d 1109 (Pa. 1994).

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B. *Insureds Who Are Assisted by Professional Advisors*

Barker and Vobornik also suggested that an insurer's "duty to inform" is limited to instances in which an insured is not assisted by professional advisors. They posit that "the duty to inform arises, at least in part, from the insured's reliance on the insurer to inform of its rights; where the insured chooses not to rely on the insurer and retains its own professional advisors, *the insurer should have no such duty.*"[55]

The proposition that an insurer is not obligated to provide information about insurance benefits when an insured is represented by a professional advisor, such as an attorney, is a limitation without a sound foundation in regard to first-party insurance coverages (such as accident insurance, disability insurance, life insurance, medical payments insurance, and uninsured/underinsured motorist insurance).[56] By making disclosures of the possible existence of coverage, rights that are collateral to the coverage, and conditions that must be complied with to preserve the right to indemnification, insurance companies are doing no more than (1) fulfilling the contractual obligations owed to insureds, (2) complying with the duty to deal fairly and in good faith with the insureds, (3) protecting the reasonable expectations of the insureds, and (4) avoiding the commission of a misrepresentation on the insureds. The involvement of an attorney on behalf of an insured does not, and should not, affect those responsibilities of an insurance company. If the attorney representing an insured is competent, any disclosure statements made by the insurance company will simply confirm matters of which the attorney is already aware. Alternatively, if the attorney is incompe-

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55. Barker & Vobornik, *supra* note 47, at 758 (emphasis added).

In the *Weber* case, the insurer argued that "an insurer has a good faith duty to disclose, counsel, and advise the insured only where the insurer knows the insured is relying solely on the insurer for advice and this duty does not arise where the insurer knows the insured is not relying solely on the insurer's advice." Weber v. State Farm Mut. Auto. Ins. Co., 873 F. Supp. 201, 205 (S.D. Iowa 1994).

56. In *Miller*, 586 A.2d at 941, Judge Ford Elliott observed:

> It should be stated that most insurance agents and brokers approach their relationship with their insured in this spirit of cooperation and trust. Therefore, is it so great a duty to impose on an insurer that if the potential for an adversarial relationship exists, it is under an obligation to so advise its own insured. And failing to do so, may not an insurer be held to have breached an affirmative duty imposed by its contract of insurance of good faith and fair dealing.

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tent, the needs of the insured are just as great as those of an individual who is not represented. The contractual relationship between an insured and the insurer—which provides the basis for all of the insurer's obligations when an insured event occurs—is not altered in the event an insured retains counsel. There does not appear to be any compelling reason why an obligation to disclose information about the coverage terms, which Barker and Vobornik have concluded may exist for an insured who is not represented by an attorney, should be abrogated by the insured's retention of counsel. Moreover, it offends a sense of "fair play" to conclude that an insured should be in a less favorable position vis-a-vis the insurance company as a result of the insured choosing to hire counsel.

C. *Existence of Coverage Is Questionable or Fairly Debatable*

In some situations, an insured's right to insurance benefits may be no more than a possibility when there are questions, factual or legal, that need to be resolved or coverage limitations that apply. When coverage is "fairly debatable," informing an insured of that possibility affords that insured an opportunity to engage in discourse with the insurer. For example, in a New Jersey Supreme Court opinion, the court reasoned:

> [I]f the insurer has factual information in its possession substantially supporting the policyholder's right to benefits, but it has a reasonable doubt as to whether the evidence is sufficient to require payment, *the obligation to exercise good faith*, upon which it knows or should know the insured is relying, *cannot be satisfied by silence or inaction*. It must notify the insured of its decision not to pay his claim. But mere naked rejection would not be sufficient.[57]

Speaking for the New Jersey Supreme Court, Justice Francis then concluded:

> *The giving of such notice should be accompanied by a full and fair statement of the reasons for its decision not to pay the benefits*, and by a clear statement that if the insured wishes to

57. Bowler v. Fidelity & Casualty Co. of N.Y., 250 A.2d 580, 588 (N.J. 1969) (emphasis added).

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> enforce his claim it will be necessary for him to obtain the services of an attorney and institute a court action within the appropriate time.[58]

Informing an insured need not involve anything more than identification of and information about coverages in insurance policies that may afford the insured a right to indemnification. The fact that an insured's right to recover may be questionable or fairly debatable should not diminish the insurer's obligations to inform its insured about the possibility that there is a right to insurance benefits.

IV. SCOPE OF THE INSURER'S OBLIGATION TO DISCLOSE

The substantial body of legislative enactments, administrative regulations, and judicial actions protecting the interests of insureds clearly attests that contractual arrangements for insurance occupy an important and special status in the United States. Consequently, it is not surprising that there is a body of judicial precedents requiring insurers to inform insureds about rights and duties in connection with possible claims for insurance benefits.[59] Some writers have commented that the nature and scope of this obligation is not clearly defined:

> One cannot predict how far the courts will ultimately extend the insurer's duty to inform the insured of the contents of his policy.[60]

> There now appears to be an emerging trend to impose on first-party insurers *some* duty to inform. Because the duty is still ill-defined, its limits are unclear.[61]

Thus far, disputes considered by appellate courts have involved at least three different types of situations. First, in several instances, courts have concluded an insurer is required to inform an insured about the existence of coverage.[62] Second, the California Supreme Court has con-

58. *Id.* (emphasis added).

59. *See* judicial opinions cited *supra* note 28.

60. ASHLEY, *supra* note 18, § 5.15.

61. Barker & Vobornik, *supra* note 47, at 758.

62. *See, e.g.*, Darlow v. Farmers Ins. Exch., 822 P.2d 820, 828 (Wyo. 1991) ("[T]he duty of good faith and fair dealing includes informing an insured as to coverage and policy requirements when it is apparent to the insurer that (1) there is

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cluded that insurers are obligated to "make sure that the insured is informed of his remedial rights."[63] And third, other courts have decided that an insurer has a duty to inform insureds about actions that must be completed in order to preserve the insured's right to insurance benefits.[64] Viewed as a group, these decisions indicate that insurers are obligated to inform insureds about the provisions of an insurance policy that affect the insured's right to benefits.

For several decades, one prominent insurer has repeatedly stressed the importance of acquiring coverage from a company that places the insured in "good hands." "Good hands" are, of course, helping hands. The image of "helping hands" provides an excellent approach to conceptualizing an appropriate scope for the obligation of insurers to inform insureds. Expressed very simply, I suggest that the scope can be

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a strong likelihood that its insured only can be compensated fully under her own policy and (2) the insured has no basis to believe that they must rely upon their policy for coverage.") (citing Gatlin v. Tennessee Farmers Mut. Ins. Co., 741 S.W.2d 324, 326 (Tenn. 1987)); Dercoli v. Pennsylvania Nat'l Mut. Ins. Co., 554 A.2d 906, 909 (Pa. 1989) ("The duty of an insurance company to deal with the insured fairly and in good faith includes the duty of full and complete disclosure as to all of the benefits and every coverage that is provided by the applicable policy or policies along with all requirements, including any time limitations for making a claim."); *Gatlin*, 741 S.W.2d at 326 ("As pointed out in *MFA Mutual Insurance Co. v. Flint*, . . . an insurer has the duty to deal with its insured 'fairly and in good faith.' This includes informing an insured as to coverage . . . ."); *Bowler*, 250 A.2d at 588 ("When a loss occurs which because of its expertise the insurer knows or should know is within the coverage, and the dealings between the parties reasonably put the company on notice that the insured relies upon its integrity, fairness and honesty of purpose, and expects his right to payment to be considered, the obligation to deal with him takes on the highest burden of good faith."); Ramirez v. USAA Casualty Ins. Co., 235 Cal. Rptr. 757, 761 ("It is basic that an insurer has a duty to disclose policy terms to its insureds."); *see also* Barker & Vobornik, *supra* note 47, at 758.

63. Sarchett v. Blue Shield, 729 P.2d 267, 276-77 (Cal. 1987) ("[T]he duty of good faith does not permit the insurer passively to assume that its insured is aware of his rights under the policy. The insurer must instead take affirmative steps to make sure that the insured is informed of his remedial rights.") (citing Davis v. Blue Cross, 600 P.2d 1060 (Cal. 1979)); *see Davis*, 600 P.2d at 1063 ("[W]e have concluded that the trial court properly denied the insurer's petitions on the ground that the insurer breached its duty of good faith dealing to its insureds by failing timely or adequately to apprise them of the availability of the arbitration procedure.").

64. *See Gatlin*, 741 S.W.2d at 326 ("As pointed out in *MFA Mutual Insurance Co. v. Flint*, . . . an insurer has the duty to deal with its insured 'fairly and in good faith.' This includes informing an insured as to . . . policy requirements.").

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assessed by answering a single question. Viewed prospectively, the question is:

> *Is it possible that disclosing information will be helpful to an insured in securing benefits afforded by an insurance coverage the insurer has issued?*[65]

If a disclosure might be helpful, an insurer should act. Phrased as a normative statement:

> *An insurer is required to inform insureds about all rights and duties that relate to possible coverage for an occurrence that may warrant the payment of insurance benefits.*

Providing information does not entitle an insured to payment of claims that are excluded by the policy. It does not afford protection in excess of that which is provided for in the contract. And, it does not abrogate any of the limitations contained in the contract.[66] When an insurance company is aware of something that may be helpful to an insured—including the existence of coverage, rights related to the coverage, or steps that need to be taken to preserve the right to recover—the insurer should be obligated to inform the insured. If an insurer is in doubt about whether the insured is aware of such a matter, the insurer should act.

V. CONCLUDING OBSERVATIONS

Insurers should conduct their business so that securing the benefits provided by an insurance contract does not become a game of "hide and seek." When an insurer is notified of an occurrence that may be covered, it is beyond question that insurance companies must respond to the notification by rendering a good faith performance. In Comment (d) of section 205 of the Restatement (Second) of Contracts, the authors state:

> *Good faith performance*. Subterfuge and evasions violate the obligation of good faith in performance even though the actor believes his conduct to be justified. But the obligation goes

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65. Viewed retrospectively, the question is:
Is it possible that disclosing information to an insured would have been helpful?

66. *Cf.* Rawlings v. Apodaca, 726 P.2d 565, 571 (Ariz. 1986).

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> further: *bad faith . . . may consist of inaction, and fair dealing may require more than honesty.*[67]

Moreover, judicial opinions in many states have stressed that insurance companies are obligated to fulfill their commitments to insureds by conduct that constitutes the "utmost" in good faith and fair dealing. The significance of appropriately discharging this duty is amplified by the importance courts have placed on protecting the reasonable expectations of insurance purchasers *and* the public interest—especially in regard to coverages which are mandated by legislation—in assuring indemnification for losses which are covered by insurance. Insurance companies are appropriately required to be enterprises that instruct employees and agents handling claims to be more than honest and to assiduously avoid acts of bad faith through inaction. To paraphrase an ancient adage:

Providing an "ounce" of information to
an insured is far better than a
"pound" of explanations or
justifications for the
failure to inform
an insured.

67. RESTATEMENT (SECOND) OF CONTRACTS § 205, cmt. d, at 100 (1985) (second emphasis added).

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VISUALIZING MORAL HAZARD

Seth J. Chandler[*]

I. INTRODUCTION

Contracting parties act in an effort to maximize their happiness in light of the agreements they have made. Often, those actions will differ from those they would have taken had no agreement been reached. A corporate officer's optimal diligence in investigating the wisdom of some corporate action may differ where the corporation has agreed to indemnify the officer for most forms of error. A homeowner's vigor in cleaning house may differ where a cleaning service has agreed to leave a house in some specified state of order. A driver's steadfastness in affixing security devices to a steering wheel may diminish when an automobile insurer has agreed to indemnify the driver in the event the car is stolen. Law and economics scholarship generally refers to these sorts of contract-induced changes in behavior as "moral hazard."

If they could negotiate without costs and anticipate all changes in behavior, contracting parties could eliminate moral hazard by each party's conditioning its own obligations on the other party's conformity to specified levels of behavior. Often, these specifications might require each party to perform in the same manner that it would have had no contract been made. The contract between corporation and officer could,

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for example, require the officer to use the same degree of diligence as that required by corporations in which directors were uninsured.[1] The contract with the cleaning service could require that the homeowner install dust filters with the same frequency as had been done in some period of time preceding the inception of the cleaning agreement. The contract with the automobile insurer could require that the driver affix security devices to the steering wheel under all circumstances where a risk-neutral party would find it prudent to do so.

Reality is not so supportive of the contracting process, however. Contracting parties have neither the time, nor, in many cases, the foresight, to condition obligations on the absence of every form of post-contractual opportunism. While the cleaning service may remember to include a clause regarding swap-outs of dust filters, it may neglect to condition its obligation on the homeowner's not leaving the front door open for unduly long periods.

Even if the negotiation process were free, monitoring conformity with contractual obligations and conditions is costly. It may be difficult to tell whether it would have been prudent for the driver making a brief stop at a dry cleaner to have affixed a security device. It may be difficult to tell how frequently the homeowner installs dust filters. Moreover, to the extent that monitoring of compliance is imperfect, the existence of contractual conditions creates the opportunity for damaging error.[2] One party may be denied the benefit of its contract based on an erroneous finding that conditions intended to deter moral hazard have not been met. Another party may be victimized by moral hazard because of an erroneous assumption that those conditions have been met. Monitoring is thus costly and, in many instances, imperfect.

1. The standard need not be this vague, of course, though under many circumstances it will be unduly costly to specify in advance all the precautions the potential insured must take. *See generally* Steven Shavell, *Damage Measures for Breach of Contract*, 11 BELL J. ECON. 466 (1981) (describing when the parties will reach a "Pareto efficient complete contingent contract" that sets forth in detail all the contractual requirements under all states of the world and when the parties will leave determination of obligations under unusual states to after-the-fact court determination).

2. It is in part for this reason that American courts generally construe ambiguous provisions that might be either promises or conditions as conditions. Barnes v. Wood, 750 P.2d 1226, 1232 (Utah Ct. App. 1988) (citing cases); RESTATEMENT (SECOND) OF CONTRACTS § 227 (1979).

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Much of contract law can be understood as an attempt to regulate moral hazard. The obligation of good faith and fair dealing now widely implied into contracts[3] provides a general rule against "inappropriate" opportunistic behavior. The covenants one typically finds in corporate bonds provide another example.[4]

In recent years, scholars have examined the phenomenon of moral hazard in considerable detail.[5] Unfortunately, because of well-intentioned efforts at (1) mathematical rigor and (2) analytic tractability, a great deal of this scholarship has been inaccessible or inapposite to the bulk of the legal community.[6] Byzantine notation found in the literature, coupled with a desire for brevity, further deter any attempts at understanding.

This Article is intended to help relieve this deficiency in the study of moral hazard. It does so in three distinctive but interacting ways. First, the Article diminishes the problems much law and economics scholarship has faced in making presentation of the subject comprehensible to those without extraordinary levels of mathematical aptitude. It does so through exposition of a somewhat simple case using diagrams rather than mathematics as the primary pedagogic device. While this reliance on visual tools will not relieve the problem of inaccessibility in its entirety—the material is unavoidably difficult—the hope is that the presentation will appeal to a different audience than do the austere equations occupying the foreground of much law and economics schol-

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3. *See, e.g.*, U.C.C. § 1-203 (1978); RESTATEMENT (SECOND) OF CONTRACTS § 205 (1979).

4. *See* Clifford W. Smith, Jr. & Jerold B. Warner, *On Financial Contracting: An Analysis of Bond Covenants*, 7 J. FIN. ECON. 117 (1979).

5. Useful summaries of much of the literature are found in Patricia M. Danzon & Scott E. Harrington, *The Demand for and Supply of Liability Insurance*, *in* CONTRIBUTIONS TO INSURANCE ECONOMICS 25 (George Dionne ed., 1992) [hereinafter CONTRIBUTIONS] and George Dionne & Scott E. Harrington, *An Introduction to Insurance Economics*, *in* FOUNDATIONS OF INSURANCE ECONOMICS 1, 14-18 (George Dionne & Scott E. Harrington eds., 1992) [hereinafter FOUNDATIONS].

6. Much of the scholarship relies on a degree of mathematical sophistication beyond the realm of the average lawyer or even the average academic in the field of tort or contract. *E.g.*, Sanford J. Grossman & Oliver D. Hart, *An Analysis of the Principal-Agent Problem*, 51 ECONOMETRICA 7 (1983).

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arship.[7] Thus, the Article is useful in part for the teaching of moral hazard.

Second, while presenting a simple case, the Article develops a rich model that provides a broader grouping of academics with an intelligible methodology to facilitate further research as to the effects of moral hazard in more complex situations. Liability insurance is used as the paradigmatic contract, but the analysis can be extended to a variety of contracting situations. Unlike some previous efforts in the field, which either ignore the possibility for varying levels of control over moral hazard[8] or control the extent of moral hazard artificially and without apparent justification,[9] the model employed here makes control of moral hazard the natural consequence of rational choice under contracts that make use of conditions. More specifically, the model employed here looks at optimization behavior by an injurer that has purchased a contract that attempts to control moral hazard by conditioning the insurer's indemnity obligation on the injurer's post-contractual behavior. By permitting use of a more complex contract than that often found in law and economics literature, the model both more naturally and more accurately depicts the moral hazard mechanism. Likewise, although the feature is not implemented in the simple case presented here, the model permits study of moral hazard under legal systems whose perfection in determining both fault and compliance with conditions contained in the contract is determined in part by factors outside the parties' control and by the contractual commitment of costly resources in determining compliance with contractual conditions.[10]

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7. The equations underlying the graphical presentation are tucked away in the appendix. The computer program that represents algorithms that actually implement the expressions found therein is available from the author on request.

8. *See* STEVEN SHAVELL, ECONOMIC ANALYSIS OF ACCIDENT LAW (1987). Under no circumstances should this remark be taken as a criticism of Professor Shavell's brilliant and elegant pioneering of this field. This Article simply extends Shavell's analysis to a somewhat more complex scenario using a different presentation style.

9. *See* ERIC RASMUSEN, GAMES AND INFORMATION: AN INTRODUCTION TO GAME THEORY 140-47 (1989). Again, absolutely no criticism is intended here. The artificiality of the controls on moral hazard in fact greatly simplifies a brief and clear presentation of the phenomenon. This model sacrifices some of that brevity in the hopes of attaining additional realism, and is forced to resort to numerous diagrams in an effort to regain the clarity of Professor Rasmusen's exposition.

10. Part A of the appendix, with its discussion of certain "auxiliary functions" and implementation of costly monitoring, stakes out precisely how this feature is implemented.

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By combining a simple presentation with a rich model of moral hazard, the Article also makes more evident certain substantive conclusions about liability insurance and the relationship between the tort system and the insurance regulatory system. In particular, the analysis shows the following:[11]

- Liability insurance can emerge as a partial "cure" for a judicial system's setting fault standards at levels that would otherwise induce risk-averse injurers to undertake inefficiently high levels of precaution.

- If the parties to an insurance arrangement can cheaply and accurately reduce initial informational asymmetries, as through use of contractual conditions whose satisfaction is simple to measure, injurers in a free market will purchase insurance that compensates them fully for their loss.[12] Complete insurance does not drastically increase the likelihood of accidents, because, in an effort to keep premiums low, the injurer wants the insurer to condition its indemnity obligation on the injurer's undertaking of substantial precautions against accident.

- Cheap and accurate monitoring, while working to the advantage of the injurer, increases the number of accidents that will occur. The increase in accident frequency engendered by perfection of the insurance market is problematic when accidents injure parties other than the injurer and when the legal system is imperfect in its efforts to compensate these external accident victims who cannot bargain with the injurer.[13] When coupled with an

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11. Some of the propositions advanced in this Article, like those advanced in other game-theoretic models, cannot be "proven" in a strict analytic sense. They are in part the results of careful application of numerical methods and simulation. For a discussion of the necessity and desirability of this methodology in complex modeling, see ALFREDO MEDIO, CHAOTIC DYNAMICS: THEORY AND APPLICATIONS TO ECONOMICS 22-24 (1992).

12. *See* RASMUSEN, *supra* note 9, at 140-47. The results here reduce to those of games with symmetric information.

13. If the victim and the injurer could bargain cheaply with each other, as may sometimes occur in quasi-contractual relationships that involve professional services such as medicine, any inadequacy in the compensation offered by the tort system would shift societal resources from victims to injurers. The Coase Theorem suggests

effective insurance system, the American negligence system, for example, which excuses the injurer from liability provided that it maintained a specified level of precaution, tends to allocate wealth to injurers rather than accident victims.

- Prohibition of liability insurance, coupled with a tort regime based on fault, can be understood as an effort to shift societal wealth away from potential injurers and toward potential victims. Whether victims in fact prefer a prohibition of liability insurance depends on the financial responsibility of the injurer, the victim's own degree of risk aversion, the degree to which the tort system is fully compensatory, and the extent to which an unregulated market in liability insurance stimulates accidents.

II. THE STRUCTURE OF THE GAME USED TO MODEL MORAL HAZARD

A. *Introduction to Game Structure*

Contracting and the behavior that follows can be thought of as a game. An offeror specifies certain terms and conditions. An offeree then has two responses. One option is to reject the offer and engage in certain behaviors that may affect the risk of injury to the offeree and, potentially, others. A second option is to accept the offer and engage in perhaps different behaviors that, with the formation of a contractual relationship, now affect the offeror, in addition to the offeree and third parties. A corporation may offer an officer a contract that decreases the officer's compensation but provides a level of indemnity if the officer injures the corporation, at least provided that the officer adheres to certain requirements. The officer either rejects the contract and pursues a level of diligence in conducting corporate affairs or accepts the contract and pursues a different level of diligence. An automobile insurer may offer a driver a contract that requires payment of a premium but provides security against the consequences of the negligence system in the event the driver accidentally injures someone else. The driver either accepts the contract and drives greater miles with perhaps a diminished level of care or rejects the contract and drives fewer miles with perhaps a heightened level of care.

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that there would be no effect on "efficient" accident production, however. *See* Robert Cooter, *Coase Theorem*, THE NEW PALGRAVE 457 (John Eatwell et al. eds., 1987).

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Figure 1

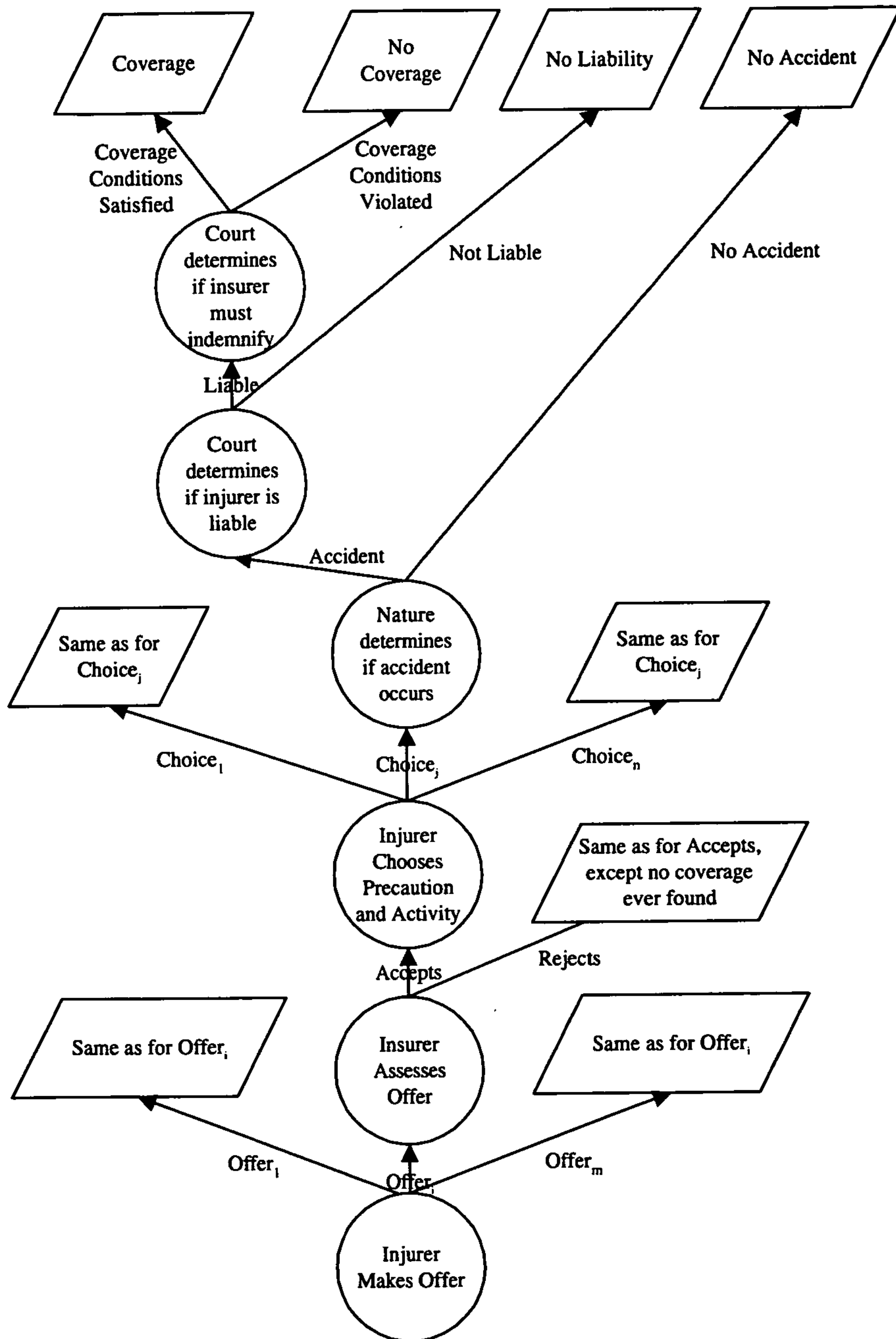

Figure 1 illustrates the structure of the particular game under examination here. The game has three players: an insurer, an injurer and a victim. By insurer, the game refers to an entity possessing the following characteristics: (1) the entity is unable, apart from its structuring of an insurance contract, to affect the likelihood of an accident occurring; and (2) the entity's welfare following an accident is affected only insofar as it has entered into a contract with the injurer. By injurer, the game refers to an entity possessing the following characteristics: (1) the entity is capable through physical activity of altering the likelihood of an accident occurring; (2) the entity's welfare may be altered by an accident, either directly or through application of tort law; and (3) the entity is able to bargain with an insurer. By victim, the game refers to an entity possessing the following characteristics: (1) the entity is unable to affect the likelihood of an accident; (2) the entity's welfare is affected (usually adversely) if an accident occurs; and (3) the entity is unable to bargain with either insurer or potential injurer.[14]

The broad definitions employed in the description of this game mean that while the vocabulary of liability insurance is used throughout this Article, the analysis it employs can be extended to a variety of contracting situations. "First-party" insurance such as property insurance or health insurance can be modeled, for example, as a game in which the "victim" is not injured as the result of an accident.[15]

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14. Transaction costs are the source of this inability to alter the structure of the offer. In this model, the victim does not know which (if any) of the thousands of potential injurers will hurt her. Negotiating with every possible injurer is too expensive to justify the expense. The model could be extended to deal with accidents occurring when the injurer and victim are at least theoretically able to negotiate, as for example in a doctor-patient relationship. In such an event, the "equilibrium" outcomes described here would amount only to threat points created by the tort system and held by each of the parties. These threat points are sometimes called the "non-cooperative solution." The model would then need to be extended, perhaps using the techniques of cooperative game theory, *see generally* Michael Carter, *Cooperative Games*, *in* VARIAN, *supra* introductory footnote (*) (providing clear explanation of field), or perhaps using non-cooperative bargaining theory, *see generally* H. SCOTT BIERMAN & LUIS FERNANDEZ, GAME THEORY WITH ECONOMIC APPLICATIONS 101-17 (1993) (providing explanation of principles), to demonstrate how the victim, injurer and insurer would negotiate from these initial endowments created by tort law to a cooperative equilibrium that improved the welfare of each. Such an examination is beyond the scope of this Article, however.

15. Property insurance against natural hazards may also require a restriction on the model to situations in which a level of "activity" does not alter the likelihood of an accident. Apart from putting a cushion under a prize vase or taking similar precau-

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The game involves three steps: (1) contract formation, (2) behavioral choices by the injurer, and (3) the application of forces outside the control of insurer or injurer on the choices made by each.

1. The First Step of the Game: Contract Formation

The game starts with a potential injurer making an offer to an insurer. The offer has six relevant components: (1) a price (generally known as a premium that the injurer will pay the insurer); (2) a "precaution condition," that is, a level of precaution the injurer must take before the insurer will have an obligation to the injurer; (3) a specification of the resources that the insurer will devote to detecting whether the injurer has satisfied the precaution condition;[16] (4) an "activity condition," that is, a level of activity the injurer must not exceed;[17] (5) a specification of the resources that the insurer will devote to detecting whether the injurer has satisfied the activity condition; and (6) an amount of money known as the indemnity level that the insurer will transfer to or on behalf of the injurer if the injurer is held liable for certain specified activities and the injurer has satisfied the various coverage conditions. An example of such an offer is as follows: In exchange for a premium equal to ten percent of the liability the injurer will suffer in the event an accident occurs, the insurer will provide indemnity for fifty percent of that liability so long as the injurer is not grossly negligent and does not exceed double the level of activity in which it engaged prior to the insurance arrangement. The insurer commits to spend enough money on monitoring of these precaution and activity conditions to ensure that a court is always accurate in its determinations of compliance.

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tions, there is little one can do, for example, to alter the risk of an earthquake destroying the vase.

16. The assumption that the insurer *commits* to a level of post-accident monitoring is somewhat unrealistic. A more sophisticated model would permit the insurer to commit to some methodology for determining its post-accident level of monitoring. For example, the insurer might commit to a methodology wherein its level of monitoring accorded with some initial impression as to how close its insured was to violating the relevant condition. This Article avoids this complication, however, on the assumption that the marginal utility of this refinement would be outweighed by its marginal complexity.

17. "Must" in this context means that if the injurer violates the activity condition, the insurer is excused from an otherwise existing obligation to indemnify the injurer.

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It may appear somewhat exotic for the injurer to be constructing the insurance contract. In reality, of course, it is usually an insurer that constructs an offer; the injurer either accepts or rejects.[18] The injurer moves first in this game, however, to reflect the assumption that the insurer plays in a competitive market in which it is not permitted to make any profit. Allowing the injurer to "move first" permits it to extract all the surplus from the transaction.[19] Those troubled by the assumption may think of the injurer as extending an offer that the insurer has already suggested or invited.

The insurer then decides to accept or reject the offer. In making this choice, the insurer considers how an injurer that becomes its insured will likely behave given the existence of the insurance relationship and the expected effect the injurer's choices will have on its own profitability. The insurer accepts any offer that yields an expected positive or zero profit.[20]

2. The Second Step: Behavioral Choices by the Insured

In the second step of the game, the injurer makes some behavioral choices. In the model under consideration here, the injurer chooses a level of precaution against an accident occurring and chooses a level of activity. Activity results in the injurer receiving either positive or negative profits and an increased likelihood of an accident that may, de-

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18. In all American consumer transactions and most American commercial insurance transactions, it is the insurer that constructs the main outlines of the insurance offer. *See generally* ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW § 2.8 (1988). Indeed, judicial interpretation of the doctrine of *contra proferentem* is significantly predicated on this reality. KENNETH S. ABRAHAM, DISTRIBUTING RISK 120-21 (1986); SPENCER KIMBALL, CASES AND MATERIALS ON INSURANCE LAW 5-8 (1992). Modeling the game as one in which the injurer goes first but in which the insurer can reject contract offers is a standard vehicle for simulating competitive markets, however, and is far simpler than formally permitting an insurer to go first and then letting the injurer seek out other insurers with more desirable offers.

19. *See* RASMUSEN, *supra* note 9, at 141-42.

20. The concept of "profit" employed here is the economic concept, not the accounting notion. An entity makes zero economic profit if it earns a normal rate of return on its investment. *See* ROBERT COOTER & THOMAS ULEN, LAW AND ECONOMICS 387 (1988); Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules*, 99 YALE L.J. 87, 108 n.99 (1989) ("Economic profits are the residual earnings after all implicit and opportunity costs are accounted for.").

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pending on the functioning of the tort and insurance systems, decrease the wealth of the injurer.

3. The Third Step: Actions by Forces Outside the Control of the Parties

In the third step of the game, forces outside the control of either party are brought to bear. These forces determine (1) whether an accident[21] occurs during the relevant time period and injures a victim; (2) whether the injurer will be held liable to the victim for that accident; and (3) in the event the injurer accepted a contract with the insurer, whether the injurer will be deemed to have satisfied the precaution and activity conditions. The greater the precaution the injurer has taken and the lower the level of activity, the less likely it is that an accident will occur. In fault-based liability systems such as the American negligence system, high levels of precaution also decrease the likelihood that the court will obligate the injurer to compensate the victim for its injury. Finally, if the judicial system is reasonably accurate in its determinations, high levels of precaution will decrease the likelihood that the insurer will be able to use failure of the precaution condition as excusing an obligation to indemnify its insured.

4. Computing Expected Payoffs from the Game

A premise behind conventional game theory, adhered to here, is that the parties will select strategies encompassing contract formation and post-contractual behavior in order to maximize their expected level of

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21. For the sake of simplicity, this Article assumes that at most one accident can occur during the relevant time period. In reality, of course, multiple accidents can occur. Aggregate limits represent attempts by insurers to limit their liability for multiple accidents. A more sophisticated model would therefore recognize that the insurer's welfare following a payment on behalf of the insured is not reduced by the entire amount of the payment. Instead, it is reduced by the amount of the payment less the expected value of payouts from future accidents during the policy period having damages between (a) the unreduced policy limits and (b) the policy limits reduced through operation of the aggregate limit. Although this distinction is potentially of great importance because of the potential for excessive settlement payouts from one accident to increase the insured's exposure in other accidents, *see* Texas Farmers Ins. Co. v. Soriano, 881 S.W.2d 312 (Tex. 1994) (involving multiple claimants and the same accident), this Article avoids this complication on the belief that it is not particularly relevant to the problem under study.

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utility[22] given (1) the expected strategies of other players and (2) the application of the forces outside their control. In determining their strategies, therefore, the insurer and potential injurer determine their probability-weighted average level of utility created by the interaction of their own choices with expected responses and with events outside their control.[23] The object of the following discussion, then, is to determine which combination of strategies, including accepted insurance contracts and post-contractual levels of precaution and activity, turn out to be ones from which none of the players have any incentive to deviate.

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22. Provided the utility function of the player is invertible, one could also "solve the game" by choosing strategies that maximize what is sometimes known as "certainty equivalent wealth." *See* Mark J. Machina, The Economic Theory of Individual Behavior Toward Risk: Theory, Evidence and New Directions 17-22 (1983) (report of the Center for Research on Organizational Efficiency, Stanford University). For examples of this type of analysis, see N. Gregory Mankiw & Stephen P. Zeldes, *The Consumption of Stockholders and Nonstockholders*, 29 J. FIN. ECON. 97, 105 (1991), and Jay Stewart, *The Welfare Implications of Moral Hazard and Adverse Selection in Competitive Insurance Markets,* 32 ECON. INQUIRY 193 (1994). Certainty equivalent wealth means the amount of wealth that, if held with certainty, would provide the same level of "utility" as the lottery created when the outcomes of various strategy combinations are determined by forces outside the control of the players. Consider, for example, a player whose utility increases with the square root of its net worth (for positive net worth). The certainty equivalent wealth of a lottery in which there is a 50% chance that it will end up with a wealth level of nine and a 50% chance that it will end up with a wealth level of one has a certainty equivalent wealth equal to four. This is so because wealth equal to four (the posited "certainty equivalent") yields a utility level of two (its square root), and a 50% chance of obtaining a utility level of three (the square root of nine), and one (the square root of one) likewise yields an expected utility of two (50% x 3 + 50% x 1).

The virtue of the lesser-used "certainty equivalent wealth" concept is that, by denominating the positions of the players in terms of dollars rather than "utils," the terminal positions of the players can be added to determine the overall "efficiency" of the proposed rule of law. *See infra* pp. 151-52. For reasons of simplicity and convention, however, most of this Article uses the "expected utility" approach.

23. To be more technical, the parties determine their expected level of utility for all strategy combinations, where a strategy combination (or, equivalently, a strategy profile) represents the combination of strategies selected by all players in the game. A strategy, in turn, represents a set of decisions by each player as to what action it will take at all distinguishable opportunities it will have to take action. For a clear and elementary discussion of this point, see BIERMAN & FERNANDEZ, *supra* note 14, at 67-80. For a clear and rigorous discussion, see DAVID M. KREPS, A COURSE IN MICROECONOMIC THEORY 376-80 (1990).

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III. The Process of Finding the Optimal Feasible Insurance Contract

Determining the equilibrium insurance contract is a three-step process. The first step is to determine the injurer's optimal levels of precaution and activity in response to all insurance offers while holding fixed a specified legal regime, a specified set of injurer characteristics, and a specified set of insurer characteristics.

The term "legal regime" refers to (1) the process by which the legal system determines "fault," i.e., whether an entity is responsible for damages it causes another; (2) the system's accuracy with regard to various levels of effort by the insurer in determining (a) whether an injurer has satisfied the conditions, if any, immunizing it from liability for an accident and (b) whether an injurer has satisfied the conditions, if any, the insurer has placed on its obligation to indemnify its insured; and (3) the extent to which the legal system compensates victims for their full losses arising out of an accident. Negligence, coupled with costless perfect accuracy in determining fault and compliance with coverage conditions, and coupled with perfect compensation of victims in the event fault is found, is a legal regime. Strict liability, coupled with imperfect accuracy in determining compliance with coverage conditions and coupled with only fifty percent compensation of victims, is another legal regime. A completely accurate traditional civil law system with its concepts of fault and responsibility is yet another.[24]

The term "personal characteristics of the injurer" refers to (1) the injurer's level of wealth prior to engaging in some economic activity; (2) the liability potentially incurred by an accident resulting from the economic activity; (3) the cost of undertaking precautions that reduce the risk of an accident; (4) the rewards and costs from behavior that result in accidents; (5) the injurer's level of risk aversion; and (6) the pleasure or displeasure the injurer receives from injuring someone else.

The term "characteristics of the insurer" refers to the costs confronting the insurer in monitoring the injurer's compliance with its precaution and activity conditions. The insurer is always assumed to be neutral towards risk.

The second step is to restrict the set of offers to "Minimum Profit Offers," i.e., those that have a premium such that when the injurer un-

24. *See* K. W. RYAN, AN INTRODUCTION TO THE CIVIL LAW 109-36 (1962); 1 JEAN DOMAT, THE CIVIL LAW §§ 1586-1595 (William Strahan trans., 1850).

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dertakes its optimal levels of precaution and activity, the insurer receives the lowest amount of nonnegative profit. Under most circumstances, this will restrict the set of offers to zero profit offers. The third step is to restrict the set of "Minimum Profit Offers" to those that yield the highest level of utility to the injurer. The Article now walks through this approach to the problem[25] in greater detail, employing diagrams as necessary to aid understanding. These diagrams show, among other things (1) how the tort system and the use of contractual conditions in liability insurance contracts combine to alter the decision of the injurer as to levels of precaution and activity; (2) how the insurer determines the premium to charge for an insurance contract; and (3) how the injurer selects from a variety of contracts all yielding minimal profit to the insurer but bearing different levels of indemnity and different sorts of conditions.

A. *The Optimal Choices Given a Contract*

1. Introduction

The first step in determining the insurance arrangement an injurer will choose and the behavior induced thereby is to ascertain the injurer's optimal behavior under all offers that might be made given a legal regime, and given the personal characteristics of the injurer and insurer. To illustrate this process, I initially employ a legal regime with the following characteristics: (1) fault-based liability[26] with fault determined only by the level of precaution taken by the injurer[27] and

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25. Parts A and B of the appendix set forth the mathematics behind this approach.

26. It is important to note that this model does *not* assume that courts will set the level of precaution that exonerate the injurer equal to the socially "efficient" level of precaution, i.e., the level of precaution that efficiently maximizes the net social product from the activity in question less the costs of precaution and the expected accident losses. *See* SHAVELL, *supra* note 8, at 217 (proving that this formula yields the Pareto Optimal level of precaution). It fails to make this assumption because there is little reason to think that courts will always know what the "efficient" level of precaution is or that political pressures will not sway courts away from making "efficient precautions" the determinant of liability. It is the refusal to make this assumption that creates the modest disagreement noted *infra* note 54 between the conclusions of this Article and the conclusions of Professor Gary Schwartz in *The Ethics and Economics of Tort Liability Insurance*, 75 CORNELL L. REV. 313 (1990).

27. The negligence system that prevails in the United States is an example of a fault-based standard that generally bases liability on the level of precaution and

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(2) perfect accuracy on the part of courts (regardless of the effort employed by the parties) in determining an injurer's satisfaction of the fault standard.

The personal characteristics of the injurer described in this initial illustration are as follows: (1) the injurer is assumed to be financially responsible for any accident that may occur, and any judgment against the injurer resulting from that accident is significantly less than the injurer's initial wealth; (2) precautions are costly and exhibit diminishing marginal returns—that is, it takes progressively more and more money to achieve additional reductions in risk; (3) the injurer receives a fixed marginal benefit from engaging in the economic activity but incurs progressively increasing marginal costs of engaging in that activity;[28] (4) the injurer is risk averse;[29] and (5) the injurer takes no pleasure or displeasure in injuring someone else apart from the financial consequences of injury.

The insurer's characteristics are as follows: (1) the insurer is able to achieve perfect monitoring of compliance with its precaution and activi-

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ignores the level of activity. An injurer driving 100 miles per hour at the time of a crash cannot defend on grounds that the low frequency with which she drives actually results in a low expected accident rate. Similarly, an injurer driving 50 miles per hour on an open freeway cannot be held liable on the grounds that the very high frequency with which she drives actually results in a high expected accident rate. *See* SHAVELL, *supra* note 8, at 25-26 (noting this fact about the negligence system and possible exception under RESTATEMENT (SECOND) OF TORTS § 297 (1965) when courts have great knowledge as to the utility of the activity in question).

28. This assumption is consistent with the situation faced by producers of goods in a competitive market. The amount of revenue they receive per unit is fixed by the market and does not vary according to the amount of goods they produce. The marginal cost of production increases as the number of units produced increases. RICHARD G. LIPSEY & PETER O. STEINER, ECONOMICS 209-33 (4th ed. 1975). For purposes of this model, one could equivalently assume that the marginal revenue per unit of activity decreases while the cost of activity remains constant. This latter characterization might be more consistent with activities such as automobile pleasure driving.

29. More specifically, the insured is assumed to possess a constant absolute level of risk aversion. Absolute risk aversion is described in John W. Pratt, *Risk Aversion in the Small and in the Large*, 32 ECONOMETRICA 122 (1964), and Kenneth J. Arrow, *Insurance, Risk and Resource Allocation*, *reprinted in* ESSAYS IN THE THEORY OF RISK BEARING (Kenneth J. Arrow ed., 1971), and is sometimes known as Arrow-Pratt risk aversion. The topic is dealt with lucidly in Robert J. Korsan, *Decisions, Uncertainty and All That: Nothing Ventured, Nothing Gained: Modeling Venture Capital Decisions*, 4 MATHEMATICA J. 74 (1994).

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ty conditions and (2) monitoring of compliance is costless to the insurer.

While this model makes several unrealistic assumptions, it facilitates easier access to the basic issues implicated by the problem of moral hazard while providing a template for study of moral hazard under more realistic conditions.[30]

The matrix of plots contained in Figure 2 illustrates how the injurer's choices as to level of precaution and level of activity affect the injurer's utility. It illustrates the relationship for a sample of six contracts the insurer might offer.[31]

The three plots in the left hand column show the injurer's utility over the set of possible precaution and activity choices for insurance offers under which the insurer charges a premium equal to five percent of the amount of indemnity paid by the insurer in the event of an accident and under which the insurer imposes no precaution condition. The three plots in the right hand column show the injurer's utility over the set of possible precaution and activity choices for insurance offers with an identical premium but under which the insurer conditions its indemnity obligation on the injurer maintaining at least fifty percent of the level of precaution required to escape liability under the fault-based system.

The different rows in the matrix of plots shown in Figure 2 reflect different levels of indemnity contained in the insurance offer. The top row shows "offers" with no indemnity.[32] The middle row shows offers

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30. Simply by adjustment of several variables, for example, the model accommodates study of injurers not financially responsible for the injuries they cause, legal systems involving strict liability, and insurers facing costly and imperfect monitoring of their insureds. To facilitate use of this Article as a vehicle for the teaching of moral hazard, study of the more complex optimization problems created by adjustment of these variables is not included herein, however.

31. All six offers assume the insurer imposes an activity condition that the injurer not undertake more than 89% of the activities it would have undertaken if it were immune from accident liability. As explained in detail later, *see infra* text accompanying note 54, the model uses this value for the activity condition because an injurer that has become risk neutral but that is otherwise identical to that presented here would, in the legal regime discussed, optimize its behavior by undertaking 89% of the activity level that it would undertake if the legal system failed to impose liability for accidents.

32. Those who have pondered the Anglo-American legal doctrine of "consideration" or the civil law doctrine of "cause" may have trouble with an offer under which the insurer pays nothing if an accident occurs. *See* 1 E. ALLAN FARNSWORTH,

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with incomplete indemnity in which the insurer pays for fifty percent of the liability incurred by the injurer in the event of an accident. The bottom row shows offers with complete indemnity in which the insurer pays all the liability incurred by the injurer in the event of an accident.

All of the plots in Figure 2 share the same axes. The "x-axis" of the plots shown in Figure 2 measures the level of precaution taken by the injurer.[33] The "y-axis" of the plots measures the injurer's activity level. The height of the surface shown in Figure 2 represents the "level" of utility achieved by the injurer given its choice as to a level of precaution against accidents and a level of activity potentially causing accidents. Pointers in each plot show the level of precaution (c*) and activity (n*) at which the surface shown in each plot reaches its highest point and thus show the optimal levels of precaution and activity.[34]

A walk through each of the plots helps explain how the injurer's choice of an optimal level of precaution and an optimal level of activity varies according to the type of insurance offer made. These plots thus make more explicit the process other scholars have described as to how the injurer optimizes its post-contractual behavior given its purchase of a particular contract.[35]

FARNSWORTH ON CONTRACTS §§ 2.2, 2.11 (1990); RYAN, *supra* note 24, at 44-49 (explaining civil law doctrine of "cause"). Such persons are encouraged to think of the offer as one in which, in the event of an accident, the insurer pays the smallest level of indemnity that would be required to satisfy the doctrine of consideration. The indemnity required to satisfy the doctrine of consideration is sufficiently small, however, to leave the corresponding computations unaffected.

33. The precise method employed for giving a numeric measure to precaution is unimportant to the conclusions reached here. One can think of it conveniently as a dollar amount spent on precaution or the dollar equivalent loss suffered by the injurer as the result of taking nonmonetary precautions.

34. The numeric value of the "height" is meaningless; the only relevant factors are whether a point on the surface is higher or lower than another point. To be more technical, expected utility theory has been used to convert cardinal utility functions over the injurer's wealth into a von Neumann-Morganstern utility function over the injurer's level of precaution and activity. *See generally* C. J. MCKENNA, THE ECONOMICS OF UNCERTAINTY (1986), and R. D. LUCE & H. RAIFFA, GAMES AND DECISION (1957) (discussing the assumptions required to legitimize this conversion).

35. *See, e.g.*, SHAVELL, *supra* note 8, at 221-22.

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Figure 2

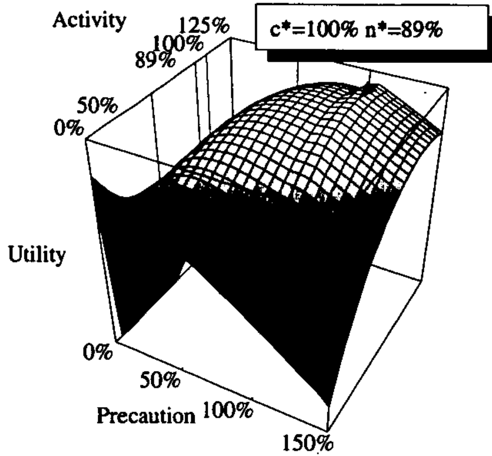

Figure 2.1.1: Indemnity = 0%
Prec. Cond.=0% Act. Cond. = 89%

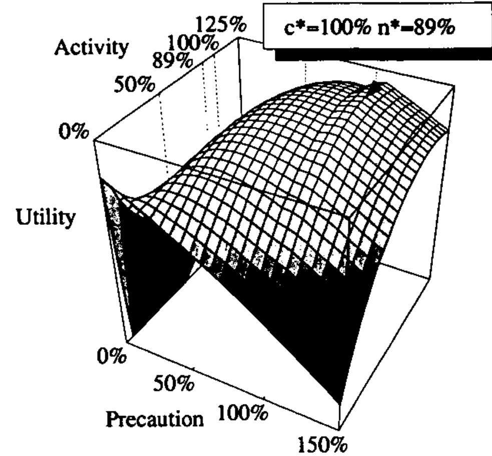

Figure 2.2.1: Indemnity=0%
Prec. Cond.=50% Act. Cond. = 89%

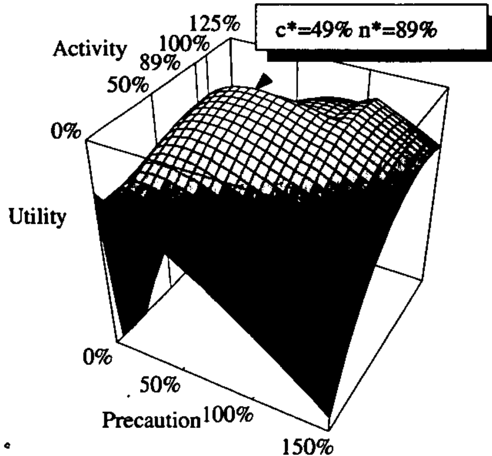

Figure 2.1.2: Indemnity=0%
Prec. Cond.=50% Act. Cond. = 89%

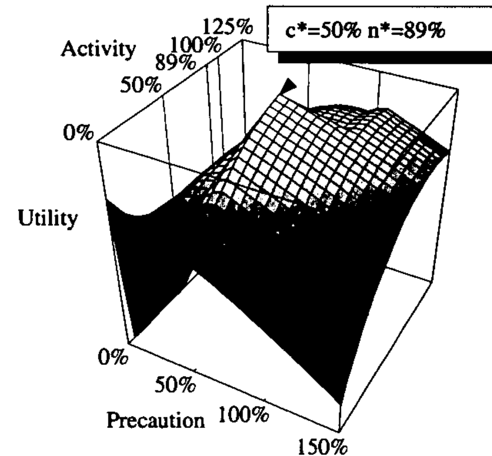

Figure 2.2.2: Indemnity=50%
Prec. Cond.=50% Act. Cond. = 89%

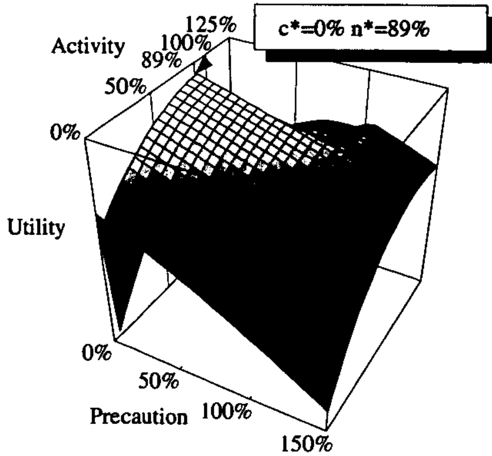

Figure 2.1.3: Indemnity=0%
Prec. Cond.=100% Act. Cond. = 89%

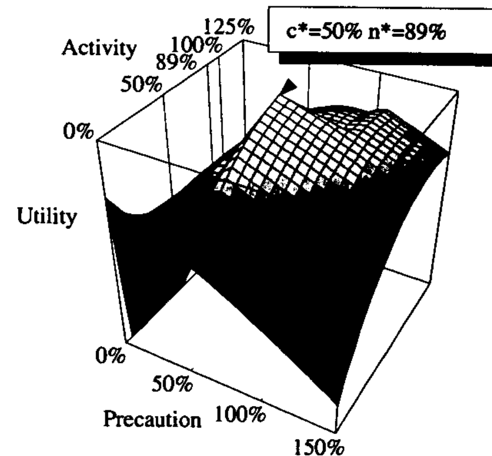

Figure 2.2.3: Indemnity=100%
Prec. Cond.=50% Act. Cond. = 89%

2. No Precaution Condition

a. No Insurance

When no insurance coverage is offered, the risk-averse injurer does best to take just enough precaution against accident to satisfy the requirements of the fault-based system. Graphically, the point of optimal precaution and activity (c^*, n^*) lies an infinitesimal amount to the right of the slight surface discontinuity that exists when the injurer's precaution level finally exceeds that required by the fault system. Lower levels of precaution, while they would reduce the costs of precaution incurred by the injurer, prove unwise because they subject the injurer to a risk of relatively high levels of expected liability against which the injurer is uninsulated by insurance. Higher levels of precaution, while reducing the risk of accident, prove unwise because the fault-based system already excuses the injurer from liability for those accidents. Under a fault-based system such as negligence, additional expense on precaution just wastes resources.

When no insurance is offered, the injurer pursues the same level of activity that it would pursue absent liability for accidents. It does so because, given its satisfaction of the fault standard and the assumedly perfect functioning of the judicial system, the injurer has no liability for accidents it causes. Still higher levels of activity, while providing additional wealth for this injurer, result in increasing production costs and are therefore rejected. Lower levels of activity needlessly sacrifice additional wealth and are therefore rejected too.[36]

b. Incomplete Insurance

As shown by the plot in Figure 2.1.2, under the legal and economic regime illustrated here, incomplete insurance without imposition of any

36. It is worth noting that when insurance coverage is infinitesimally small or nonexistent, this injurer almost does best not to undertake any activity or precaution at all. That is, if an offer of no indemnity and a modest premium were the only offer an insurer could make, this injurer would not make a terrible decision by shutting down productive activity altogether. Indeed, increasing the cost of precaution or increasing the level of precaution needed to satisfy the negligence system would result in the injurer's optimal decision being to undertake no activity whatsoever. The availability of "better" insurance contracts than depicted here thus has the potential to stimulate productive activity.

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precaution condition induces the injurer to reduce its optimal precaution level to about forty-nine percent of that required by the fault-based system and its optimal level of activity to the maximum permitted by the activity condition.[37] Graphically, the optimal point (c*, n*) lies towards the middle of the surface and an infinitesimal amount in front of the discontinuity created when higher levels of activity cause the injurer to forfeit coverage.[38] The optimal level of precaution declines from its level when no indemnity was offered, because the existence of incomplete insurance partly insulates the injurer from the higher levels of expected liability that accompany lower expenditures on precautions. Thus, the risks associated with failure to satisfy the fault-based system no longer look so bad to the injurer.

Incomplete insurance coupled with the absence of a precaution condition decreases optimal activity because, at least as long as the injurer does best *not* to satisfy the fault-based system of liability, the injurer now must take liability issues into account in determining optimal activity. If the injurer violates the activity condition by undertaking more activity than permitted, it forfeits insurance coverage. This forfeiture results in serious liability when accidents occur because the injurer's precaution level is insufficient to insulate it from liability. Thus, the issue is whether the marginal benefits associated with higher levels of activity are worth the higher expected loss that would occur as

37. Somewhat surprisingly, in a negligence system and an insurance contract bearing a low precaution condition, the insured will often prefer a draconian activity condition that would require it to radically curtail its activity in order to preserve coverage. Insureds that significantly profit from activity prefer a draconian activity condition precisely because they will fail to satisfy the condition. Instead, they will take the level of precaution required by the negligence system and avoid liability. The insurer, foreseeing that the insured will behave in this fashion, is able to charge essentially no premium for the policy. The insured prefers this equilibrium to one in which the existence of a liberal activity condition, coupled with a lenient precaution condition, induces it into behavior resulting in a high rate of accidents and, derivatively, a very high premium. To avoid the costs associated with moral hazard, the insured spends enough on accident avoidance to satisfy the negligence system.

38. The careful reader may be curious as to why the activity condition fails to generate a surface discontinuity in Figure 2.1.1. The absence of a surface discontinuity is due to the absence of any indemnity offered by the insurer. That is, the injurer's satisfaction of the activity condition is irrelevant, because even if it satisfies the condition it still receives no benefit from the insurer. An activity condition thus generates a surface discontinuity and therefore acquires an ability to determine optimal levels of precaution and activity only when the insurer offers some positive indemnity to the injurer.

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a result of forfeiting insurance coverage. Under the assumptions made here, forfeiture is foolish. The injurer thus does best to confine itself to the lower level of activity permitted by the insurer's activity condition.

c. *Complete Insurance*

As shown by the plot in Figure 2.1.3, an injurer that is completely insured and subject to no precaution condition does best to take no precautions at all against accidents. Graphically, the optimal combination of precaution and activity lies at the left edge of the surface and just in front of the surface discontinuity generated by the activity condition. The injurer chooses not to undertake any precautions because, if an accident does occur, the insurer picks up the bill. It is thus unwise for the injurer indifferent to the sufferings of others to waste resources on precautions. The injurer again undertakes as much activity as it can without violating the activity condition.[39]

3. Precaution Condition

A walk through the plots on the right hand side of Figure 2 shows the injurer's utility for various levels of precaution and activity and various levels of indemnity when the insurer requires the injurer to maintain at least one-half the level of precaution required by the negligence system.

a. *No Insurance*

When no indemnity is available, the existence of a precaution condition is meaningless and thus fails to alter the injurer's optimal choice of precaution level and activity. Thus, the plot in Figure 2.2.1 looks precisely like its counterpart in Figure 2.1.1.

39. While the completely insured injurer would, in the absence of an activity condition, undertake the same level of activity as it would were it immune from the tort system, the forfeiture of insurance coverage entailed by such a decision renders such a choice inadvisable.

b. Incomplete Insurance

Figure 2.2.2 can be generated by recycling prior work. It is formed by (1) vertically "chopping" Figures 2.2.1 and 2.1.2 at the level of precaution required by the precaution condition and (2) stitching the "left hand piece" of Figure 2.2.1 together with the "right hand piece" of Figure 2.1.2. This composite structure exists because, given the assumed perfection of the judicial system, the injurer will not be indemnified for liability if precaution levels are lower than those established by the precaution condition.[40] Thus, for precaution levels lower than that established by the precaution condition, Figure 2.2.1 (no indemnity) measures the injurer's expected utility. For precaution levels greater than or equal to the precaution condition, the injurer will be indemnified in the event an accident occurs. The precaution condition therefore becomes irrelevant. Thus, for precaution levels greater than that established by the precaution condition, Figure 2.1.2 (incomplete indemnity) measures the injurer's utility.

Because of the composite construction of Figure 2.2.2, the optimization process may proceed by allowing the injurer to compare two optima. The injurer must choose between the optimal level of precaution and activity given that it has failed to satisfy the precaution condition and the optimal level of precaution and activity given that it has satisfied the precaution condition.

Under the legal regime under consideration, this injurer does best to take the minimum amount of precautions required by the precaution condition (fifty percent)[41] and the maximum amount of activity permitted by the activity condition (eighty-nine percent). Graphically the opti-

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40. While this construction of Figure 2.2.2 may seem unnecessarily complex, it facilitates an understanding of the injurer's expected utility levels and optimization procedures when confronted with an imperfect legal regime. Under such circumstances, the injurer's expected utility may be thought of as a blending of Figure 2.2.1 and Figure 2.1.2, with the weight placed on Figure 2.2.1 (no indemnity) increasing as one moves leftwards or towards the back of the figure and the weight placed on Figure 2.1.2 (incomplete indemnity) increasing as one moves rightwards or towards the front of the figure.

41. The injurer takes a somewhat greater amount of precautions than it did when no precaution condition existed because the former level of precaution would no longer satisfy the precaution condition and would thus result in the absence of any insurance protection against liability. For a slight additional precaution cost, the injurer regains the incomplete indemnity it enjoyed prior to the imposition of a precaution condition.

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mal point (c*, n*) lies at the tip of the promontory created by the combination of the precaution condition surface discontinuity and the activity condition surface discontinuity.

c. *Complete Insurance*

Figure 2.2.3 is constructed in much the same way as Figure 2.2.2. It is formed by the stitching together of the left hand part of Figure 2.2.1 and the right hand part of Figure 2.1.3, both figures vertically chopped at the level of precaution specified by the precaution condition. This composite construction exists because, for levels of precaution less than the precaution condition, the injurer's utility is identical to that shown in Figure 2.2.1. It is as if the injurer has no insurance. For levels of precaution greater than or equal to the precaution condition, the injurer's utility is identical to that shown in Figure 2.1.3. Thus, the injurer is again left to compare two optima and to choose the best of the two.

Given the legal regime in place here, its own characteristics and those of the insurer, the injurer again does best to take just enough precaution to satisfy the precaution condition and to take as much activity as possible and not violate the activity condition.[42] Had no activity condition existed, the completely insured injurer would have wished to have undertaken the optimal level of activity that exists when it is immune from liability, but it is not willing here to sacrifice complete insurance for those limited benefits.

4. Generalizing the Results to Find Optimal Levels of Precaution and Activity

Plots like those shown in Figure 2 can be drawn for all conceivable insurance offers in a given legal regime for a particular injurer and insurer. From these figures one can derive the injurer's optimal levels of precaution and activity for any given offer within that regime. Figures 3 and 4 illustrate part of such an endeavor.

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42. Figure 2.2.3 is highly similar to Figure 2.2.2 because in both plots it is the precaution condition that largely determines the results of the injurer's optimization problem. In both instances, the injurer would actually prefer to take fewer precautions than the precaution condition requires. In neither instance, however, is it willing to forfeit coverage to save the precaution costs.

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Figure 3

Figure 3.1: No Precaution Condition

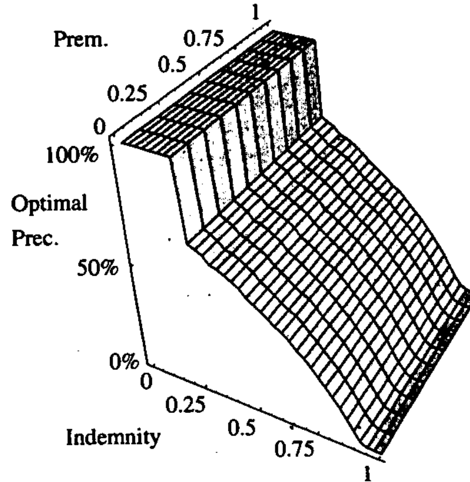

Figure 3.2: 50% Precaution Condition

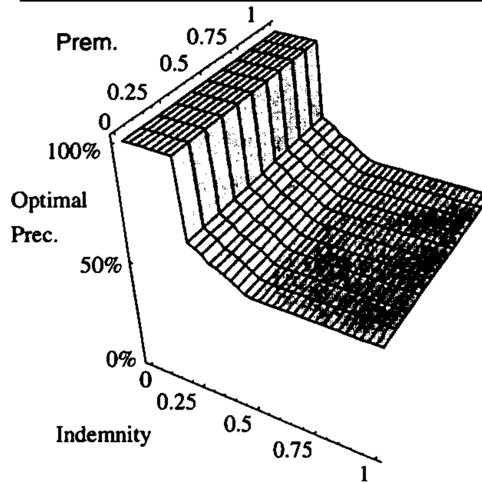

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Figure 4

Figure 4.1: No Precaution Condition

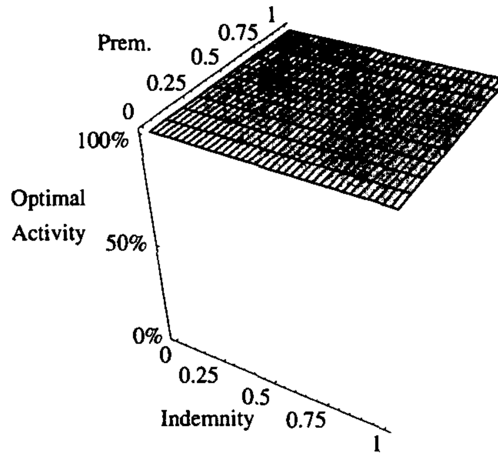
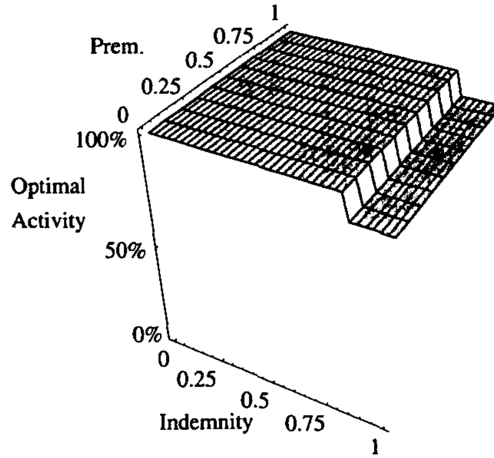


Figure 4.2: 50% Precaution Condition



In both figures, the indemnity level included in the insurance contract is shown on the x-axis while the premium charged is shown on the y-axis. The surfaces shown in Figure 3 demonstrate the optimal level of precaution given the legal regime, injurer, and insurer described thus far. Figure 3.1 shows optimal precautions when an eighty-nine percent activity condition is in place and no precaution condition exists. Figure 3.2 shows optimal precautions when an eighty-nine percent activity condition is in place but the insurer sets a precaution condition equal to fifty percent of the requirement of the fault-based system. Figure 4 shows the corresponding plots for activity level: Figure 4.1 shows optimal activity when no precaution condition exists, and Figure 4.2 shows optimal activity when the fifty percent precaution condition exists.

As can be seen from Figure 3, in this legal regime, this injurer's optimal level of precaution satisfies the demands of the fault-based system until the level of indemnity offered crosses a threshold level, here about twenty percent of liability.[43] The premium charged for the insurance does not appear to affect the threshold.[44] Once the level of indemnity exceeds this threshold, the injurer's optimal level of precaution no longer satisfies the fault-based system. Rather, optimal precaution levels drop precipitously. In Figure 3.1, where no precaution condition is imposed, the injurer's optimal level of precaution drops steadily until, when indemnity is nearly complete, optimal precaution drops to zero. As shown in Figure 3.2, when a fifty percent precaution condition is imposed, the decline in optimal precaution levels induced by increasing levels of indemnity tracks that shown in Figure 3.1 until, at about the fifty percent indemnity level,[45] the precaution condition begins to

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43. Indemnity levels less than this 20% threshold fail to provide the injurer with protection sufficient enough to induce it to depart from the security resulting from taking the precautions needed to satisfy the fault system. There is nothing "magic" about the 20% figure. Lower precaution costs would increase the amount of indemnity that would need to be offered to induce the injurer to depart from satisfying the fault system. A more lenient fault-based system would likewise increase the amount of indemnity that would need to be offered to induce the injurer to depart from satisfying the fault system.

44. The failure of the premium charges to affect the optimal level of precaution stems from the constant absolute level of risk aversion this insured is assumed to have over the range of wealth positions in which it might end up following either an accident or no accident.

45. The fact that the *50%* precaution condition begins to have bite at about the *50%* indemnity level is just a coincidence.

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have bite. For still higher levels of indemnity, the injurer now undertakes just enough precaution to satisfy the precaution condition, sacrificing a preference for lower levels of precaution in order to retain the benefits of insurance.

As can be seen from Figure 4, the optimal level of activity is linked to the optimal level of precaution. So long as indemnity levels are too low to induce the injurer to run afoul of the fault-based system, the injurer maintains an activity level equivalent to what it would have undertaken if its activities had no potential for creating liability at all. This relationship exists because, so long as the injurer is satisfying the fault-based system, it *has* no liability for accidents. The optimal level of activity changes at the same threshold indemnity level that first induced the injurer to take fewer precautions than required by the fault-based system. The injurer's optimal level of activity drops because the injurer is now liable for accidents when they occur and is not fully insulated by insurance from liability for those accidents. Activity, with its potential for causing accidents, is now more costly than before.[46]

The information in Figure 3 and Figure 4 can be combined to determine the expected level of accidents for given insurance offers. Figure 5 shows the relationship and illuminates the potentially significant effects of moral hazard. Figure 5.1 shows the expected level of accidents when the contract between injurer and insurer contains no precaution condition. Accident levels stay low until the insurance contract bears more than about a twenty percent indemnity level. From that threshold onwards, accident frequency increases steadily, rising to a virtual certainty as indemnity levels approach 100%. Figure 5.2 shows the expected level of accidents when the insurer conditions its obligation to indemnify on the injurer's having maintained at least fifty percent of the precaution level required by the fault-based system. Up until the fifty percent indemnity level, at which point the precaution condition begins to have bite, accident frequency is identical to that when no precaution existed. For higher levels of indemnity, however, accident frequency remains constant, as the injurer takes just enough precautions

46. While the injurer might prefer to increase its level of activity as the level of indemnity grows and its net liability for accidents thus declines, the activity condition, perfectly monitored by the insurer, deters it from doing so. The marginal gains associated with higher levels of activity are not worth forfeiture of the increasingly generous insurance benefits.

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Figure 5

Figure 5.1: No Precaution Condition

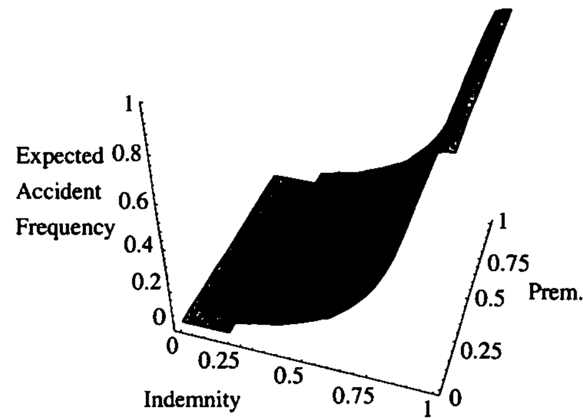
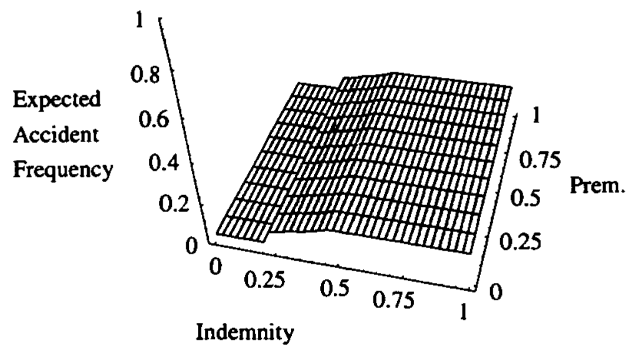


Figure 5.2: 50% Precaution Condition



to satisfy the precaution condition and the maximum amount of activity permitted by the activity condition.

Figures such as 3, 4, and 5 could be drawn for any number of legal regimes and for any variety of injurers and insurers. One could, for example, examine optimization of precaution and activity under strict liability, where there is no level of precaution that immunizes the injurer from liability. Or one could examine optimization of precaution and activity when the cost of precaution is high, or when the marginal revenue from heightened activity levels is low. One could examine the effect of conditioning the insurer's indemnity obligation on higher levels of care or on lower levels of activity. But the variety of analyses potentially available are of little use until one determines how optimization decisions about precaution and activity determine the insurance contracts that are likely to be formed. Thus, this Article avoids these complications and instead proceeds with the next major step in determining the equilibrium risk-sharing contract under conditions of moral hazard.

B. *Restricting the Offers to a Feasible Set*

The next step in determining an equilibrium is to narrow the set of offers extended by the injurer to those which will, *after the injurer optimizes its level of precaution and activity*, yield minimal nonnegative expected profits to the insurer. Only those offers satisfying this condition are optimal for the injurer.[47]

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47. In situations such as this, involving a financially responsible injurer with a constant level of risk aversion, finding the minimal nonnegative expected profits is conceptually not particularly difficult. Recall that as shown in Figure 5, and as discussed above, for a financially responsible insured with a constant absolute level of risk aversion, the premium charged for insurance does not affect accident frequency. Nor does the premium charged affect optimal precaution or activity levels. *See supra* text accompanying note 44. These invariances mean that one determines the optimal choices of the insured for *any* premium level—say zero—and then computes the premium that would be required to compensate the insurer fully for the corresponding expected level of indemnity obligations. In a graphical sense, one finds the intersection of two lines, one showing revenue and the other showing expected indemnity obligations. The y-value of the expected indemnity line only had to be calculated for one premium level, however. Alternatively, one plotted the difference between revenue and expected indemnity obligations and found the smallest nonnegative value. Figure 6 below illustrates this methodology.

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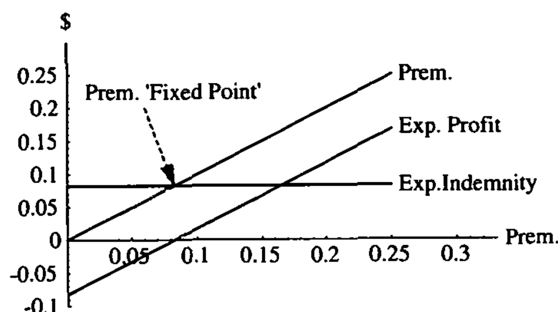
1. The Relationship Among Indemnity Level, Premium, Coverage Conditions, and Profit

The plots in Figure 7 illuminate the relationship among the features of the insurance offer and the profit of the insurer within the legal regime used thus far for illustration. The "Zero Profit Locus"[48] in Figure 7.1 shows the combination of indemnity levels and premiums that yield the insurer zero profit when no precaution condition is imposed and the standard eighty-nine percent activity condition is imposed.[49]

Figure 6



In some sense, Figure 6 illustrates the finding of a premium "fixed point": one looks for the premium that would induce the injurer to take a level of precaution and activity that would in turn *not* require the insurer to alter the premium in order to break even. So long as there are no discontinuities in the expected indemnity payments as the premium amount varies, Brouwer's Fixed Point Theorem guarantees that there is at least one premium "fixed point." *See generally* HUKUKANE NIKAIDO, INTRODUCTION TO SETS AND MAPPING IN MODERN ECONOMICS 303-09 (K. Sato trans., 1970) (proving theorem). When expected optimal precaution and activity levels (and the corresponding accident frequency level) vary according to the premium that is charged, the task of finding a "fixed point" becomes more difficult. Indeed, if changes in premiums induce changes in whether the injurer satisfies precaution and activity conditions, then no classic "fixed point" may exist at all. Instead, the problem may enter the realm of Catastrophe Theory. *See* VLADIMIR I. ARNOLD, CATASTROPHE THEORY (G. Wasserman trans., 3d ed. 1992).

48. The term is borrowed from Richard J. Arnott, *Moral Hazard and Competitive Insurance Markets*, *in* CONTRIBUTIONS, *supra* note 5, at 325, 335, and is used in the same sense as Professor Arnott uses it.

49. One could derive the Zero Profit Locus by plotting the expected profit of the insurer insuring a particular injurer for all combinations of premium and indemnity in a given legal regime. The points on that surface with a "height" or profit level of

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The Zero Profit Locus in Figure 7.2 shows the combination of indemnity levels and premiums that yield the insurer zero profit when the insurer conditions coverage on the injurer's maintaining at least fifty percent of the precautions required by the fault-based system and on the injurer's not undertaking more than eighty-nine percent of the activity that it would were it immune from tort liability. Indemnity/premium combinations to the "northwest" of the Zero Profit Loci yield the insurer positive expected profits and are thus unlikely to be offered by injurers; those to the "southeast" yield the insurer negative expected profits and are thus rejected by insurers.

2. A Closer Look at the Zero Profit Loci

Much can be learned about optimal insurance contracts by careful study of the Zero Profit Loci. Where, as in these examples, the cost of care is relatively low and the legal regime is one of negligence perfectly and costlessly verified by the judiciary, the insurer can accept offers involving limited incomplete insurance without charging *any* premium. The insurance is free because the indemnity provided in the event of an accident is not sufficient to induce the injurer to save the extra costs associated with maintaining precautions sufficient to satisfy the tort system. Thus, the injurer never incurs any liability. As the insurance becomes more complete, however, the rigors of maintaining the extra level of precaution sufficient to prevail against allegations of fault becomes relatively less attractive. For the payment of a premium and, on occasions when an accident does occur, the difference between the liability incurred and the indemnity, the injurer can now reduce its costly precautions down to the level required by the insurer. While the injurer will now have liability when an accident occurs, the existence of fairly complete insurance makes such an outcome more palatable than the costs attendant on always taking enough precautions to satisfy the tort system. Thus, when the indemnity is great enough to induce the injurer to undertake fewer precautions than required by the fault system, the insurer must begin to charge for the insurance.

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zero constitute the Zero Profit Locus. In fact, this is how the depictions of the Zero Profit Locus shown in Figure 7 were created.

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Figure 7

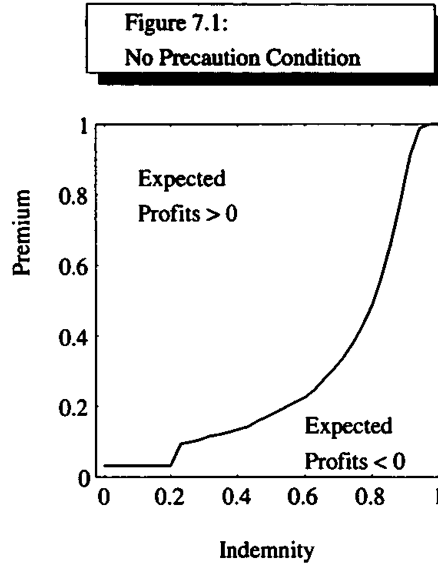

Figure 7.1:
No Precaution Condition

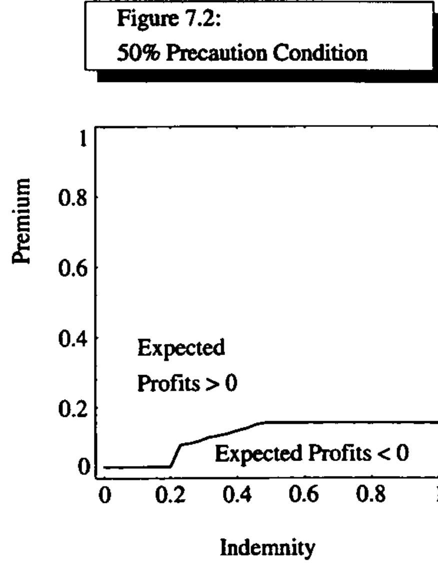

Figure 7.2:
50% Precaution Condition

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3. Conclusion

Plots such as those shown in Figure 7 can be drawn for all conceivable insurance offers in a variety of legal regimes and for a variety of injurers and insurers. One could, for example, examine shifts in the Zero Profit Locus induced by increases in the cost of monitoring the injurer's compliance with coverage conditions or increases in other forms of insurance overhead. One could examine the effect of strict liability, or the effect of legal rules permitting the insurer to reduce its indemnity obligation when the injurer is insolvent. Again, however, understanding these complexities is of minimal value until one understands the procedure by which the injurer chooses among the feasible offers.

C. The Optimal Feasible Offer

1. The Relationships Among the Feasible Offer, the Injurer's Utility, the Frequency of Accidents, and Victim Compensation

The process undertaken thus far has yielded a set of "feasible" offers an injurer could extend to an insurer. "Feasible," in this context, means the offer with the lowest premium that yields the insurer nonnegative economic profits. The issue now becomes determining which of these feasible offers an injurer will likely extend. The remaining procedure is conceptually simple: the injurer picks the feasible offer that yields it the greatest level of expected utility.

The surface shown in Figure 8, the most important diagram in this Article, provides a three-dimensional visualization of this remaining part of the process.[50] It thus makes explicit what has at best been only implicit in law and economics scholarship: the ways in which the tort system and the variety of possible contracts available to an injurer combine to determine injurer utility.

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50. There is an intimate relationship between Figure 7 and Figure 8. Figure 8 is constructed as follows: (1) for each precaution condition, find the corresponding Zero Profit Locus; (2) for each Zero Profit Locus, determine the expected utility of the insured at each point along the locus; (3) for each Zero Profit Locus, construct the Cartesian product of all points on the Zero Profit Locus with the precaution condition, and project that point onto a three-dimensional space having indemnity level, precaution condition, and utility level as its bases.

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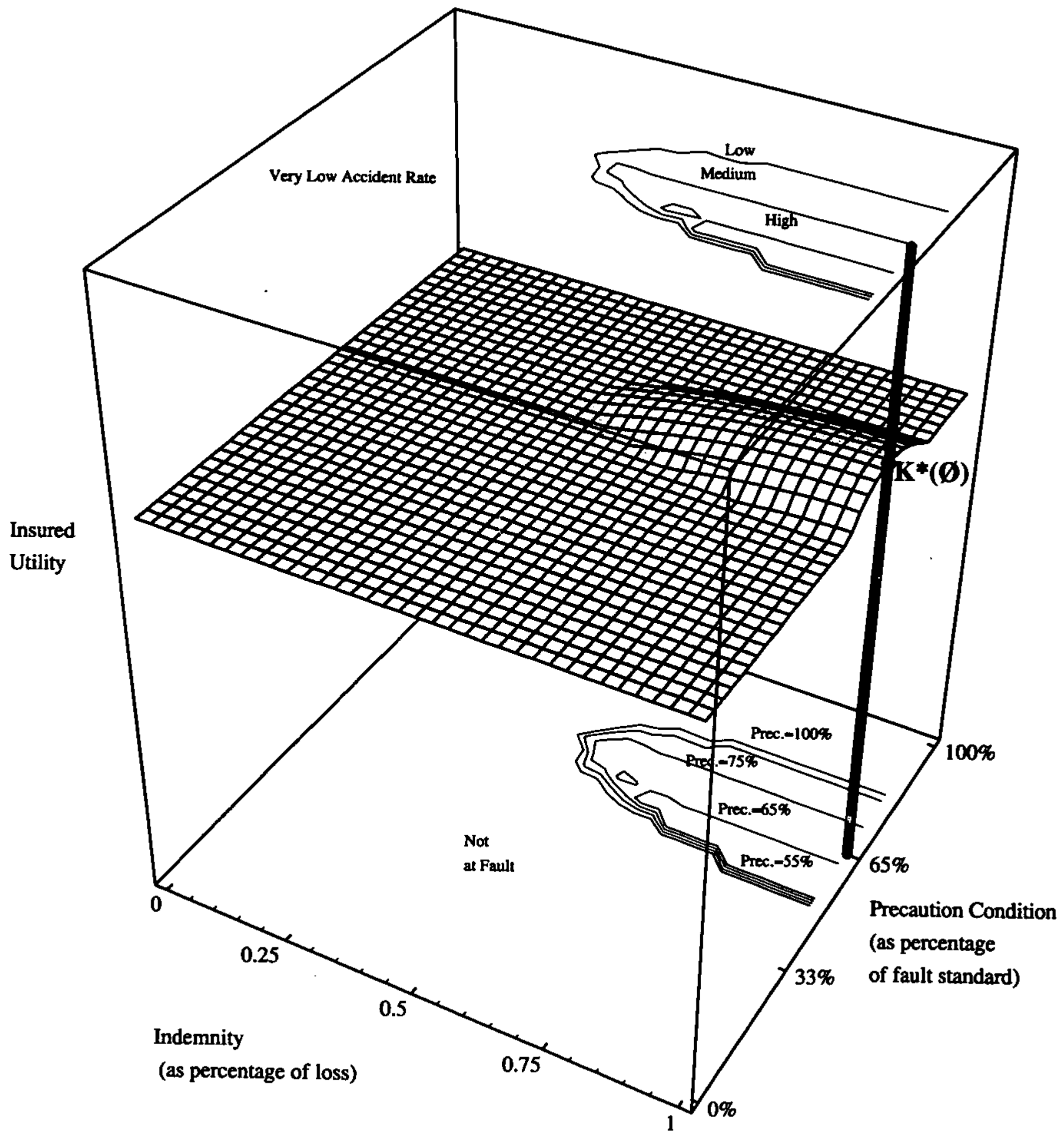
Figure 8
Optimal Insurance Contract



The axes on this diagram are somewhat different from those employed earlier. As before, the x-axis shows the indemnity level offered by the insurer. In other words, it shows the proportion of liability incurred by the injurer for which the insurer will offer indemnity. No insurance thus corresponds to an indemnity level of "0." Full insurance thus corresponds to an indemnity level of "1." The y-axis shows the precaution condition imposed by the insurer as a percentage of the fault standard imposed by the legal regime. That is, it shows the level of precaution the injurer must be found to have maintained before the insurer has an obligation to indemnify the injurer. High precaution conditions mean that the insurer will not be liable unless the injurer was very careful. Low precaution conditions mean that the insurer will be liable unless the injurer was very careless. A thirty-three percent precaution condition means, for example, that the insurer will indemnify the insured for liability incurred provided it took at least thirty-three percent of the precautions that would have been required to satisfy the fault-based system. The z-axis shows the utility of the injurer corresponding to these offers given the specified legal regime, an optimal activity condition,[51] and the personal characteristics of the injurer.[52]

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51. For the optimal contract the injurer must not have undertaken more than 89% of the activity that it would have undertaken were there no tort liability. When the tortfeasor is compelled to purchase a contract with a less severe precaution condition than that in the optimal contract, the optimal activity condition declines as well, provided that the restriction is not so severe as to induce the insured to abandon the insurance market altogether. This relationship between precaution condition and optimal activity condition exists because, at the lower levels of precaution induced by the less severe precaution condition, activity becomes more costly to the insured since it induces a greater number of accidents. Accidents are costly to the insured because they increase the insured's premium or because they increase the insured's personal liability to the extent of any incompleteness in the indemnity level. Conversely, when the tortfeasor is compelled to purchase a contract with a more severe precaution condition than in the optimal contract, the optimal activity condition increases, again provided that the floor on permissible precaution conditions is not so high as to induce the insured to abandon the insurance market altogether. The relationship between precaution condition and optimal activity condition again stems from the fact that the greater level of precaution induced by the more severe precaution condition makes activity less costly for the insured. Thus, the insured undertakes more activity.

52. It may be noted that the premium level heretofore occupying the y-axis is no longer present, and indeed, that the role of the insurance premium in determining the insured's utility is no longer apparent. Premium information may be suppressed, however, because the feasible offer defined by a level of indemnity and a precaution

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Figure 8 also contains three other features useful in analyzing the effects of moral hazard. First, several "accident contours" shown on the "ceiling" of Figure 8 partition the set of feasible offers into different levels of accident frequency. Each accident contour line shows insurance contracts that result in the same frequency of accidents. Thus, the area marked "very low accident rate" delineates those insurance contracts that induce behavior by the injurer corresponding to very low rates of accident (here, less than four percent). Accident frequency generally increases as insurance contracts that feature higher levels of indemnity and lower precaution conditions are chosen. Thus, offers in the "high accident rate" zone involve more than five times the accident frequency of offers in the "very low rate" zone.

Second, several "precaution contours" shown on the "floor" of Figure 8 partition the set of feasible offers into different levels of precaution. Each contour line shows insurance contracts that result in the same level of precaution being taken by the injurer. The precaution contour marked "Precaution = 100%" is of particular importance. This contour divides the insurer's offers into two distinct sets. Offers to the "northwest" of this contour result in the injurer taking precautions adequate to satisfy the fault-based system. Thus, if the insurance contract that is formed lies within this zone, the fault-based system will not compensate victims for accidents. Offers to the "southeast" of this contour result in the injurer's taking inadequate precautions to satisfy the fault-based system.

Third, a vertical line marked K*(Ø) extends from floor to ceiling of Figure 8 and intersects the surface at its highest point.[53] Point K*(Ø) thus denotes the insurance contract that yields the greatest level of utility for the injurer. K*(Ø) is, in some sense, the "answer" to the question analyzed over the preceding pages. It is the contract the legal regime would induce for this injurer and insurer in a perfect and unregulated insurance market. Here, point K*(Ø) results in the injurer purchasing a complete insurance contract with a precaution condition requiring the injurer to take sixty-five percent of the precautions required by the fault-based system. The injurer responds to this contract by taking just

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condition implicitly contains a unique premium needed to yield the insurer zero profits. Thus, while premium levels can be reconstructed from the data shown in Figure 8, they are no longer necessary to determine the utility of the insured.

53. The notation is intended to evoke the realization that the optimal insurance contract K* is a function of the restrictions placed by government on the insurance market. The argument Ø used here denotes no government intervention.

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enough precautions (sixty-five percent) to satisfy the precaution condition. Accident rates are low to medium. Because the injurer does not take the level of precaution required by the fault-based system, victims are compensated by the insurer when an accident does occur.

2. Conclusions

Beyond simply illustrating the optimal insurance offer under conditions of moral hazard, Figure 8 yields five additional insights.

a. Liability Insurance Can Reduce Precaution Levels

The existence of an insurance market can decrease the amount of precaution taken by the injurer even in the absence of any imperfections in the judicial system. If the injurer were confined to points at the extreme left on the surface in Figure 8 at which no indemnity exists, the risk-averse injurer would take enough precautions to satisfy the negligence system. If the negligence standard is set higher than the "economically efficient" level, the injurer's effort to shed risk may result in an inefficiently high amount of resources being devoted to accident avoidance. When the injurer is free to select up to complete indemnity, however, the intersection of K*(Ø) with the precaution contour lines at the bottom of Figure 8 shows that the injurer chooses a lower level of precaution. This decrease stems from the fact that while a risk-averse injurer might be willing to comply with even a relatively tough negligence standard in order to avoid the risk of liability, an injurer rendered risk neutral by the availability of complete liability insurance might find compliance with that standard too costly given the absence of risk.[54]

54. It may appear that this result is disproven by what has sometimes been called Shavell's First Insurance Proof, which asserts that when insurers are able to monitor perfectly the behavior of injurers, injurers operating under a negligence rule will have no need to purchase liability insurance; thus, the theoretical availability of such insurance will not alter the optimal level of precaution taken by injurers. *See* SHAVELL, *supra* note 8, at 222-27 (proving this result); Schwartz, *supra* note 26, at 339 (so labelling the proof); *id.* at 344-49 (attempting to explain the broad existence of liability insurance in negligence-based regimes notwithstanding this proof). Since Professor Shavell's proof is regarded as authoritative, *see* RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 187 (3d ed. 1986); A. MITCHELL POLINSKY, AN INTRODUCTION TO LAW AND ECONOMICS 70-73 (2d ed. 1989), this contradiction

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b. Liability Insurance Can "Correct" for Errors in Setting the Negligence Standard Higher Than the Economically Efficient Level

Indeed, the existence of liability insurance provides an otherwise unavailable vehicle for injurers to bargain their way out of an initial legal regime that sets its fault standard at a level higher than that which, if complied with, would maximize the net social profit from activity, i.e. the net profit from activity less the sum of precaution costs and expected accident losses.[55] With liability insurance and perfect

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might suggest a defect lurking in the complexities of the model employed in this Article. In fact, however, a careful examination of Professor Shavell's proof shows that no contradiction exists. Professor Shavell proves his theorem in the case when courts exonerate injurers from liability if they took at least the socially optimal level of precaution prior to the accident. By socially optimal, Professor Shavell means that level of precaution that minimizes the sum of precaution costs and expected damages to the victim. *See supra* note 26. He likewise proves that the availability of insurance will not alter an injurer's optimal precaution level given strict liability. By strict liability, Professor Shavell means in effect a fault standard so high that even the most risk-averse injurers cannot profitably meet it.

The case Professor Shavell does not consider, however, is when the standard of liability is set at a level such that risk-averse injurers will meet the standard but risk-averse injurers will not do so. For the reasons set forth earlier, *see supra* note 26, this Article does *not* assume either that courts will perfectly determine the socially optimal negligence level or that courts will employ strict liability. Rather, it uses an intermediate fault standard. Under these conditions, injurers may well purchase liability insurance even in a perfectly functioning judicial system and the purchase of liability insurance will alter the optimal level of precaution they take. Thus, contrary to Professor Schwartz's suggestion, neither the existence of imperfections in the judicial system's ability to distinguish fault from faultless conduct nor the existence of litigation costs is the only explanation for the existence of a demand for liability insurance. *See* Schwartz, *supra* note 26, at 344-46 (explaining coexistence of liability insurance and negligence on these theories).

Indeed, a possible function of liability insurance is to correct judicial mistakes in setting the negligence standard. If courts, as they do in the example used in this Article, demand more than socially optimal levels of precaution by injurers, a free insurance market should generate contracts like K*(Ø) that fully indemnify the injurer so long as they undertake the socially optimal level of precaution and activity.

55. *See supra* note 54 (discussing why this is the socially optimal standard). The bargain cannot otherwise occur because injurers are presumed unable to bargain with victims in advance of the accident. In a broad sense, liability insurance permits purchase of a legal entitlement without transaction costs. In this realm, the Coase Theorem operates to ensure that the final level of precaution and activity taken by the injurer is the socially efficient level of this activity.

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monitoring, the injurer that might otherwise spend a significant amount on precautions to avoid liability now uses the insurance market to buy into a regime where the effective standard of liability (compliance with activity and precaution conditions) maximizes the social profit from activity. The injurer's private incentives as a result of its contract with the insurer now yield the socially optimal level of precaution and activity because the insurer, which now bears the cost of accidents, is risk neutral and thus would not recommend spending extra money on precautions just to avoid the risk created by failure to satisfy a high negligence standard. This fact suggests that a court confident in the adequacy of its remedies but uncertain as to what level of precaution and activity are optimal might wish to err on the side of being tough towards injurers and permitting an unregulated liability insurance market to correct any error.

c. *Monitoring v. Bonding*

The analysis embodied in Figure 8 shows that when the insurer can perfectly and costlessly monitor compliance with its precaution conditions, an injurer with the personal characteristics described here will do best to take fewer precautions than required by the fault-based system and purchase full insurance. The injurer thus transfers all risk to the insurer.

The vocabulary of "agency costs" may be used to restate this conclusion.[56] Faced with the risk of an accident, the injurer has several potential solutions. First, the injurer can go it alone and take high levels of expensive precaution to avoid the risk of an accident. Second, the injurer can enter into an indemnity arrangement with an insurer to show the insurer credibly that the indemnity arrangement will not be used as an overpowering inducement to throw caution to the wind. The injurer makes this showing by "bonding" its fortunes to those of the insurer: it obtains only partial indemnity against accident liability. Third, the injurer can enter into an indemnity arrangement with an insurer, but

56. The theory of agency costs is originally described in Eugene F. Fama, *Agency Problems and the Theory of the Firm*, 88 J. POL. ECON. 288 (1980), and Michael C. Jensen & William H. Meckling, *Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure*, 3 J. FIN. ECON. 305 (1976). A brief and extraordinarily clear treatment is provided in Jonathan R. Macey, *Agency Theory and the Criminal Liability of Organizations*, 71 B.U. L. REV. 315, 320-22 (1991).

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agree to permit the insurer to "monitor" its levels of precaution and to forfeit coverage if its level of precaution ever dips below a stated amount. The analysis undertaken here confirms that, where monitoring is costless, the injurer prefers a monitoring solution to a bonding solution.[57]

The result of this full-insurance/monitoring solution is that the injurer, having shed itself of all risk, undertakes the same level of precaution and activity that a risk-neutral entity otherwise identical to the injurer would undertake. Alternatively viewed, the injurer behaves in the same manner that the risk-neutral insurer would behave if the insurer faced the same precaution costs and net activity costs as the injurer.

d. The Preferred Precaution Condition

At least one court has indicated that "the law of insurance is not like the law of torts to be used as an instrument of coercion upon assureds to improve operating practices," and that "[a]ssureds do not go into the insurance market to buy themselves an overseer."[58] An examination of Figure 8 suggests that this view is often incorrect. Examine the intersection of the precaution contours on the bottom of Figure 8 with point K*(Ø). That examination shows that the injurer does best when the insurer imposes a precaution condition requiring the injurer to maintain precautions only an infinitesimal amount less than the actual amount of optimal precautions taken by the injurer. That is, point K*(Ø), for which the associated precaution condition is approximately sixty-five percent of the fault standard, lies on the sixty-five percent precaution contour. At least in a world where courts are accurate, the injurer wants a stern overseer because having one permits it to shed the most risk at the lowest possible cost.

This same concept explains the assumed conditioning of the insurer's indemnity obligation on the injurer's undertaking of less activity than if there were no tort liability. The injurer actually wants

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57. *See* Steven Shavell, *On Moral Hazard and Insurance*, 93 Q.J. ECON. 541 (1979) (Part IV.A). Bonding solutions amount to all insurance offers involving less than complete indemnity. All points offering less than complete indemnity are inferior to point K*(Ø). The "go it alone" strategy corresponds to the point on the surface of Figure 8 for indemnity levels of zero. Again, these points are all inferior to point K*(Ø).

58. New York, New Haven & Hartford R.R. Co. v. Gray, 240 F.2d 460, 465 n.7 (2d Cir. 1957) (finding "much to be said" for this assertion by counsel).

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such a condition because a risk-neutral entity otherwise identical to itself would, under the specified legal regime, undertake less activity than it would if there were no tort liability. Specifically, under the legal and economic regime described here, a risk-neutral entity otherwise identical to the injurer would undertake eighty-nine percent of the activity that it would undertake if there were no tort liability. An injurer otherwise wishing to undertake this lower level of activity does not want the insurer to raise its premiums to accommodate a well-founded worry that the existence of insurance would otherwise induce the injurer to undertake higher levels of activity than the risk-neutral entity. Thus, the injurer does best to insist on an eighty-nine percent activity condition.

In short, the injurer wants the insurer to know that it is willing to undertake precisely the same level of precaution and activity that the risk-neutral insurer would undertake if it otherwise had the same characteristics as the injurer. It is willing to be induced to so behave by severe punishment (forfeiture of coverage) in the event it deviates from that prescription. In order to reduce its risk, the injurer is willing to pay the insurer a premium equal to the expected liability resulting from accidents for undertaking precaution and activity at the insurer's preferred levels.

e. Accident Frequency and Compensation

An examination of the surface of Figure 8 also shows that, at least for the assumed fault-based legal regime and for the type of injurer discussed here, the existence of an insurance market increases the frequency of accidents but also increases victim compensation. This proposition is established by examining the left most part of Figure 8. This portion of Figure 8 shows the relationship among the injurer's precautions, the injurer's utility, and the frequency of accidents when no insurance is permitted, i.e., when the amount of indemnity offered cannot exceed zero. Because all offers bearing no indemnity lie to the left of the "Precaution = 100%" contour, this injurer will always respond by satisfying the demands of the fault system. As a result, and as shown from an examination of the top left portion of Figure 8, relatively few accidents occur. Because the injurer has satisfied the fault system, however, when accidents do occur, the victim receives no compensation from the injurer.

By contrast, at point K*(Ø), the outcome of an unfettered insurance market, the injurer takes too few precautions to satisfy the demands of the fault system. The diminished level of precaution, coupled with little diminution in the optimal level of activity, means that more accidents occur—a proposition confirmed by recalling that point K*(Ø) corresponds to low-medium levels of accident frequency. Thus the existence of a liability insurance market results here in more victims being injured, but also in victims receiving tort compensation for their injuries.

D. *Government Restrictions on Permissible Insurance Contracts and Injurer Welfare*

Figure 8 also shows the complex effect of legal restrictions on precaution conditions placed in insurance contracts. Such rules constrain the legally permissible domain of indemnity level and precaution condition to which the insurer and injurer may agree.[59] Common law rules interpreting insurance contracts to require an insurer to indemnify its insured for conduct tending towards the reckless exemplify one form of restriction.[60] Somewhat contradictory common law rules barring indemnity for intentional conduct or conduct objectively likely to lead to injury are examples of another form of restriction.[61] Bars on indemnification for certain damages incurred by the injurer are a third form of restriction.[62] Bars on indemnification for punitive damages when the

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59. The mathematics showing how government regulation of the insurance market alters the features of the optimal insurance contract is discussed in part C of the appendix.

60. *See* State Farm Fire & Casualty Co. v. Tringali, 686 F.2d 821 (9th Cir. 1982); Wheeler v. O'Connell, 9 N.E.2d 544 (Mass. 1937); Nationwide Mut. Ins. Co. v. Roberts, 134 S.E.2d 654 (N.C. 1964).

61. *See* Miller v. United States Fidelity & Casualty Co., 197 N.E. 75, 78 (Mass. 1935) (suggesting in dicta that public policy may bar coverage for recklessness). *See generally* 15 SAMUEL WILLISTON, A TREATISE ON THE LAW OF CONTRACTS §§ 1749-1749A (3d ed. 1972 & Supp. 1986); W. E. Shipley, Annotation, *Liability Insurance as Covering Accident, Damage, or Injury Due to Wanton or Wilful Misconduct or Gross Negligence*, 20 A.L.R.3d 320 (1968 & Supp. 1993); Henry A. Hentemann, *"Expected Or Intended": What Does It Mean?*, 46 INS. COUNS. J. 331 (1979).

62. Many states, for example, bar indemnification of punitive damages. *See generally* First Bank (N.A.)-Billings v. Transamerica Ins. Co., 679 P.2d 1217, 1221 (Mont. 1984) (summarizing case law); BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES § 14.02[b][1] (6th ed. 1993) (same).

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injurer's conduct has been reckless or worse are yet a fourth form of restriction.[63] The Article now examines each of these forms of restrictions.[64]

1. Ceilings on Precaution Conditions

When legal doctrines such as compulsory coverage provisions place a ceiling on the strictness of precaution conditions the insurer may impose, the injurer diminishes the amount of insurance it purchases. That is, for each ceiling on precaution conditions, there is a corresponding "intervention optimum" level of indemnity an injurer will wish to purchase.

A hard stare at Figure 8 shows that as ceilings on precaution conditions restrict the insurer and injurer to the "front" portion of Figure 8, the optimal feasible offer at first moves in a "southern" direction involving lesser levels of precaution. Then, after not too long, the optimal feasible offer moves rapidly "west" to negligible levels of indemnity. Figure 9 may assist visualization here. It shows Figure 8 with the back part of the surface removed to represent a prohibition on insurance contracts in which the insurer insists on the injurer taking more than fifty-four percent of the level of precaution required by the tort system. While the optimal level of indemnity remains unchanged, the optimal precaution condition now drops to fifty-four percent. As can be seen from an examination of the precaution contours and accident contours respectively located on the floor and ceiling of Figure 9, these more southern points induced by the ceiling generally correspond to lower levels of precaution than existed at $K^*(\emptyset)$ and likewise tend to correspond to higher accident frequency.

A close look at either Figure 8 or Figure 9 shows that if the ceiling on the permissible precaution condition was dropped just a little more, say to fifty percent of the level required by the tort system, the injurer

63. *E.g.*, Daughdrill v. Ocean Drilling & Exploration Co., 665 F. Supp. 477, 481-82 (E.D. La. 1987) (applying maritime law).

64. Compulsory insurance laws requiring injurers to have at least some level of insurance protection are actually a fifth frequently found form of restriction. In the particular example studied here, compulsory insurance laws have no effect, however. The injurer wants and obtains full insurance. Thus, to study the effects of compulsory insurance will require a different sort of injurer, a different sort of legal regime, or a different sort of insurer than exists here.

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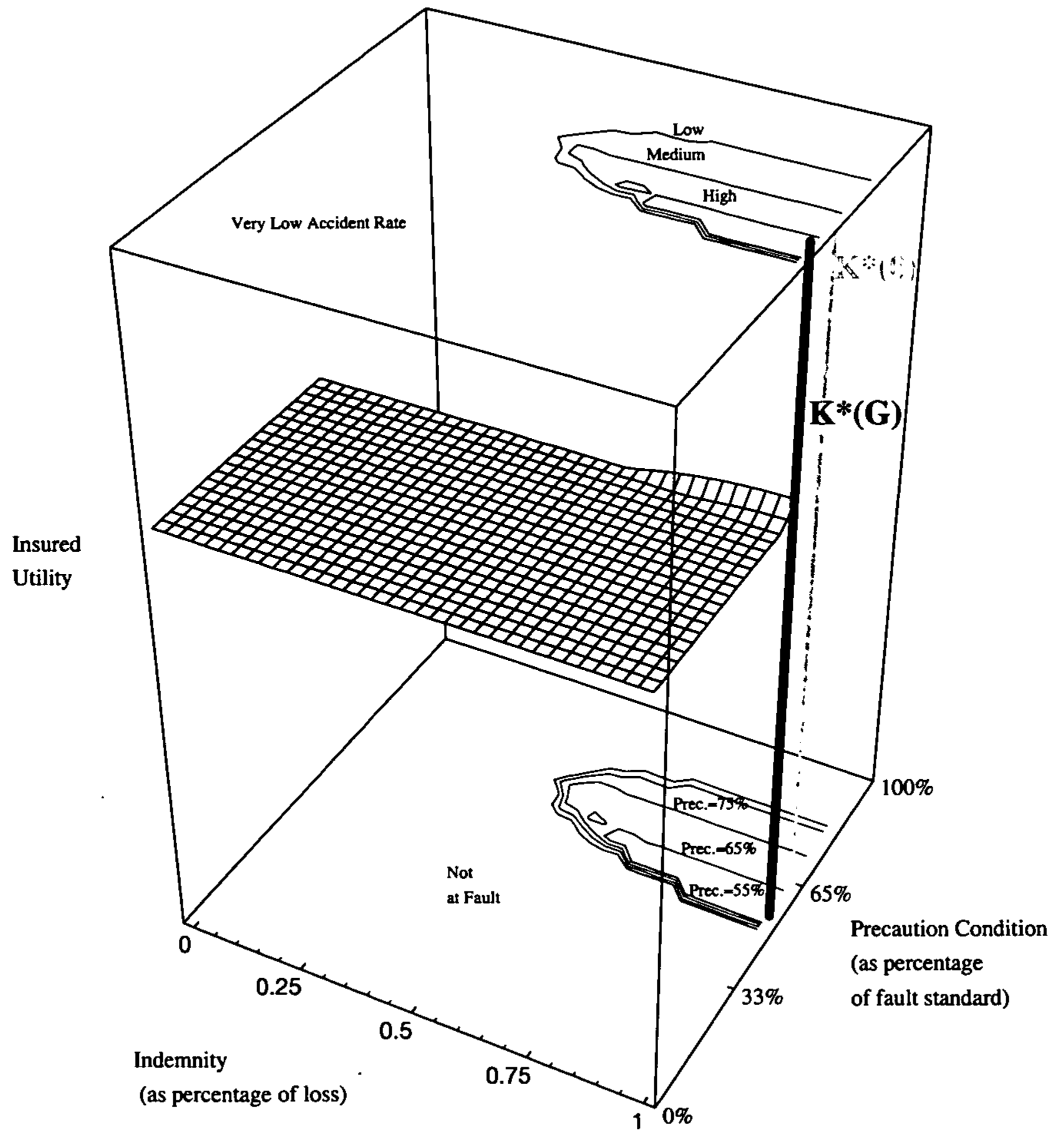
Figure 9
Optimal Insurance Contract with Ceiling on Precaution Condition



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would do best to purchase no insurance[65] and to comply with the demands of the tort system. Thus, at some level of intervention, restrictions on permissible precaution conditions produce a quantum change in the injurer's behavior. The equilibrium contract now lies in a different "basin of attraction." Rather than disobey the dictates of the fault-based standard and protect itself from risk through an insurance contract, as it had when the insurance market was unregulated, the injurer abandons the regulated insurance market and increases its level of precaution to satisfy the fault-based system.[66]

2. Floors on Precaution Conditions

Floors on permissible precaution conditions have a somewhat opposite effect. Floors restrict the injurer to the "back" portion of Figure 8 and move the injurer in a "northern" direction. As can again be seen from an examination of the precaution contours and accident contours respectively located on the floor and ceiling of Figure 8, these more northern points generally correspond to higher levels of precaution that existed at K*(Ø) and lower rates of accident frequency. The same sensitive dependence on the precise level of government intervention is present here too. When intervention is too great, the insurer prefers to protect itself from risk by taking precautions and incurring the consequent expense of satisfying the fault-based system.

3. Ceilings on Indemnity Levels

Figure 8 likewise shows the effect of laws prohibiting injurers from acquiring complete indemnity, as is the case when the law prohibits indemnification of punitive damages,[67] or as used to be the case when the law barred liability insurance altogether.[68] So long as the restric-

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65. The insured would achieve an equivalent result by purchasing insurance offering some positive indemnity but containing a low enough activity condition that the insured would be induced to violate it. *See supra* note 51.

66. Floors set lower than the free-market optimum likewise have no effect on the insured's preferred level of indemnity.

67. *See generally* KEETON & WIDISS, *supra* note 18, § 5.3(g) (summarizing case law and noting conflicting considerations and public interests).

68. For an insightful and comprehensive discussion of the legality of liability insurance in the nineteenth and early twentieth centuries, see Mary Coate McNeely, *Illegality As a Factor in Liability Insurance*, 41 COLUM. L. REV. 26 (1941).

tions are mild, such laws have little effect on victim welfare because they do not alter the level of precaution or activity undertaken by the injurer. Reductions in indemnity levels simply make compliance with the precaution condition less painful for the injurer. Severe reductions in indemnity levels have quantum effects, however. That is, at some point, the level of indemnity is so low that injurers do better to eschew the insurance market altogether and to eliminate risk by satisfying the fault-based standard. Analysis of these quantum effects is identical to that of those induced by restrictions on permissible precaution conditions.

4. Bars on Complete Indemnity for Gross Negligence or Reckless Conduct

Bars on contracts that couple relatively complete indemnity with very low precaution conditions are unlikely to have a significant effect on injurer welfare. If the insured is free to choose an activity condition, it will choose a low activity condition, violate the activity condition and instead comply with the fault standard. The insurer, anticipating this behavior, will offer such a contract for a very low or no premium. If the insured is not free to choose an activity condition, the insured may find itself paying a very high premium for the contract. Either way, such contracts are likely to be unpalatable to the insured. Thus, such restrictions may be understood as a guard against contracts mistakenly formed in such a manner or as a guard against the purchase of such contracts under assumptions not modeled here.

5. Conclusion

While in an individual case an injurer may be helped when a court uses "public policy" to excuse it from compliance with a contract with a strict precaution condition, in the long run injurers are generally hurt by these restrictions. To resort again to the language of agency costs, when the law restricts the ability of the insurer to contract based on the injurer's post-contractual behavior, the injurer prefers a solution in which it partly bonds its welfare to that of the insurer. Bars against strict precaution conditions, once understood by the insurer, lead to premium rates that force the injurer to abandon the insurance market. The injurer retains most of the risk it would wish to transfer to the in-

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surer.[69] These solutions result in lower levels of injurer welfare than existed at K*(Ø). Insurer welfare is unaffected in the long run by movement away from the free-market optimum since it is assumed to make minimal profit in any event.

E. *Government Restrictions on Permissible Insurance Contracts and Victim Welfare*

The fact that injurers are hurt (or at best unaided) by these forms of contract regulation and that insurers are unaided eliminates a conventional justification for intervention[70] in the insurance market; intervention is often premised on the need to help insured injurers.[71] This finding naturally stimulates inquiry into whether at least victims benefit by such market interventions. The Article thus now explores the effects of liability insurance and moral hazard on victims.[72] Unlike previous studies of the issue, the Article extends the analysis to situations in which government may prohibit certain forms of liability insurance while permitting others and to situations in which the tort system is not perfectly compensatory, even as to pecuniary loss.

Where, as here, the injurer is assumed to be financially responsible for injuries it causes, the position of victims resulting from restrictions on precaution conditions depends on (1) whether the restrictions induce behavior by the injurer that increases or decreases accident frequency; (2) whether the restrictions induce a "quantum effect" whereby the injurer drastically alters its precaution and activity levels so as to satisfy

69. Traditional moral hazard analysis, such as that presented in RASMUSEN, *supra* note 9, at 142-47, may now be seen as a special case of the analysis done here. Rasmusen shows that when, for whatever reason, the insured's choice as to levels of precaution is restricted and the insurer is unable to monitor that choice, the insured does best to purchase incomplete insurance. This analysis extends that work to situations where monitoring is possible.

70. In part, this result is an artifact of the injurer being able to extract all the surplus from trade with the insurer. *See supra* text accompanying note 19. Government regulation thus can almost never help the insurer.

71. *See* ABRAHAM, *supra* note 18, at 31-35.

72. In his pioneering study of the issue, Professor Shavell has discussed the optimal level of utility for a victim in either an unregulated insurance market or one in which liability insurance is prohibited. *See* SHAVELL, *supra* note 8, at 215-27. This Article extends the analysis to markets in which certain forms of liability insurance are permitted while other forms are prohibited. It likewise extends the analysis to tort systems with varying degrees of compensation.

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the fault-based standard; (3) the generosity of tort compensation; and (4) the risk aversion of the victim.

Figure 10 illustrates the issue for a modestly risk-averse victim[73] operating in a somewhat undercompensatory tort system.[74] An "undercompensatory" system is one that leaves the victim in a worse position after an accident, even after compensation through the tort system, than if no accident had occurred. A perfectly compensatory system, by contrast, is one in which the victim is indifferent to the occurrence of an accident. It gives the victim the amount of money it would have been willing to accept in order to suffer the accident in question.[75]

The x-axis (indemnity) and y-axis (precaution condition) in Figure 10 are the same here as in the graphs relating to injurer utility. The z-axis now measures the *victim's* expected utility, however. That utility may be thought of as the victim's valuation of various lotteries in which there is some chance of being left uninjured, but also some chance of being injured and relying on the tort system for compensation.[76] Thus, the overall graph depicts victim welfare as the result of the interaction among (1) the insurance contract selected by the injurer, given the injurer's characteristics, those of the legal system and those of the insurer; (2) the victim's personal characteristics; and (3) the generosity of the tort system.

Figure 10 shows that under the assumptions provided, and given an activity condition most preferred by the injurer, the victim would most prefer that the insurer and injurer enter into a contract with a somewhat stricter precaution condition than the optimal contract in an unregulated insurance market. Since the injurer is financially responsible for a judgment, the victim does not particularly care about the level of indemnity,

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73. The example assumes that the victim has a constant level of absolute risk aversion equal to one using the Arrow-Pratt formula. *See supra* note 29.

74. The example assumes that the tort system compensates the victim for 60% of its pecuniary injuries and that there are no nonpecuniary injuries.

75. For serious accidents, there may be no amount of money that adequately compensates the victim. Thus, for serious accidents, almost all tort systems may be undercompensatory. *See* SHAVELL, *supra* note 8, at 231-35 (discussing utility of fines to assure adequate deterrence); Michael Spence, *Consumer Misperceptions, Product Failure and Product Liability*, 64 REV. OF ECON. STUD. 561, 563 (1977).

76. The computation for the victim's expected utility is set forth in part A.7.c of the appendix.

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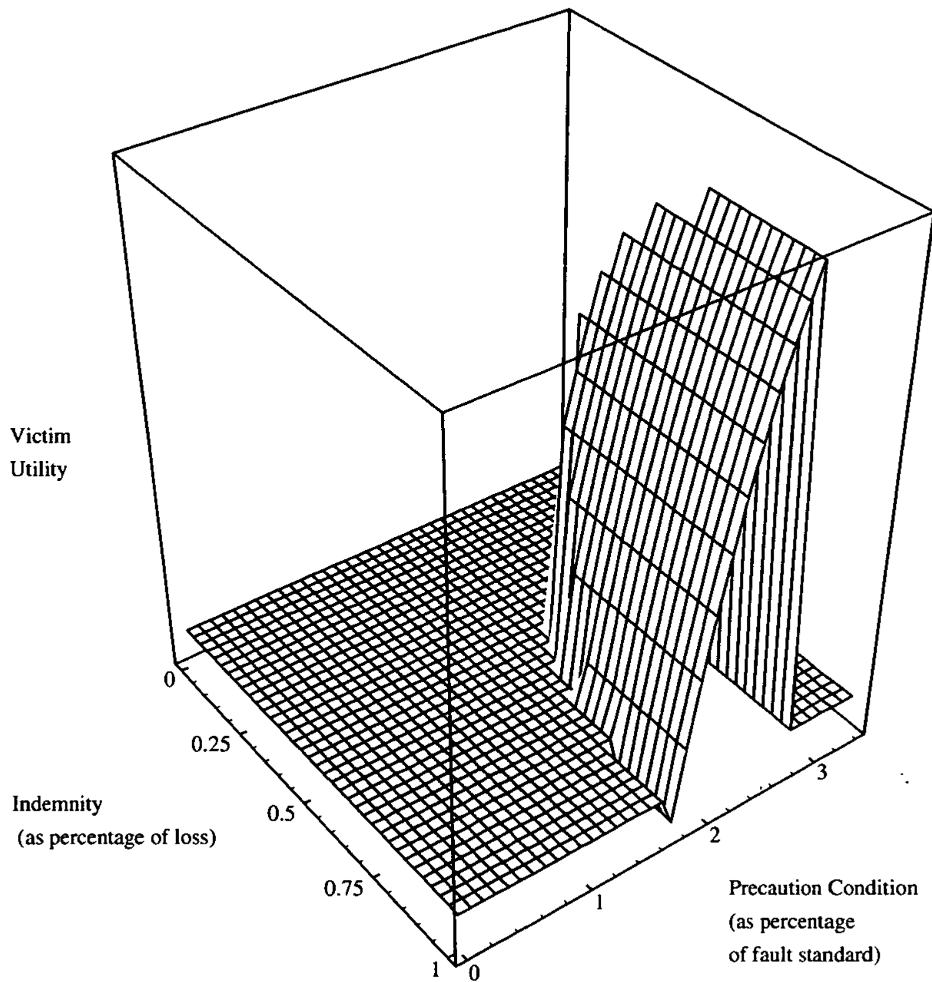
Figure 10



so long as it is great enough to induce the injurer to purchase insurance. The victim does worst when the insurer provides significant indemnity but fails to establish substantial precaution conditions. The unregulated insurance market, while maximizing the well-being of the injurer, leaves the victim in an intermediate position. The precaution condition imposed in the contract formed in the unregulated market is reasonably high, but not at the highest level that would deter the injurer from abandoning the insurance market and complying with the fault standard. Regulation that induces the injurer to abandon the insurance market and comply instead with the fault standard likewise leaves the victim in an intermediate position. This is so because, in the sample scenario, (1) the accident frequency under a free insurance market is not overwhelmingly high; (2) the injurer is financially responsible for accidents; (3) the victim has moderate risk aversion; and (4) the tort system is not grossly undercompensatory. Thus, under these circumstances, regulation that places so high a floor on precaution conditions or so low a ceiling on precaution conditions that it induces the injurer to abandon the insurance market altogether is neither a disaster nor a bonanza for the victim.

Figure 10 analyzes the relationship between victim welfare and the optimal insurance contract for one particular type of tort system. A similar analysis can be done, however, for tort systems that vary in the extent to which they compensate the accident victim. It is convenient to split this analysis into two parts, looking first at government regulation that does not induce the injurer to satisfy the fault-based standard and then looking at government insurance regulation that does induce the injurer to satisfy the fault-based standard.

1. Government Insurance Regulation That Does Not Induce the Injurer to Satisfy the Fault-Based Standard

If the injurer, after purchasing its optimal insurance contract, fails to meet the standard of care employed by the fault-based system, the position of victims depends substantially on the degree to which the tort system is compensatory and, in a sensitive fashion, on the precise extent to which the government regulates insurance contracts. If the tort system is not fully compensatory, regulation such as ceilings on permissible precaution conditions that results in increased accident frequency hurts victims. Regulation that forces the insurer to indemnify its insured even for fairly gross misconduct results in premiums so high they in-

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duce the injurer to abandon the insurance market. If the system were overly compensatory, these regulations would actually help victims. The victim's level of risk aversion does not alter the qualitative aspect of these results.

Modest floors on permissible precaution conditions, i.e., precaution conditions that do not induce the injurer to abandon the insurance market, have the opposite interaction with the generosity of the tort remedy. If the tort remedy is undercompensatory, victims prefer the lower accident rate that results from these floors. If the tort remedy is overly generous, victims dislike the lower accident rate that results. Again, the degree of generosity or stinginess of the tort remedy affects the magnitude of these effects. Victim risk aversion has little effect.

2. Government Insurance Regulation That Does Induce the Injurer to Satisfy the Fault-Based Standard

The effect of government regulation on victim welfare changes when the legal restrictions on precaution conditions have a quantum effect, that is, when they induce the injurer to take enough precautions to satisfy the fault-based system. Instead of being in a lottery in which they have a higher probability of being injured but are compensated at least somewhat for their injuries, victims now find themselves in a higher risk lottery. In the higher risk lottery created by the injurer's satisfaction of the fault system, victims have a lower probability of injury but go uncompensated in the event of injury.

The model of moral hazard employed in this Article shows that when restrictions on precaution conditions involve quantum effects, the comparative victim welfare is determined by the interplay of (1) the generosity or stinginess of the tort remedy; (2) the risk aversion of the victim; and (3) the magnitude of the induced change in accident frequency. Figure 11 summarizes the complex relationship.[77] It shows a "separating surface" lying in a three-dimensional space. The "x-axis" shows the generosity of the tort remedy measured as a proportion of perfect compensation. The "y-axis" going "into" the paper shows the risk aversion of the victim where "0" represents risk neutrality and

77. The mathematics behind Figure 11 are shown in part F of the appendix. To the author's knowledge, Figure 11 and the analysis underlying it are unique in the law and economics literature.

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higher values indicate greater levels of risk aversion. The vertical "z-axis" represents changes in accident frequency induced by moving from a legal regime that results in the injurer abandoning the insurance market to one in which insurance contracts are unregulated. A value of "2" on the z-axis, for example, means that accident frequency in an unregulated insurance market is twice as high as in a legal regime that bars liability insurance.

Points lying in front of, above, and to the left of the separating surface in Figure 11 represent combinations of tort compensation, risk aversion, and changes in induced accident frequency that would lead victims to prefer severe regulation of precaution conditions. Points lying behind, below, and to the right of the separating surface represent combinations of these factors that would lead victims to prefer the free market. When, as in the example illustrated in Figure 10, the injurer has a modest level of risk aversion, the tort system is somewhat undercompensatory, and accident frequency is a little less than three times higher under an unregulated insurance market than it is when liability insurance is prohibited, the victim actually prefers an unregulated market. The threat of an uncompensated injury caused by an induced satisfaction of the fault regime is severe enough in the victim's eyes to compensate for the deficiencies in tort compensation.

The lesson to be drawn from Figure 11 is that where the tort system sets a fairly high standard of care and where injurers are financially responsible, so long as the tort compensation system is not particularly stingy and so long as the accident rate resulting from the unregulated insurance market is not tremendously high, victims, as well as injurers, suffer from severe regulation of precaution conditions or outright bars on liability insurance. Regulation of precaution conditions sufficient to induce quantum effects makes the most sense when victims are initially risk neutral or are able to transfer risk cheaply, where tort compensation is extremely stingy, and where the free-market accident rate is extremely high.[78]

78. Since financially irresponsible injurers create effects on victims closely equivalent to unduly stingy tort remedies, one may intuit from this assertion that regulation of precaution conditions makes more sense where injurers are financially irresponsible. One might also intuit from this statement that restrictions on precaution conditions make more sense in situations where the injurer receives some nonmonetary thrill out of inflicting injury.

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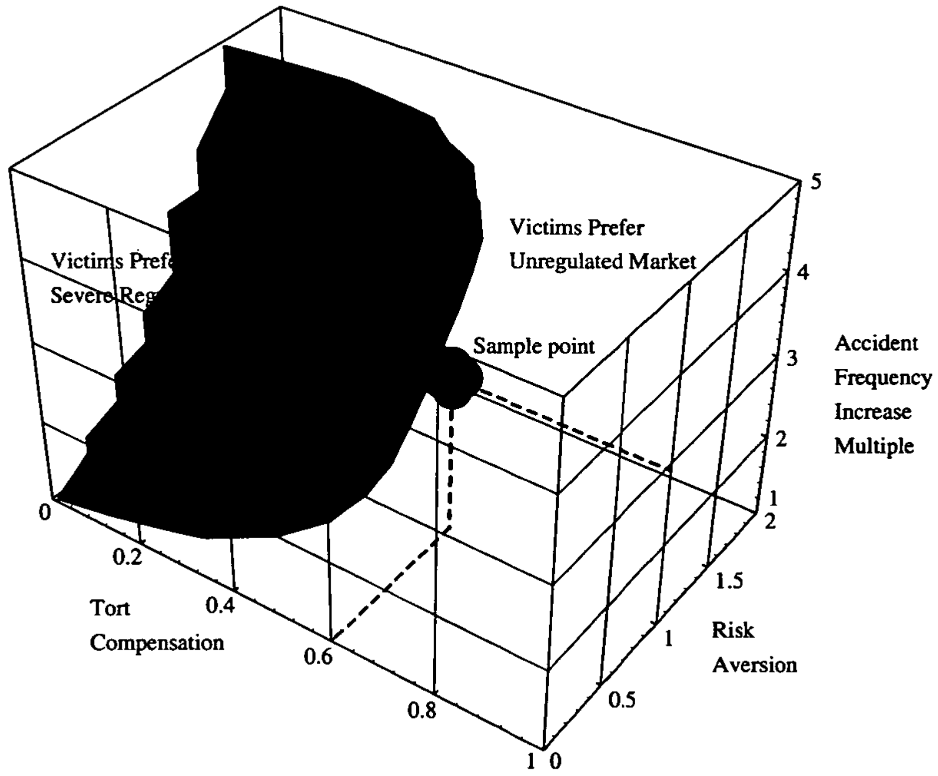
Figure 11



F. Regulation on the Pareto Frontier

Each form of government regulation concerning permissible indemnity terms and precaution conditions contained in liability insurance contracts induces the insured to purchase some liability insurance contract (including the "contract" whereby the insured obtains no indemnity). The optimal insurance contract in turn induces some optimal levels of precaution and activity that often exhibit moral hazard. These levels of precaution and activity combine to create some rate of accidents, which, depending on the tort system and the financial responsibility of the injurer, differentially affect victim welfare. Thus, each form of government regulation allocates injurer and victim welfare.

The model of moral hazard employed in this Article greatly facilitates an explicit visualization of the trade-offs created by government regulation of permissible liability insurance contracts. Figure 12 demonstrates this capability. It collapses the information contained in plots like Figures 8 and 10 into a single plot in which the injurer's utility is shown on the x-axis and victim's utility is shown on the y-axis.[79] Each point (or "utility imputation") within the shaded area on the graph corresponds to a sample insurance contract between the injurer and the insurer.[80] Thus, the absence of government intervention induces the injurer to purchase insurance contract K*(Ø). Insurance contract K*(Ø) in turn yields the injurer and victim the levels of utility corresponding to the point lying at the point marked "Unregulated Insurance Market," which is the highest level of utility for the injurer. Placing a fairly high floor on permissible precaution conditions—but not one so high that the injurer abandons the insurance market and complies with the fault standard—results in a contract that is best for the victim. The point corresponding to the utilities of injurer and victim resulting from the contract formed under this type of regulation is marked as "Best for Victim" in Figure 12. The utility imputation resulting from severe regulation that induces the injurer to purchase no liability insurance at all is marked as "Severe Regulation" in Figure 12.

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79. A formal explanation of the Pareto Frontier is found in part E of the appendix.

80. For a discussion of diagrams such as this, see KREPS, *supra* note 23, at 154-55. To the author's knowledge, this Article is unique in the law and economics literature in actually implementing the abstract notion of a Pareto Frontier that results from varying forms of government regulation.

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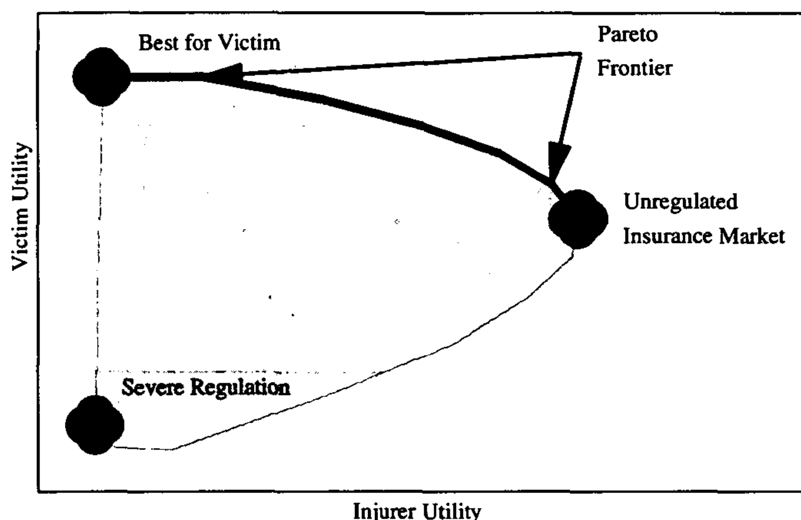
Figure 12



Also marked by a line along the northeastern portion of the shaded region in Figure 12 is something known as the "Pareto Frontier." This set of points represents the set of insurance contracts for which no alternative insurance contract exists that makes both the victim and the injurer better off. Sensible insurance regulation generally should induce formation of contracts lying on this frontier.[81] Otherwise, alternative regulations can improve the lot of both injurer and victim without injuring the insurer at all.

The concept of certainty equivalent wealth may be used to compare the contracts lying along the Pareto Frontier. That is, each level of expected utility received by the injurer from the "lottery"[82] that results from a particular insurance contract corresponds with an equivalent level of utility derived from holding an amount of wealth with 100% certainty. Similarly, each level of expected utility received by the victim

81. This Article does not consider whether there might be *combinations* of tort regimes and insurance regimes that would make both injurer and victim even better off than they are at the Pareto Frontier under the fault-based compensation system discussed here. Such an inquiry, though extraordinarily important, is considerably more complex than the issue under discussion.

82. The term "lottery" is used because each level of precaution and activity results in some possibility that an accident will not occur, leaving the injurer out the premium for insurance, and the lottery ticket and the victim in an unchanged position. There is likewise a possibility that an accident will occur, leaving (1) the injurer out the premium for the insurance and the liability for the accident reduced by any indemnity from the insurance and (2) the victim out the deficiency in any compensation realized through the tort system.

from the lottery that results from the same contract corresponds with an equivalent level of utility derived from holding some other amount of wealth with 100% certainty. By adding these two levels of wealth together, we can obtain what may be called the total certainty equivalent wealth associated with the contract. Contracts that do not maximize total certainty equivalent wealth are arguably inferior to those that do, because the biggest winner in the movement from inferior contract to maximizing contract could compensate the other party enough to make both better off.[83]

As shown in Figure 13, applying the concept of certainty equivalent wealth suggests that, given the tort regime present here and a risk-averse victim, regulation placing a modest but effective floor on permissible precaution conditions may be a good idea. The figure shows total certainty equivalent wealth as a function of permissible precaution conditions and indemnity levels. Notice that total certainty equivalent wealth is maximized at an indemnity level equal to "1" and a precaution condition just less than that which would induce quantum effects and cause the injurer to abandon the insurance market altogether. This result is driven largely by the risk aversion of the victim coupled with the inadequate compensation offered by the hypothesized tort system. To minimize the prospects of an undercompensated accident occurring, the risk-averse victim, if it could bargain with the injurer, would be willing to pay the injurer to purchase an insurance contract bearing a somewhat higher precaution condition and resulting in a correspondingly higher level of precaution. Providing the payment was high enough, the injurer would accept this deal, take somewhat greater precautions, and pay a correspondingly lower insurance premium. Both parties could be made better off. The victim would not want to bargain for too high a precaution condition, however, since this would induce the insured to abandon the insurance market and comply with the demands of the negligence regime, which would again leave the victim subject to a low but not insignificant risk of suffering an accident for which the victim goes completely uncompensated.

83. Readers familiar with the literature will recognize that I am extending the concept of Kaldor-Hicks efficiency here to situations involving risk. For good basic discussions of Kaldor-Hicks efficiency, see DAVID W. BARNES & LYNN A. STOUT, CASES AND MATERIALS ON LAW AND ECONOMICS 11-20 (1992); RICHARD A. POSNER, ECONOMIC ANALYSIS OF LAW 12-16 (4th ed. 1992); Jules L. Coleman, *Efficiency, Utility, and Wealth Maximization*, 8 HOFSTRA L. REV. 509, 509-26 (1980) (providing criticism as well).

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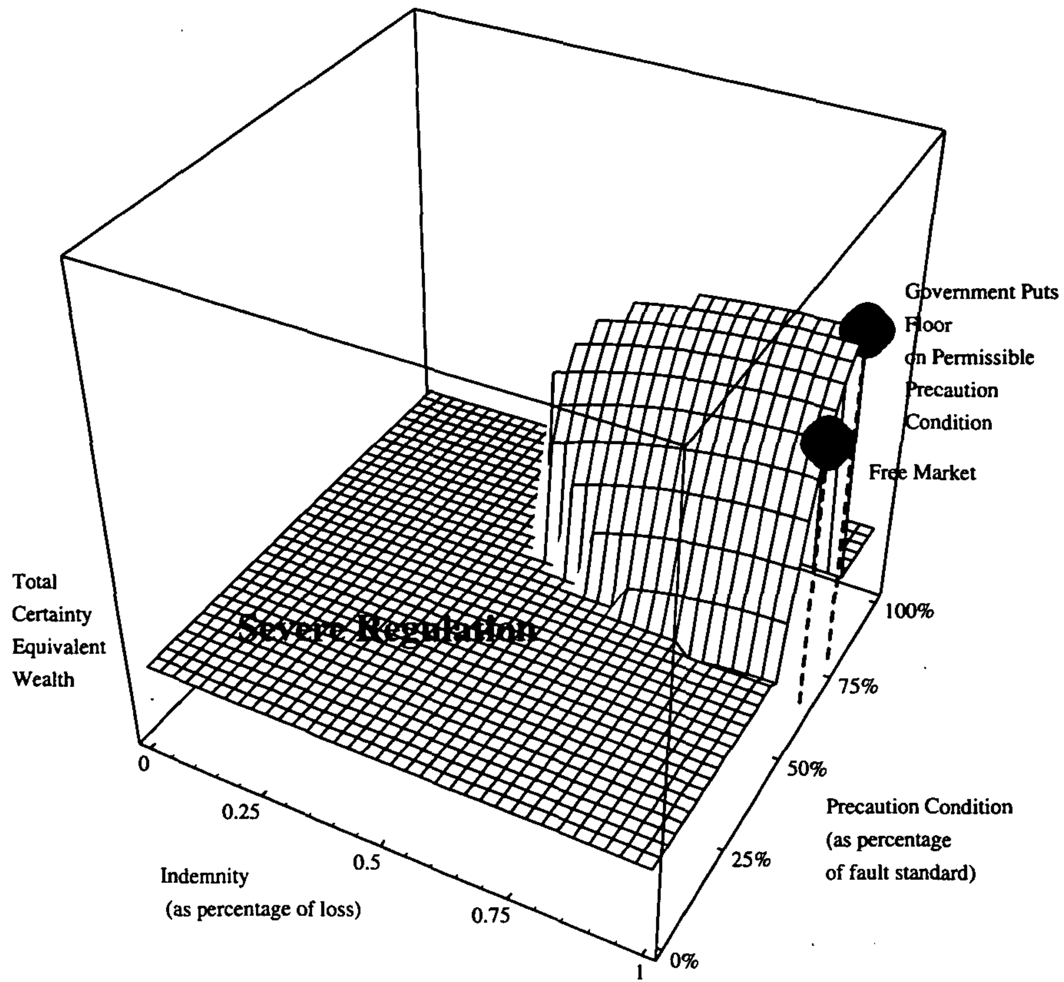
Figure 13



Before embracing insurance regulation that induces a level of precaution higher than the free-market level, it is important to note that the result would be different where the victim effectively had a low level of risk aversion, as where it was able to acquire complete insurance against the type of injuries caused by the injurer. An insurer might be willing to provide such complete insurance given that the victim is assumed in this model to be unable to alter the possibility of an accident. Under these circumstances, a victim neutral toward risk would not be able to compensate the injurer sufficiently to induce it to purchase insurance with higher than free-market precaution conditions and take correspondingly higher levels of precaution. Thus, the free market would likely create the greatest total certainty equivalent wealth.[84]

Notwithstanding these complexities, the concept of a Pareto Frontier further suggests the folly of some forms of insurance contract regulation under the assumptions given here. If the victim is significantly risk averse, the tort system is sufficiently compensatory, and the insurance market would function well enough to result in post-moral hazard precaution levels that are not excessive, regulation of the insurance market severe enough to induce its abandonment by the injurer hurts *both* the injurer and the victim. Thus, regulation barring the insurer from refusing to indemnify the injurer in the face of gross negligence or reckless behavior is foolish, because it makes both the injurer and prospective victim worse off. Similarly, under the assumptions made here about the tort system, a bar on liability insurance makes injurers and victims worse off.

IV. CONCLUSION

At one level, this Article shows how moral hazard determines the optimal form of insurance contract given a particular legal regime. While the variety of variables employed in the model used here makes generalization difficult, it is fair to recapitulate the specific conclusions of the Article as follows:

84. *Accord* POLINSKY, *supra* note 54, at 68-74.

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- Liability insurance can flourish even in perfectly accurate judicial systems.

- The existence of liability insurance coupled with the phenomenon of moral hazard will tend to decrease the level of precaution taken by injurers and will tend to increase the number of accidents.

- In an accurate judicial system, injurers will want insurers to be tough with them in conditioning their obligation to indemnify.

- Regulation of liability insurance will decrease injurer welfare and, depending on its form and the operations of the tort system, may increase or decrease victim welfare.

On a broader level, however, this Article emphasizes that the welfare of injurers and victims is determined not by the tort system or the insurance regulatory system acting alone, but by the interaction of the two. Tort law and insurance law are symbionts in a complex legal ecology. It simply makes no sense to speak positively or normatively about the effect of tort law on accident levels or victim welfare without knowing the extent to which liability insurance is able to "subvert" the goals of tort law.[85] Likewise, it simply makes no sense to speak positively or normatively about the effect of insurance law on accident levels or victim welfare without knowing whether the tort system is fully compensatory or by which standards that system imposes liability.

The symbiosis of tort law and insurance law reinforces the need for a thorough understanding of moral hazard. Moral hazard should not be seen as some sort of bizarre or evil phenomenon, but rather as a central mechanism that equilibrates insurance contracts with their tort law background. This Article has attempted to facilitate that understanding by carefully showing the injurer's process of optimization given a preexist-

85. This assertion strongly implies that the standard first-year course in "torts" taught in American law schools should either confine itself purely to doctrinal matters and pursue normative issues of "fairness," "efficiency," and "deterrence" cautiously, or should be expanded to encompass a substantial unit on basic insurance law that permits intelligent discussion of these issues. Likewise, the assertion also implies that normative discussion of "fairness" and "efficiency" in a standard insurance course cannot be coherent without a discussion of the tort law system against which insurance operates.

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ing tort law regime and a domain of permissible insurance contracts. While to be sure, the example used to illustrate the matter is simple, and while the conclusions drawn therefrom must thus be extended with great caution beyond their stated domain, the process delineated here nonetheless identifies the issues that must be considered in evaluating a system of insurance contract regulation.

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V. APPENDIX

A. *Notation*

The following notation is used throughout this appendix.[a]

1. Notation Relating to the Insurance Contract

K is the set of contracts; $\pi(k), k \in K$ is the premium associated with a given contract; $\underline{c}(k), k \in K$ is the precaution condition associated with a given contract; $\underline{n}(k), k \in K$ is the activity condition associated with a given contract; $q(k), k \in K$ is the level of indemnity associated with a given contract; $m_{\underline{c}}(k), k \in K$ is the amount of monitoring of compliance with the precaution condition; and $m_{\underline{n}}(k), k \in K$ is the amount of monitoring of compliance with the activity condition.

2. Notation Relating to the Legal Regime

Λ is the set of legal regimes; $\bar{x}(\lambda), \lambda \in \Lambda$ is the set of precaution and activity combinations that will excuse the injurer from liability; $c(\bar{x})$ is the minimum level of precaution that will excuse the injurer from liability; $t(\lambda), \lambda \in \Lambda$ represents the extent to which a legal system adequately compensates the victim, so that $t(\lambda) < 1$ represents a legal system that is undercompensatory; $\sigma_{\bar{x}}(\lambda), \lambda \in \Lambda$ represents the accuracy of the legal system in determining whether the combination of precaution and activity engaged in by the injurer satisfies $\bar{x}(\lambda)$; $\sigma_{\underline{c}}(\lambda, m_{\underline{c}})$ represents the accuracy of the legal system in determining whether the injurer has complied with the precaution condition in the contract, given the insurer's level of monitoring of compliance; $\sigma_{\underline{n}}(\lambda, m_{\underline{n}})$ represents

a. The notational system attempts, insofar as possible, to replicate that developed by Professor Shavell, *supra* note 8.

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the accuracy of the legal system in determining whether the injurer has complied with the activity condition in the contract, given the insurer's level of monitoring compliance.

3. Notation Relating to the Injurer

An injurer J with initial wealth u, and a utility of wealth function U, faces a cost of precautions ψ_c, revenue from activity ψ_n, a cost of activity function ζ, and has the ability to choose a combination x of precaution level and activity such that $c(x)$ denotes the precaution level associated with x and $n(x)$ denotes the activity level associated with x. The probability of an accident is denoted as $p(x)$. The liability of the injurer in the event of an accident is denoted as d.

4. Notation Relating to the Insurer

An insurer S faces a cost of monitoring injurer precautions $\psi_{\underline{c}}$ and a cost of monitoring injurer activities $\psi_{\underline{n}}$.

5. Notation Relating to the Victim

A victim has an initial wealth v and a utility of wealth function V. The true loss of the victim in the event of an accident is equal to ℓ, which is equal to $d/t(\lambda)$.

6. Probability Functions

The function $\eta(x,\bar{x}(\lambda),\sigma_{\bar{x}}(\lambda))$ represents the probability that a court will find the injurer liable for an accident given the combination of activity and precaution levels engaged in and the accuracy of the judicial system.

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The function $\theta\left(x,\underline{c}(k),\sigma_{\underline{c}}\left(\lambda,m_{\underline{c}}(k)\right),\underline{n}(k),\sigma_{\underline{n}}\left(\lambda,m_{\underline{n}}(k)\right)\right)$ represents the probability that a court will find a duty of the insurer to indemnify the injurer given (1) the combination of precautions and activities actually engaged in by the injurer; (2) the precaution condition in the contract; (3) the accuracy with which the court determines compliance with the precaution condition in the contract; (4) the activity condition in the contract; and (5) the accuracy with which the court determines compliance with the activity condition.

7. Expected Utility and Profit Functions

a. Expected Utility of the Injurer

The expected utility of an injurer that has purchased a contract k may be written as $EU(x,k)=\left[1-p(x)\right]U_0+$

$$p(x)\left(\begin{array}{l}\eta\left(x,\bar{x}(\lambda),\sigma_{\bar{x}}(\lambda)\right)\left(\begin{array}{l}\theta\left(x,\underline{c}(k),\sigma_{\underline{c}}\left(\lambda,m_{\underline{c}}(k)\right),\underline{n}(k),\sigma_{\underline{n}}\left(\lambda,m_{\underline{n}}(k)\right)\right)U_{q-d}+\\ \left[1-\theta\left(x,\underline{c}(k),\sigma_{\underline{c}}\left(\lambda,m_{\underline{c}}(k)\right),\underline{n}(k),\sigma_{\underline{n}}\left(\lambda,m_{\underline{n}}(k)\right)\right)\right]U_{-d}\end{array}\right)+\\ \left(1-\eta\left(x,\bar{x}(\lambda),\sigma_{\bar{x}}(\lambda)\right)\right)U_0\end{array}\right),$$

where $U_{q-d}=U\left(u+\psi_n n(x)+q(k)-\pi(k)-\zeta\left(n(x)\right)-\psi_c c(x)-d\right)$;
$U_{-d}=U\left(u+\psi_n n(x)-\pi(k)-\zeta\left(n(x)\right)-\psi_c c(x)-d\right)$; and
$U_0=U\left(u+\psi_n n(x)-\pi(k)-\zeta\left(n(x)\right)-\psi_c c(x)\right)$.

This complex expression can be understood as the sum of (1) the probability that no accident will occur, multiplied by the injurer's utility in the event of no accident; (2) the probability that if there is an accident the court will find the injurer liable, multiplied by the expected

utility of the injurer in the event the court finds it liable; and (3) the probability that if there is an accident the court will find the injurer not liable, multiplied by the expected utility of the injurer in the event the court does not find it liable. The expected utility of the injurer in the event the court finds it liable can in turn be seen as the sum of (1) the probability that a court will find coverage to exist, multiplied by the injurer's utility in the event of coverage and (2) the probability that a court will not find coverage to exist, multiplied by the injurer's utility in the event of no coverage.

b. *Expected Profit of the Insurer*

The expected profit of the insurer that has entered into a contract k may be written as $EP(x,k)=[1-p(x)]\pi_0 +$

$$p(x)\begin{pmatrix} \eta(x,\bar{x}(\lambda),\sigma_{\bar{x}}(\lambda))\begin{pmatrix}\theta(x,\underline{c}(k),\sigma_{\underline{c}}(\lambda,m_{\underline{c}}(k)),\underline{n}(k),\sigma_{\underline{n}}(\lambda,m_{\underline{n}}(k)))\pi_{q-d} + \\ [1-\theta(x,\underline{c}(k),\sigma_{\underline{c}}(\lambda,m_{\underline{c}}(k)),\underline{n}(k),\sigma_{\underline{n}}(\lambda,m_{\underline{n}}(k)))]\pi_{-d}\end{pmatrix} + \\ (1-\eta(x,\bar{x}(\lambda),\sigma_{\bar{x}}(\lambda)))\pi_0 \end{pmatrix},$$

where $\pi_0 = \mathrm{Min}(\pi(k), \mathrm{Max}(0, u+\psi_n n(x) - \zeta(n(x)) - \psi_c c(x)))$,

$$\pi_{q-d} = \mathrm{Min}(\pi(k), \mathrm{Max}(0, u+\psi_n n(x) - \zeta(n(x)) - \psi_c c(x))) - q(k) - \psi_{\underline{c}} m_{\underline{c}}(k) - \psi_{\underline{n}} m_{\underline{n}}(k); \text{ and}$$

$$\pi_{-d} = \mathrm{Min}(\pi(k), \mathrm{Max}(0, u+\psi_n n(x) - \zeta(n(x)) - \psi_c c(x))) - \psi_{\underline{c}} m_{\underline{c}}(k) - \psi_{\underline{n}} m_{\underline{n}}(k).$$

This complex expression can be understood as the sum of (1) the probability that no accident will occur, multiplied by the insurer's profit in the event of no accident; (2) the probability that if there is an accident the court will find the injurer liable, multiplied by the expected

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profit of the insurer in the event the court finds the injurer liable; and (3) the probability that if there is an accident the court will find the injurer not liable, multiplied by the expected profit of the insurer in the event the court does not find the injurer liable. The expected profit of the insurer in the event the court finds the injurer liable can in turn be seen as the sum of (1) the probability that a court will find coverage to exist, multiplied by the insurer's profit in the event of coverage and (2) the probability that a court will not find coverage to exist, multiplied by the insurer's profit in the event of no coverage.

c. Expected Utility of the Victim

The expected utility of the victim in a given legal regime may be written as $EV(x,k)=[1-p(x)]V(v)+$

$$p(x)\begin{pmatrix} \eta(x,\bar{x}(\lambda),\sigma_{\bar{x}}(\lambda))\begin{pmatrix}\theta(x,\underline{c}(k),\sigma_{\underline{c}}(\lambda,m_{\underline{c}}(k)),\underline{n}(k),\sigma_{\underline{n}}(\lambda,m_{\underline{n}}(k)))V_{q-d}+\\ [1-\theta(x,\underline{c}(k),\sigma_{\underline{c}}(\lambda,m_{\underline{c}}(k)),\underline{n}(k),\sigma_{\underline{n}}(\lambda,m_{\underline{n}}(k)))]V_{-d}\end{pmatrix}+\\ (1-\eta(x,\sigma_{\bar{x}}(\lambda)))V\left(v-\frac{d}{t(\lambda)}\right)\end{pmatrix},$$

where $V_{q-d}=V\left(v+\mathrm{Min}(d,\mathrm{u}+\mathrm{q})-\frac{d}{t(\lambda)}\right)$; and $V_{-d}=V\left(v+\mathrm{Min}(d,\mathrm{u})-\frac{d}{t(\lambda)}\right)$.

This expression can be understood as the sum of (1) the probability that no accident will occur, multiplied by the victim's utility in the event of no accident; (2) the probability that if there is an accident the court will find the injurer liable, multiplied by the expected utility of the victim in the event the court finds it liable; and (3) the probability that if there is an accident the court will find the injurer not liable,

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multiplied by the utility of the victim in the event the court does not find it liable. The expected utility of the victim in the event the court finds the injurer liable can in turn be seen as the sum of (1) the probability that a court will find coverage to exist, multiplied by the victim's utility in the event of coverage and (2) the probability that a court will not find coverage to exist, multiplied by the victim's utility in the event of no coverage. The victim's position following a finding of liability is (1) its initial position (2) plus that portion of a judgment that the injurer and, when coverage exists, its insurer must cover (3) minus the loss in the event of an injury, which is equal to the liability of the injurer divided by the degree of compensation afforded by the tort system.

B. Basic Derivation of the Optimal Insurance Contract

The optimal combination of precaution and activity, x^*,[b] for a given contract can be understood as

$$x^*(k) = \left\{ \text{x: } \underset{x \in X}{\text{argmax}} \; EU(x,k) \right\}.$$ [c]

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b. The implicit assumption that x^* is a function mapping its arguments to a single real value, as opposed to a correspondence mapping the arguments to multiple real values, is not strictly accurate, but based on the author's experience, is sufficiently accurate to be usable here. An accessible discussion of von Neumann-Morganstern utility functions may be found in BIERMAN & FERNANDEZ, *supra* note 14, at 29-34.

c. The actual process of finding the utility maximizing combination of precaution and activity can be quite difficult. Calculus, the usual method of finding a maximum, does not function well because the utility function is discontinuous and the derivative functions within the continuous pieces do not have roots that can be determined algebraically. Thus, in conducting the "experiments" discussed in this Article, a modern numeric method known as "simulated annealing" was employed. Briefly put, optimization by simulated annealing is a numerical method developed in the late 1980s for determining with great confidence the global extrema of a function. *See generally* Michael Wofsey, *Technology: Shortcut Tests Validity of Complicated Formulas*, WALL ST. J., Sept. 24, 1993, at B1. The method is particularly useful for functions that have numerous local extrema or whose local extrema cannot be determined using analytic techniques. *See generally* William L. Goffe et al., *Global*

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Given this function, we can define a set of offers $\underline{k}$ that represent the offers that minimize the insurer's surplus from the transaction.

$$\underline{k} = \left\{ k\text{: } \underset{\{k:EP(x,k)\geq 0\}}{\operatorname{argmin}} EP\left(k, x^*(k)\right) \right\}.$$

The injurer's objective is to find the offer(s) $\underline{k}^*$ that minimizes the insurer's surplus from the transaction and that maximizes its own utility.

$$\underline{k}^* = \left\{ \underline{k}\text{: } \underset{\underline{k}}{\operatorname{argmax}}\, \mathrm{v}[\underline{k}] \right\}, \text{ where } \mathrm{v}[\underline{k}] = EU\left(\underline{k}, x^*(\underline{k})\right).$$ [d]

Optimization of Statistical Functions with Simulated Annealing, 60 J. ECONOMETRICS 65 (1994) (discussing technique and providing refined algorithm); William L. Goffe et al., *Simulated Annealing: An Initial Application in Econometrics*, 5 COMPUTER SCIENCE IN ECONOMICS AND MANAGEMENT 133 (1992) (discussing algorithm); Lester Ingber, *Adaptive Simulated Annealing* (ASA), [ftp.alumni.caltech.edu: /pub/ingber/ASA-shar, ASA-shar.Z, ASA.tar.Z, ASA.tar.gz, ASA.zip], Lester Ingber Research, McLean, VA (1993); Lester Ingber, *Very Fast Simulated Re-Annealing*, 12 MATHL. COMPUT. MODELLING 967 (1989).

d. In some sense, this methodology transforms a "direct" von Neumann-Morganstern utility function into a more tractable and informative "indirect" utility function. A direct utility function is one like $EU(k,x)$ that accurately represents the injurer's preferences for various choices as to precaution and activity in the face of a specified legal regime, its own characteristics, characteristics of the insurer, and an insurance contract. An indirect utility function is one like $\mathrm{v}(\underline{k})$ that represents the insured's preferences between insurance contracts given a specified legal regime, its own characteristics, and the insurer's characteristics, and assumes that the injurer will always choose the optimal levels of precaution thereunder. *See generally* KREPS, *supra* note 23, at 18-46 (discussing relationship between preferences and utility functions as well as transformation of traditional direct utility functions into indirect utility functions).

Because the indirect expected utility function is discontinuous and because the roots of its derivatives cannot be determined algebraically, simulated annealing was used to determine the global optimum of the tortfeasor's utility function. A penalty function was employed to prevent the insured from purchasing insurance that yielded a negative profit to the insurer. Thus, the findings in this Article are the results of "nested simulated annealing" in which simulated annealing is used to determine some of the arguments to a function which is then in turn optimized using simulated annealing. To the author's knowledge, this Article is unique in the legal literature in

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C. The Effect of Government Regulation

We now derive the optimal contract under circumstances where a government regulation constrains the set of contracts that are lawful for the injurer and insurer to form. Let G represent the set of government restrictions on contracts between insurer and injurer. The optimal contract $\underline{k}^*(G)$ may be written as

$$\underline{k}^*(G) = \left\{ \underline{k} \colon \underset{\underline{k} \in K-G}{\operatorname{argmax}} \, \nu[\underline{k}] \right\}.$$

D. Victim Welfare

Expected victim welfare given government regulation of G may be expressed as

$$EV(G) = EV\left(x^*\left(\underline{k}^*(G)\right), \underline{k}^*(G)\right).$$

E. Injurer Welfare, Victim Welfare and the Pareto Frontier

The set of Pareto Optimal government regulations of the insurance market for a given legal regime may be defined as

$$G^* = \left\{ \begin{array}{l} G \colon \left\{ EU(G) \geq EU(G'), \forall\, G' = \left\{ G \colon EV(G) = EV(G') \right\} \right\} \cap \\ \left\{ EV(G) \geq EV(G''), \forall G'' = \left\{ G \colon EU(G) = EU(G'') \right\} \right\} \end{array} \right\}.$$

its use of simulated annealing and unique in scholarly literature in its use of nested simulated annealing.

Thus, the Pareto Frontier may be defined as

$$\{EU(G^*), EV(G^*)\}, \forall G^*.$$

F. Victim Preference for Severe Regulation

The separating surface shown in Figure 11 may be defined as the set of $t(\Lambda)$, ratios of accident probabilities $\delta = \frac{p(x^*(\underline{k}^*(\varnothing)))}{p(x^*(\underline{k}^*(G_{severe})))}$ and constant levels of victim risk aversion $\beta = -\frac{V''}{V'}$, that satisfy the following equation

$$EV(x^*(\underline{k}^*(\varnothing)), \underline{k}^*(\varnothing)) = EV(x^*(\underline{k}^*(G_{severe})), \underline{k}^*(G_{severe})).$$

Some mathematical sophistication or substitution of some numbers into the formula shows that points to the left, above and in front of the separating surface represent combinations of these parameters where the victim would prefer regulation creating quantum effects, whereas points to the right, below and behind the separating surfaces represent combinations of these parameters where the victim would prefer the free market.

PLEADING THE POLICY LIMIT AS A SPECIAL DEFENSE: AN ATTEMPT TO CLARIFY CONNECTICUT UNINSURED MOTORIST COVERAGE

*Kara A. Murphy**

I. INTRODUCTION

Connecticut courts have decided more cases in the area of uninsured and underinsured motorist coverage disputes than in all other areas of insurance coverage combined.[1] In an attempt to further clarify what is and is not permitted under the uninsured and underinsured motorist statute, the Supreme Court of Connecticut may have inadvertently created more confusion with its decision in *Bennett v. Automobile Insurance Co. of Hartford*.[2]

The conflict presented in *Bennett* is between the statutory limit of liability of insurers under section 38a-336(b) of the General Statutes of Connecticut and the right to remittitur when a jury verdict exceeds the policy limit. Must the insurance company plead the policy limit as a special defense in order to preserve its right to remittitur after the jury awards its verdict? The Supreme Court of Connecticut held that, given the particular facts of the case, the Automobile Insurance Company of Hartford did not have to plead the policy limit as a special defense. From now on, however, insurance companies will have to plead the policy limit as a special defense in order to preserve the right to remittitur. Thus, taking the analysis one step further, an insurance company failing to plead the policy limit as a special defense will waive its right to remittitur and will be forced to pay an award above the policy limit

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1. JON BERK & MICHAEL C. JAINCHILL, CONNECTICUT LAW OF UNINSURED AND UNDERINSURED MOTORIST COVERAGE v (1993 & Supp. 1993-1994).

2. 230 Conn. 795, 646 A.2d 806 (1994).

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despite the language of section 38a-336(b). This creates the "anomalous situation" in which a person may recover more from his own insurance company than he would have recovered from the tortfeasor's insurance company (had the tortfeasor been adequately insured), the exact inequity section 38a-336(b) was intended to prevent.

Part II of this Note will address the history, decision and theories behind the *Bennett* case. Part III will discuss the use of special defenses in Connecticut and whether pleading the policy limit is a proper use of a special defense. Part IV will examine Connecticut's uninsured motorist statute (section 38a-336) and the policies behind it. Part V will discuss General Statutes section 52-216a, which prohibits juries from hearing certain types of evidence and permits remittitur. Section 52-216a is relevant because the *Bennett* opinion raises a few questions about what types of evidence may be presented to the jury. In part VI, other jurisdictions that have addressed this issue will be discussed. Finally, part VII will propose other possible solutions to this problem.

II. *BENNETT V. AUTOMOBILE INSURANCE CO. OF HARTFORD*

A. *Facts and History of the Case*

On June 24, 1989, Lori Misura and her passenger, John Bennett, were driving southbound through the green light on Dwight Street in New Haven, at the intersection of George Street. Misura's car was broadsided on the passenger's side by an unknown driver travelling east on George Street. Misura's uninsured motorist policy included coverage for hit-and-run drivers.[3]

The uninsured motorist provision carried a policy limit of $100,000 per accident, regardless of the number of persons injured or claims made.[4] Misura's original complaint explicitly mentioned the policy limit. In a motion in limine, the defendant argued that policy limits were irrelevant to any issue in the case. The defendant objected to the men-

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3. Bennett v. Automobile Ins. Co. of Hartford, 32 Conn. App. 617, 618, 630 A.2d 149, 150 (1993), *rev'd*, 230 Conn. 795, 646 A.2d 806 (1994); *Bennett*, 230 Conn. at 797, 646 A.2d at 807. *See generally* Appellate Court Records and Briefs, *Bennett*, 32 Conn. App. 617 (1993) (No. AC 11636) (Affidavit of Lori Misura, 1-17-91), *rev'd*, 230 Conn. 795 (1994).

4. *Bennett*, 32 Conn. App. at 618, 630 A.2d at 150; *Bennett*, 230 Conn. at 797, 646 A.2d at 807. *See generally* Appellate Court Records, *supra* note 3 (Declarations Page, Appendix of Defendant-Appellee).

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tion of the policy limit in the complaint, stating that the policy limit should be removed to avoid prejudicing the jury with the knowledge of the limitation of liability.[5] Misura removed any mention of the policy limit from the complaint.[6]

Bennett subsequently settled with the defendant for $37,115.00.[7] Misura's case, however, went to trial, resulting in a verdict for the plaintiff in the amount of $92,000. The jury had no knowledge of the $100,000 policy limit or the prior settlement with Bennett.[8]

Three weeks later, the defendant filed a motion to open judgment and for remittitur.[9] The defendant claimed that there was an error at

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5. Liability had been admitted; the only issue was damages. Misura's original complaint acknowledged that the uninsured motorist coverage was "up to a policy limit of $100,000 per accident." *Bennett*, 32 Conn. App. at 618-19, 630 A.2d at 150; *Bennett*, 230 Conn. at 798, 646 A.2d at 808. *See generally* Appellate Court Records, *supra* note 3 (Appendix of Defendant-Appellee, Plaintiff's Complaint dated 6-5-90; Motion in Limine dated 4-30-92; Second Amended Complaint dated 4-30-92).

6. *Bennett*, 32 Conn. App. at 618, 630 A.2d at 150; *Bennett*, 230 Conn. at 798, 646 A.2d at 808.

7. *Id.*

8. *Id.*

9. The motion was made pursuant to Connecticut Practice Book §§ 325 and 326 and General Statutes § 52-228.

Practice Book § 325 provides:

> REMITTITUR WHERE JUDGMENT TOO LARGE. If any judgment is rendered, by mistake or clerical error, for a larger sum than is due, the excess may be remitted by the party recovering the judgment, at any time, reasonable notice being first given to the adverse party or his attorney; and the court may thereupon order the record or such judgment to be corrected, and affirm the same for the amount to which it has been remitted.

CONN. PRAC. BOOK § 325 (1995).

Practice Book § 326 provides in part:

> SETTING ASIDE OR OPENING JUDGMENTS. Unless otherwise provided by law and except in such cases in which the court has continuing jurisdiction, any civil judgment or decree rendered in the superior court may not be opened or set aside unless a motion to open or set aside is filed within four months succeeding the date on which it was rendered or passed.

CONN. PRAC. BOOK § 326 (1995).

Section 52-228 provides:

> If any judgment is rendered, by mistake or clerical error, for a larger sum than is due, the party recovering the judgment may have the amount of the judgment decreased by remittitur to the amount which is due, provided reasonable notice has been given to the adverse party or his attorney. The court may thereupon order the record of judgment to be corrected, and affirm the judgment for the amount to which it has been decreased.

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the time the judgment had been rendered in that the defendant was entitled to an evidentiary hearing on collateral source payments, which never occurred. In addition, the defendant argued that, in light of General Statutes section 38a-336(b), it was not required to pay more than the policy limit of $100,000. Since the insurance company was to pay Bennett $37,115.00, and had already paid Misura $1,483.89 in no-fault benefits, only $61,401.11 of coverage remained on the policy.[10] The judge agreed with the insurance company and granted a remittitur thereby reducing Misura's award to $61,401.11.[11]

B. The Appellate Court Decision

The Connecticut Appellate Court reversed the trial court and held that remittitur was improper in this case. Judge Landau agreed with the plaintiff that since no mention of the $100,000 policy limit was included in the complaint and the defendant failed to plead the policy limit as a special defense, the defendant was precluded from later complaining that the verdict was in excess of the policy limit.[12]

In Connecticut, the complaint has several purposes. It puts the defendant on notice of all claims against him, limits the issues to be decided at trial, and prevents surprise. The amended complaint acts as a withdrawal of the original complaint and is controlling at trial. The original complaint becomes part of the history of the case. The plaintiff in *Bennett* was not constrained by the original complaint. The issues before the jury, therefore, did not include the $100,000 policy limit, nor was the damage award limited to that amount.[13]

The appellate court concluded that the insurance company's failure to plead the policy limit as a special defense precluded it from claiming

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CONN. GEN. STAT. § 52-228 (1995).

10. There was a question as to whether the insurance company had actually paid Bennett his settlement money. *Bennett*, 32 Conn. App. at 618-19, 630 A.2d at 150; *Bennett*, 230 Conn. at 798-800 & n.11, 646 A.2d at 808-09. *See generally* Appellate Court Records, *supra* note 3 (Motion to Open Judgment and for Remittitur 5-27-92; Appendix to Plaintiff-Appellant's Brief, Defendant's Memorandum in Support of Motion to Open Judgment and for Remittitur, 5-27-92; Defendant-Appellee's Brief pp. 15-16).

11. Misura was awarded $61,401.11 plus interest in the amount of $14,797.67. *Bennett*, 32 Conn. App. at 619, 630 A.2d at 150; *Bennett*, 230 Conn. at 799-800, 646 A.2d at 809.

12. *Bennett*, 32 Conn. App. at 619-20, 630 A.2d at 150-51.

13. *Id.* at 620, 630 A.2d at 151.

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the benefit of the policy limit after trial. Connecticut Practice Book section 164 provides a list of defenses that must be specially pleaded. This list is not exhaustive, however.[14] In insurance litigation, certain defenses, such as exceptions or exclusions in the policy and breaches of condition, must also be specially alleged.[15] The complaint alleged that the defendant's insurance policy entitled Misura to "any sums" she was legally entitled to recover, not any sums up to the $100,000 policy limit. Therefore, according to Judge Landau, the failure of the defendant to specially plead the policy limit precluded the defendant from using the limit to reduce the verdict after it was rendered.[16]

The court rejected the defendant's argument that the trial court properly reduced the damage award to coincide with the settlement with Bennett, and that General Statutes section 38a-336(b) automatically limits the recovery to the policy limit. The payment to Bennett was a question of fact that should have remained in the province of the jury.[17] According to the court, because the defendant failed to raise the payment to Bennett as a special defense, the defendant thereby waived the payment as a defense.[18] In light of these facts, the court held that remittitur was improperly granted and that the trial court should reinstate the full verdict subject to collateral source payments made to or for Lori Misura.[19]

Judge Lavery dissented, reasoning that in uninsured motorist actions an insurer's liability is statutorily limited to the policy limit by General Statutes section 38a-336(b).[20] The purpose of the uninsured motorist statute, according to Judge Lavery, is to compensate an insured to the extent that the insured would have been compensated had the tortfeasor carried liability insurance.[21] The reason that the recovery is limited to the policy limit is to prevent the injured party from being better off by being hit by an uninsured driver than by one who is insured at the statutory minimum.[22]

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14. *Id.* at 621, 630 A.2d at 151.

15. *Id.*

16. *Id.* at 622, 630 A.2d at 152.

17. There was a question as to whether the insurance company had actually paid Bennett his settlement money. *Id.* at 623, 630 A.2d at 152.

18. *Id.* at 623-24, 630 A.2d at 152-53.

19. *Id.* at 624-25, 630 A.2d at 153.

20. *Id.* at 625, 630 A.2d at 153.

21. *Id.*

22. *Id.*

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Although the plaintiff contended that the defendant waived protection of the policy limit by not pleading it as a special defense, the amount of coverage was undisputed and the plaintiff pleaded the policy limit in the first complaint. The contract limit did not prove or disprove the amount of the plaintiff's damages and, as such, was irrelevant to the jury's consideration of damages. According to Judge Lavery, the majority decision re-creates the anomaly the statute was designed to prevent. By requiring a special defense, if the insurer fails to plead the policy limit, the insured could recover more than he or she contracted for in the insurance policy.[23]

C. The State Supreme Court Decision

The Supreme Court of Connecticut reversed the appellate court decision.[24] The court began its analysis with General Statutes section 38a-336(b).[25] The uninsured motorist statute reflects the public policy that an injured party should have access to insurance coverage even

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23. *Id.* at 626-27, 630 A.2d at 154.

24. *Bennett*, 230 Conn. at 800, 646 A.2d at 809.

> The issues on appeal were:
>
> 1. Whether the Appellate Court was correct in holding that General Statutes § 38a-336 does not limit the amount of the plaintiff's recovery to the amount of the limits of liability in the insurance policy less the amount paid by the defendant in settlement to a co-plaintiff? 2. Whether the Appellate Court was correct in holding that an insurer, in order to take advantage of a limitation of liability to an insurance policy, must plead the policy limits as a special defense where there is no reference to the policy limits in the complaint? 3. Whether the Appellate Court was correct in holding that in an uninsured motorist action in which there are two plaintiffs seeking recovery under a single policy and one plaintiff settles his claim before trial, the defendant must plead the payment of the settled claim as a special defense?

Bennett, 230 Conn. at 796-97 n.2, 646 A.2d at 807.

25. Section 38a-336(b) provides:

> An insurance company shall be obligated to make payment to its insured up to the limits of the policy's uninsured motorist coverage after the limits of liability under all bodily injury liability bonds or insurance policies applicable at the time of the accident have been exhausted by payment of judgments or settlements, but in no event shall the total amount of recovery from all policies, including any amount recovered under the insured's uninsured motorist coverage, exceed the limits of the insured's uninsured motorist coverage.

CONN. GEN. STAT. § 38a-336(b) (1995).

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though the uninsured motorist does not have insurance to compensate for the injury. Subsection (b) has an additional goal. It limits recovery to the policy limit of the insured in order to avoid the anomalous situation where an injured party can recover more from his or her own insurance company than from the tortfeasor's insurance had the tortfeasor been adequately insured.[26]

The court rejected Misura's claim that although her policy limited recovery to $100,000, the insurance company could not seek shelter under section 38a-336(b) without pleading the policy limit as a special defense.[27] Facts that must be pleaded as a special defense are those that may be consistent with the pleadings but show that the plaintiff has no cause of action.[28] The purpose of a special defense, like the other pleadings, is to notify the court and other parties of what issues will be tried.[29] Which facts must be specially pleaded depends on the nature of those facts relative to the issues in the case.[30]

The court reasoned that the defendant's failure to specially plead the policy limit did not deprive it of the benefits of the policy provision or of section 38a-336(b). The plaintiff already knew about and acknowledged the fact that the $100,000 policy limit existed. In addi-

26. *Bennett*, 230 Conn. at 800-01, 646 A.2d at 809.

27. *Id.* at 801-02, 646 A.2d at 809.

Practice Book § 164 provides:

> THE ANSWER—DENIALS; SPECIAL DEFENSES. No facts may be proved under either a general or special denial except such as show that the plaintiff's statements of fact are untrue. Facts which are consistent with such statements but show, notwithstanding, that he has no cause of action, must be specially alleged. Thus, accord and satisfaction, arbitration and award, coverture, duress, fraud, illegality not apparent on the face of the pleadings, infancy, that the defendant was non compos mentis, payment (even though nonpayment is alleged by the plaintiff), release, the statute of limitations and res adjudicata must be specially pleaded, while advantage may be taken, under a simple denial, of such matters as the statute of frauds, or title in a third person to what the plaintiff sues upon or alleges to be his own.

CONN. PRAC. BOOK § 164 (1995).

28. *Bennett*, 230 Conn. at 802, 646 A.2d at 809.

29. *Id.*

30. *Id.*

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tion, throughout the court proceedings, the defendant made it clear that it would seek remittitur if the jury verdict exceeded the policy limit.[31]

> Thus, because there was no dispute that the plaintiffs' recovery was limited by the express and unambiguous terms of the policy and Misura was on notice that the defendant intended to seek a reduction, by posttrial motion, of any verdict in excess of the policy limit, the trial court properly reduced the award notwithstanding the defendant's failure to plead the $100,000 limitation as a defense.[32]

The fact that the defendant failed to plead its settlement with Bennett as a special defense did not preclude it from seeking remittitur. General Statutes section 52-216a prohibits the release of settlement agreements to the jury because of the potential for prejudice.[33] Since Bennett's settlement was not an issue in the case, it did not have to be specially pleaded and was properly withheld from the jury.[34]

The court concluded that, given the facts of this case, it was unnecessary for the defendant to plead the policy limit as a special defense. The court added, however, that in the interests of justice, all insurance companies should, in the future, plead the policy limit as a special defense even when undisputed.[35] If the facts raised by the special defense do not need to be resolved by the jury, the special defense will

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31. *Id.* at 802-03, 646 A.2d at 810.
32. *Id.* at 803, 646 A.2d at 810.
33. *Id.* at 804, 646 A.2d at 811.

Section 52-216a provides:

> READING OF AGREEMENTS OR RELEASES TO JURY PROHIBITED. ADJUSTMENTS FOR EXCESSIVE AND INADEQUATE VERDICTS PERMITTED. An agreement with any tortfeasor not to bring legal action or a release of a tortfeasor in any cause of action shall not be read to a jury or in any other way introduced in evidence by either party at any time during the trial of the cause of action against any other joint tortfeasors, nor shall any other agreement not to sue or release of claim among any plaintiffs or defendants in the action be read or in any other way introduced to a jury. If the court at the conclusion of the trial concludes that the verdict is excessive as a matter of law, it shall order a remittitur and, upon failure of the party so ordered to remit the amount ordered by the court, it shall set aside the verdict and order a new trial. . . . This section shall not prohibit the introduction of such agreement or release in a trial to the court.

CONN. GEN. STAT. § 52-216a (1995).

34. *Bennett*, 230 Conn. at 804-05, 646 A.2d at 811.
35. *Id.* at 806, 646 A.2d at 812.

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not be given to the jury, but instead will be addressed by the court before rendering judgment.[36] This procedure, according to the court, will place the court and all parties on notice of the policy limit so that it can be resolved in light of section 38a-336(b).[37]

The final portion of the court's opinion raises a few troubling issues. The use of a policy limit as a special defense not only appears to be improper but also is troubling in its potential effect on uninsured motorist causes of action. If the insurance company fails to plead the policy limit as a special defense, it is unclear whether the insurance company will have waived its right to remittitur. If the right to remittitur is thereby waived, the insurance company may be liable for more than the policy limit despite the language of section 38a-336(b). Furthermore, if a policy limit must be pleaded as a special defense, settlements with co-plaintiffs and claims of set-off may also have to be specially pleaded. Additionally, in cases where the policy limit is at issue, the question is open as to whether the amount of the policy limit will then become a question of fact for the jury despite its prejudicial quality.

III. Special Defenses

The purpose of pleading is to notify the court and opposing counsel of the issues to be tried. In addition, a special defense prevents concealment and surprise by raising basic issues before trial.[38] The rule in *Bennett* is that the policy limit should be pleaded as a special defense even when undisputed. However, this appears to be an improper use of a special defense.

Connecticut Practice Book section 164 provides:

> THE ANSWER—DENIALS; SPECIAL DEFENSES. No facts may be proved under either a general or special denial except such as show that the plaintiff's statements of fact are untrue. Facts which are consistent with such statements but show, notwithstanding, that he has no cause of action, must be specially alleged. Thus, accord and satisfaction, arbitration and award,

36. *Id.*

37. *Id.*

38. DuBose v. Carabetta, 161 Conn. 254, 260-61, 287 A.2d 357, 360 (1971); Biller v. Harris, 147 Conn. 351, 357, 161 A.2d 187, 190 (1960); Farrell v. St. Vincent's Hosp., 203 Conn. 554, 557, 525 A.2d 954, 957 (1987).

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> coverture, duress, fraud, illegality not apparent on the face of the pleadings, infancy, that the defendant was non compos mentis, payment (even though nonpayment is alleged by the plaintiff), release, the statute of limitations and res adjudicata must be specially pleaded, while advantage may be taken, under a simple denial, of such matters as the statute of frauds, or title in a third person to what the plaintiff sues upon or alleges to be his own.

The list of the types of special defenses is not exhaustive.[39] What must be pleaded as a special defense depends on the facts relative to the issues in the case.[40] Consequently, through case law, the list of special defenses continues to grow.[41]

According to Professor Edward Stephenson in *Connecticut Civil Procedure*, general and special denials restrict evidence to issues relevant to the allegations in the complaint. However, what exactly must be generally denied or specially pleaded is difficult to distinguish.[42] In general, however, there are two categories of special defenses—matters of discharge and matters of justification or excuse.[43]

Matters of discharge are those facts that have occurred since the complaint and thereby destroy the cause of action.[44] For example, accord and satisfaction, payment, release, statute of limitations and res judicata are matters of discharge. Matters of discharge should be pleaded by the defendant because to require otherwise places an undue burden on the plaintiff. Although the plaintiff should be required to show that at one time he or she did have a cause of action, it would be burdensome to require the plaintiff to negate subsequent events which could destroy the cause of action. The plaintiff in such a situation would be required to plead all of the defendant's possible defenses. The

39. *Bennett*, 32 Conn. App. at 621, 630 A.2d at 151; *DuBose*, 161 Conn. at 260, 287 A.2d at 360.

40. *Bennett*, 230 Conn. at 802, 646 A.2d at 809.

41. In insurance litigation, breaches of condition and exceptions or exclusions in coverage must be specially pleaded. *See, e.g.*, Fogarty v. Fidelity & Casualty Co., 120 Conn. 296, 180 A. 458 (1935); Harty v. Eagle Indem. Co., 108 Conn. 563, 143 A. 847 (1928); Sortito v. Prudential Ins. Co., 108 Conn. 163, 142 A. 808 (1928).

42. 1 EDWARD STEPHENSON, CONNECTICUT CIVIL PROCEDURE § 127, at 518-19 (2d ed. Supp. 1982).

43. *Id.* at 519.

44. *Id.*

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burden of pleading subsequent events which destroy the cause of action is therefore properly on the defendant.[45]

"Matters of justification or excuse on the other hand are based on facts contemporaneous with or prior to the facts alleged in the complaint and operate to show that, if everything is considered, the plaintiff never had a cause of action."[46] With matters of justification or excuse, no particular principle exists as to whether a matter is "a condition precedent to liability (and therefore to be pleaded and proved by the plaintiff) or as a condition subsequent to liability (to be pleaded and proved by the defendant)."[47] Stephenson explains liability under the substantive law in the following manner. "D is liable to P if a, b and c are true unless d, e or f is also true. The 'if' factors are part of the plaintiff's case; the 'unless' factors are part of the defendant's case."[48] The law distributes the burden between the parties by assessing which party is more likely to have access to proof and by assessing the difficulty of negating rather than affirming the facts.[49]

In the context of insurance litigation, exclusions or exceptions to coverage, breaches of condition, and limitations on coverage all must be specially pleaded. The Supreme Court of Connecticut addressed how an insurance company should plead a breach of condition such as insurability in *Sortito v. Prudential Insurance Co.*[50] A question arose as to when plaintiff's decedent was inflicted with tuberculosis. If the condition existed before the policy was issued, the decedent was not in "sound health" as the policy required and the insurance company would not have to pay the proceeds.[51] The plaintiff alleged in the complaint that all the conditions of insurability had been met. The defendant insurance company responded by specially pleading a breach of the "sound health" condition. The court agreed that when an insurance company intends to deny that a condition precedent to insurability has been satisfied, it should do so by using a special defense.[52] Professors Tait and LaPlante also agree with the use of a special defense to controvert compliance with conditions precedent. "As a matter of pleading,

45. *Id.* at 519-20.
46. *Id.* at 519.
47. *Id.* at 521.
48. *Id.*
49. *Id.*
50. 108 Conn. 163, 142 A. 808 (1928).
51. *Id.* at 165-66, 142 A. at 809.
52. *Id.* at 167-68, 142 A. at 810.

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one suing on an insurance policy may allege in general terms that he has complied with all conditions precedent of the policy and the insurer must then specifically deny compliance with those conditions it wishes to contest."[53]

The issue of exclusions or exceptions to coverage was addressed by the court in *Fogarty v. Fidelity & Casualty Co.*[54] The defendant insurance company issued the plaintiff an insurance policy insuring him "against loss on account of damages to, or loss of"[55] his truck "including operating equipment while attached thereto, if caused by collision with any object or by upset (excluding damage by fire, tire damage unless other damage is coincident, and any loss or damage caused directly or indirectly by any accident excluded under the policy as a cause of bodily injury or death)."[56] A question of coverage arose because of a fire that broke out in the cab of the truck and ultimately led to the crash of the truck. The defendant did not specially plead the fire as an exclusion to coverage. However, the court stated that

> [i]f the defendant intended to claim that the loss was within the provision excluding damage by fire, it should have specially pleaded to that effect . . . it did not do so and, a claim having been made to the trial court that thereby it was precluded from taking advantage of the limitation contained in the clause, the effect of the clause may be eliminated from our consideration.[57]

Releases and limitations of liability are also properly a special defense. A release of liability is clearly subject to a special defense because if there is no liability, there is no cause of action.[58] The appel-

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53. COLIN C. TAIT & JOSEPH A. LAPLANTE, TAIT AND LAPLANTE'S HANDBOOK OF CONNECTICUT EVIDENCE 80 (2d ed. 1988 & Supp. 1994); *see also* Pawlinski v. Allstate Ins. Co., 165 Conn. 1, 8, 327 A.2d 583, 587 (1973).

In addition, when an insurance company pleads the failure to fulfill a condition precedent, the burden of proof remains on the plaintiff to prove that the conditions precedent have been complied with. Harty v. Eagle Indem. Co., 108 Conn. 563, 565, 143 A. 847, 848 (1928).

54. 120 Conn. 296, 180 A. 458 (1935).

55. *Id.* at 298, 180 A. at 458.

56. *Id.*

57. *Id.* at 299-300, 180 A. at 459 (citations omitted).

58. King v. Malone, 91 Conn. 342, 345, 99 A. 691, 693 (1917); New England Sav. Bank v. FTN Properties L.P., 32 Conn. App. 143, 146, 628 A.2d 30, 32 (1993).

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late court has held that "a limitation of liability, whether contractual or statutory, is, in substance and effect, a partial release of liability and, as such, is properly the subject of a special defense."[59] In *New England Savings Bank v. FTN Properties L.P.*,[60] the court cited two cases to support its position. *Ryszkiewicz v. New Britain*[61] involved a local charter provision which limited the city's liability for a slip and fall to $1000.[62] The defendant pleaded the charter provision as a special defense. The state supreme court did not address the propriety of pleading the statute as a special defense but instead decided the case on other grounds.[63] The subject of the special defense in *Nothnagle v. New York, New Haven & Hartford Railroad*[64] was a tariff schedule filed with the Interstate Commerce Commission which limited liability for lost baggage to twenty-five dollars. The defendant pleaded the limitation as a special defense, but once again the state supreme court did not address the special defense issue.[65]

While the insurance policy in *Bennett* appears to fall within the rule of *Ryszkiewicz* and *Nothnagle* because the policy limit is a limitation of liability, it can be distinguished on several grounds. One distinguishing feature is notice. The plaintiff in *Ryszkiewicz* had no notice of the statutory limit of liability until after her injury. Similarly, in *Nothnagle*, the plaintiff did not receive notice of the limitation until after the loss occurred. In the insurance context, however, the insured contracts for

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Appleman also states that limitations in the amount of liability should be specially pleaded. "An insurer, seeking to reduce or limit the amount of its liability, must plead and prove the policy provisions or particular circumstances upon which such limitation is based, including a contention that no demand has been made. Thus such a defense must fail in the absence of evidence supporting it." JOHN APPLEMAN & JEAN APPLEMAN, 20B INSURANCE LAW & PRACTICE § 11996 (West 1982 & Supp. 1994). The cases Appleman cites to support this proposition are similar to cases cited in Connecticut where the limit of liability is an exclusion or exception to the policy or it involves a condition precedent. Appleman does not cite any cases similar to Connecticut that state that a policy limit special defense is necessary to maintain a statutory right to the limit.

59. *New England Sav. Bank*, 32 Conn. App. at 146, 628 A.2d at 32.

60. 32 Conn. App. 143, 628 A.2d 30 (1993).

61. 193 Conn. 589, 479 A.2d 793 (1984).

62. The limitation of liability is part of the New Britain city charter as amended by the General Assembly in 30 Spec. Acts. 404, No. 420 § 2709 (1961). *Id.* at 591, 479 A.2d at 795.

63. *Id.* at 591, 479 A.2d at 795.

64. 139 Conn. 278, 93 A.2d 165, *aff'd*, 346 U.S. 128 (1953).

65. *Id.* at 279-80, 93 A.2d at 165-66.

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the specific amount of coverage and that amount is prominently displayed on the declarations page of the policy. In addition, the plaintiff in *Bennett* pleaded the $100,000 policy limit in her first complaint. Thus, the plaintiff clearly had notice of the $100,000 limitation of liability.

More importantly, *Ryszkiewicz* and *Nothnagle* did not involve contracted-for amounts. In the insurance context, the limitation of liability involves a contracted-for amount between the parties. In *Ryszkiewicz*, the parties neither contracted for nor mutually agreed to the limitation of liability. While the tariff schedule in *Nothnagle* can be viewed as part of the contract between the railroad and the passengers, it is one of adhesion in which the passengers have no choice but to agree, having had no opportunity to negotiate over the limitation of liability. Insurance contracts are also contracts of adhesion, but the amount of coverage is agreed upon by the parties unlike the limitation of liability in *Nothnagle*. With an insurance contract, the insured cannot negotiate with the insurance company over many of the contract provisions because of statutory and regulatory requirements. However, the parties can negotiate over the amount of coverage in the policy. With a tariff schedule such as the one in *Nothnagle*, the passenger has neither notice of the contractual limitation of liability nor the opportunity to negotiate over the amount of the limitation of liability.

Does a policy limit special defense fall within the requirements of a special defense as outlined in the *Practice Book* or in Connecticut case law? The problem is that pleading the policy limit does not show that the plaintiff has no cause of action. The insurance company is not denying that there is a cause of action. Instead, the insurance company is limiting its liability to the contracted-for amount. The statement that the insurance company is making is "yes, all of those facts are true, but if we are liable, we only owe you *x* amount." Under the rule of Practice Book section 164, a special defense would be "yes, all of those facts are true, but we are not liable for any amount because of *x* fact." This is precisely why exclusions in the policy or breaches of conditions required for insurability are special defenses. If the injured party was not insured under the policy because of a lack of coverage for that occurrence or a lack of insurability, then there would be no cause of action. With regard to a policy limit, however, the insurance company is not discharging itself or excusing itself from coverage, but rather, it is limiting the amount of coverage to the amount the parties agreed to at the time the insurance policy was issued.

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Perhaps a better way to view a policy limit special defense is in terms of the other purpose of a special defense, that is, to provide notice of the issues. "The purpose of pleading is to apprise the court and opposing counsel of the issues to be tried, not to conceal basic issues until the trial is under way and the plaintiff's witnesses have testified."[66] Viewed in this light, the policy limit special defense makes perfect sense in that it puts all parties on notice about what issues would be important at trial. However, in many cases the amount of the policy limit is not at issue. Thus, the insurance company will have to plead and prove that which probably will not be at issue. "This rule of pleading serves a consideration of convenience, namely, the avoidance of pleading and proving at length the performance of manifold conditions as to which there will probably be no issue."[67] There seems to be no logical reason for requiring an insurance company to plead a policy limit as a special defense except for the sake of pleading it. Why plead that which is not at issue? In an uninsured motorist case, coverage and liability are frequently admitted, and damages may be the only issue. The policy limit is a restriction on liability, not on the amount of damages.[68] The injured party's damages may be an amount in excess of the contracted-for amount in the insurance policy. The policy limit restricts the insurance company's exposure to the mutually agreed-upon amount in the policy. Since the injured party's damages may exceed the policy limit, the injured party could then attempt to recover the excess amount of damages from the tortfeasor.

The other important question raised by the *Bennett* decision regards the ramifications of a failure to plead the policy limit as a special defense. "We have repeatedly held that '[t]he failure to file a special defense may be treated as waived when it appears that no objection was raised to the offer of evidence on the issue at trial.'"[69] "Any de-

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66. DuBose v. Carabetta, 161 Conn. 254, 261, 287 A.2d 357, 360 (1971); Biller v. Harris, 147 Conn. 351, 357, 161 A.2d 187, 190 (1960).

67. *DuBose*, 161 Conn. at 262, 287 A.2d at 360-61.

68. In a hit-and-run case, the policy limit may become both a restriction on the amount of liability and a restriction on the amount of damages. It restricts damages because the hit-and-run driver may never be located. Thus, the only recovery the injured party can receive is from his or her own insurance company.

69. Damora v. Christ-Janer, 184 Conn. 109, 112, 441 A.2d 61, 64 (1981) (quoting Frager v. Pennsylvania Gen. Ins. Co., 161 Conn. 472, 479, 289 A.2d 896 (1971)); *see also* Thompson & Peck, Inc. v. Harbor Marine Contracting Corp., 203 Conn. 123, 132, 523 A.2d 1266, 1270 (1987).

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fect in the pleadings is therefore deemed to have been waived."[70] Thus, if coverage is admitted, and the defendant does not object at trial to the evidence of coverage and fails to plead the policy limit as a special defense, the policy limit will be deemed waived. If the defense is waived, the insurance company will not be able to seek remittitur to bring the verdict within the policy limit and will have in effect waived its rights under Connecticut General Statutes section 38a-336(b). Consequently, the policy behind the uninsured motorist statute will be undermined. The anomalous situation the statute was designed to avoid will thereby be re-created. The insured will be able to recover more from his insurance company than from the tortfeasor's insurance company despite the language and policy behind section 38a-336(b).

The opinion in *Bennett* leaves unanswered the issue of what defense attorneys should do in disputes involving uninsured motorist claims. While the court stated that the policy limit should be specially pleaded, it is unclear if the insurance company would have to plead a settlement with a co-plaintiff or other third parties such as the one in *Bennett*.[71] In *Bennett*, the court stated that since the settlement with Bennett was

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70. Elis v. Rogers, 15 Conn. App. 362, 366, 544 A.2d 663, 665 (1988).

71. The plaintiff suggested several alternatives as to how the defendant could have preserved its rights and avoided prejudice to the jury. It could have done so by a motion for summary judgment on policy limits, by requesting that the pleadings not be sent to the jury room, by motion under Practice Book § 386 to limit exposure, or through a request for admission under Practice Book § 238. *See* Brief of Plaintiff-Appellant at 12, Appellate Court Records, *supra* note 3.

Practice Book § 386 provides:

> SUMMARY JUDGMENTS—JUDGMENT FOR PART OF A CLAIM. If it appears that the defense applies to only part of the claim, or that any part is admitted, the moving party may have final judgment forthwith for so much of his claim as the defense does not apply to, or as is admitted, on such terms as may be just; and the action may be severed and proceeded with as respects the remainder of the claim.

CONN. PRAC. BOOK § 386 (1995).

Practice Book § 238 provides in part:

> ADMISSION OF FACTS AND EXECUTION OF WRITINGS—REQUESTS FOR ADMISSION. (a) A party may serve in accordance with Sec. 120 upon any other party a written request for admission, for purposes of the pending action only, of the truth of any matters relevant to the subject matter of the pending action set forth in the request that relate to statements or opinions of fact or of the application of law to fact, including the existence, due execution and genuiness of any documents described in the request.

CONN. PRAC. BOOK § 238 (1995).

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not an issue, it did not have to be specially pleaded.[72] The question of whether a settlement with a co-plaintiff has to be specially pleaded if it is at issue remains open. If the insurance company has to plead the policy limit as a special defense, it may also have to do so with regard to a settlement payment to a co-plaintiff or another third party. Of course, like a policy limit special defense, a settlement payment special defense would have to be kept from the jury in order to avoid prejudice.[73]

Another issue that may have to be pleaded as a special defense is set-off.[74] In *Peck v. Jacquemin*, one co-defendant pled by special defense that he was entitled to set-off in the amount of $100,000 if damages were assessed against him.[75] This figure represented the amount the other co-defendant paid as a settlement with the plaintiff. The trial court ruled that the defendant could claim set-off and examine the plaintiff in the presence of the jury about the settlement with the other co-defendant.[76] The supreme court held that in light of Connecticut General Statutes section 52-216a, which prohibits settlement agreements from being introduced to the jury, the issue of the settlement could not be revealed to the jury.[77] Thus, if an attorney pleads set-off as a defense in uninsured motorist coverage suits, the issue will have to be resolved by the judge and not the jury.

The question remains, however, as to how attorneys should properly plead in an uninsured motorist cause of action. Attorneys may wish to plead a special defense in order to preserve their clients' rights at a later point in the trial. Attorneys could resort to something similar to what Stephenson refers to as an "equivocal" plea.[78] If the defendant is unsure as to whether to make a general denial or a special defense, he could raise his defense by stating "the defendant denies the allegation that . . ."[79] If the complaint includes the allegation, then the defen-

72. Bennett v. Automobile Ins. Co. of Hartford, 230 Conn. 795, 804-05, 646 A.2d 806, 811 (1994).

73. Belanger v. Village Pub I, Inc., 26 Conn. App. 509, 514, 603 A.2d 1173, 1176 (1992); Peck v. Jacquemin, 196 Conn. 53, 58, 491 A.2d 1043 (1985).

74. *See* General Consolidated, Ltd. v. Rudnick, 4 Conn. Cir. Ct. 581, 237 A.2d 386 (1967); *Peck*, 196 Conn. at 54, 491 A.2d at 1044.

75. *Peck*, 196 Conn. at 54, 491 A.2d at 1045.

76. *Id.* at 56, 491 A.2d at 1046.

77. *Id.* at 58, 491 A.2d at 1047.

78. STEPHENSON, *supra* note 42, at 525.

79. *Id.*

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dant's statement is a sufficient denial. If no allegation is in the complaint, the defendant's plea acts as a special defense. The special defense may be defective in form, but such a defect can be waived or corrected later in the pleadings.[80] Similarly, in the context of uninsured motorist litigation, an attorney could plead a settlement or set-off as a special defense in the event that it becomes an issue in the case. However, it seems illogical to plead that which may not be an issue in the case. Yet in light of the *Bennett* decision, attorneys may not have any choice but to plead that which may or may not become an issue in order to preserve their clients' rights at the end of the trial.

IV. THE CONNECTICUT UNINSURED MOTORIST STATUTE

The uninsured motorist statute[81] was adopted with a variety of purposes in mind. The primary purpose was to "provide protection to innocent victims of 'financially irresponsible' motorists."[82] In addition, "[t]he broad remedial purpose of the coverage is to protect and make whole an individual injured at the hands of an uninsured/underinsured motorist."[83]

The uninsured motorist statute has been revised since its enactment in order to overcome two anomalies in coverage.[84] The court first recognized the anomalies in *Simonette v. Great American Insurance Co.*[85] Since the statute at the time only covered uninsured motorists, the court recognized that in underinsured motorist actions the injured party would be better off if the tortfeasor carried no liability insurance rather than less than the statutory minimum amount.[86] This anomaly was once again recognized by the court in *Roy v. Centennial Insurance Co.*[87] The court in both of these cases, however, felt that it was up to the

80. *Id.*

81. CONN. GEN. STAT. § 38a-336 (1995). The uninsured motorist statute also includes underinsured motorist coverage.

82. BERK & JAINCHILL, *supra* note 1, at 13 (quoting Fidelity & Casualty Co. v. Darrow, 161 Conn. 169, 176, 286 A.2d 288, 291 (1971)).

83. BERK & JAINCHILL, *supra* note 1, at 14 (quoting American Universal Ins. Co. v. DelGreco, 205 Conn. 178, 197, 530 A.2d 171, 181 (1987)).

84. BERK & JAINCHILL, *supra* note 1, at 13-14.

85. 165 Conn. 466, 338 A.2d 453 (1973).

86. *Id.* at 471, 338 A.2d at 455.

87. 171 Conn. 463, 370 A.2d 1011 (1976).

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legislature not the judiciary to correct this anomaly.[88] The court in *Roy* stated:

> The purpose of mandatory insurance, minimum liability insurance levels, and uninsured motorists protection requirements can only be to ensure that certain minimum protections are afforded all motorists. These statutory devices cannot serve to eliminate all differences in treatment which may result to an insured due to the varying levels of insurance carried by motorists or because of varying financial resources of motorists. If the minimum levels of protection are inadequate, it is the function of the legislature, not the judiciary, to raise those levels. Failing legislative action, the cautious motorist may, under § 38-175c, as amended, purchase additional personal protection. This court cannot, however, by a tortured construction of the statutory and regulatory provisions, indirectly eliminate possible inequities in coverage, where the legislature has failed to do so directly.[89]

The legislature did react to this anomaly in 1979 by providing underinsured as well as uninsured motorist coverage.[90] With this amendment, an injured party would no longer be better off if the tortfeasor carried no liability insurance rather than less than the statutory minimum.[91]

The uninsured motorist statute was further amended in 1983 to address an additional coverage anomaly. The amendment provided uninsured motorist coverage with limits for bodily injury and death equal to those for liability imposed by law unless the insured requested less in writing. This amendment effectively mandated coverage to the injured party in the amount he would have received had the tortfeasor been insured to the same extent as the injured party.[92]

With these amendments, the public policy behind the uninsured motorist statute was complete. It "assure[d] that every insured recovers damages he or she would have been able to recover if the uninsured motorist had maintained a policy of liability insurance."[93] "The cover-

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88. *Simonette*, 165 Conn. at 471-73, 338 A.2d at 455-56; *Roy*, 171 Conn. at 475-76, 370 A.2d at 1017.

89. *Roy*, 171 Conn. at 475-76, 370 A.2d at 1017. General Statutes § 38-175c has been renumbered as § 38a-336.

90. Reddy v. New Hampshire Ins. Co., 28 Conn. App. 145, 150, 612 A.2d 64, 67 (1992).

91. *Id.* at 149-50, 612 A.2d at 67.

92. *Id.* at 150, 612 A.2d at 67.

93. BERK & JAINCHILL, *supra* note 1, at 14; *see also* Smith v. Safeco, 225 Conn.

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age is not intended, however, to place the insured, who was injured by an uninsured motorist, in a better position than one who is harmed by a motorist having the same insurance as the insured."[94]

The most important provision of the uninsured motorist statute in the *Bennett* opinion is subsection (b).

> An insurance company shall be obligated to make payment to its insured up to the limits of the policy's uninsured motorist coverage after the limits of liability under all bodily injury liability bonds or insurance policies applicable at the time of the accident have been exhausted by payment of judgments or settlements, but in no event shall the total amount of recovery from all policies, including any amount recovered under the insured's uninsured motorist coverage, exceed the limits of the insured's uninsured motorist coverage.[95]

This provision limits the extent of the insurance company's liability to the amount contracted for in the policy. The ruling in *Bennett*, however, questions the availability of the protection of the statute. If the insurance company fails to plead the policy limit as a special defense, it seems to follow that the insurance company would be precluded from seeking the protection of section 38a-336(b) because it failed to give notice through a special defense. Therefore, if the insurance company fails to plead the special defense, it will be forced to pay a jury verdict above the policy limit regardless of the limitation in section 38a-336(b). The anomalous situation will be re-created at that point. The injured party will be able to recover more from his insurance company than he originally contracted for in the policy. As a result, the injured party may be able to recover more from his insurance company through the uninsured motorist provision than from the tortfeasor's insurance company if the tortfeasor had been adequately insured.

566, 573, 624 A.2d 892, 869 (1993); Bodner v. United Servs., 222 Conn. 480, 499, 610 A.2d 1212, 1222 (1992); Streitweiser v. Middlesex Mut. Assurance Co., 219 Conn. 371, 377, 593 A.2d 498, 501 (1991); Harvey v. Travelers Indem. Co., 188 Conn. 245, 249, 449 A.2d 157, 159-60 (1982).

94. BERK & JAINCHILL, *supra* note 1, at 14; American Motorists v. Gould, 213 Conn. 625, 631, 569 A.2d 1105, 1109 (1990) (citing Dewberry v. Auto-Owner Ins. Co., 363 So. 2d 1077, 1081 (Fla. 1978)).

95. CONN. GEN. STAT. § 38a-336(b) (1995).

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V. Sections 52-216a and 52-228 of the General Statutes of Connecticut

The *Bennett* decision inextricably intertwined two important statutes and the distinct issues involved in those statutes. Both section 52-216a and section 52-228 allow for remittitur under certain circumstances.[96] Some cases have even gone so far as to discuss the two statutes as if they were one and the same.[97] In *Bennett*, the Supreme Court of Connecticut briefly discussed the issue of remittitur and the applicability of section 52-228 in a footnote.[98] The court stated that remittitur rests largely within the discretion of the trial court and will not be overruled unless there is an abuse of discretion.[99] The *Bennett* court felt that the procedure used by the defendant was not improper and that remittitur was properly within the discretion of the trial court.[100]

The court in *Bennett* did, however, use section 52-216a, not for its remittitur purpose, but for its guidance on the issue of prejudice to the jury. Section 52-216a prohibits the introduction of evidence concerning settlements and releases to the jury.

> An agreement with any tortfeasor not to bring legal action or a release of a tortfeasor in any cause of action shall not be read to a jury or in any other way introduced in evidence by either party at any time during the trial of the cause of action against any other joint tortfeasors, nor shall any other agreement not to sue or release of claim among any plaintiffs or defendants in the action be read or in any other way introduced to a jury.[101]

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96. Section 52-216a provides in part: "If the court at the conclusion of the trial concludes that the verdict is excessive as a matter of law, it shall order a remittitur . . . ." CONN. GEN. STAT. § 52-216a (1995). Section 52-228 provides in part: "If any judgment is rendered . . . for a larger sum than is due, the party recovering the judgment may have the amount of the judgment decreased by remittitur to the amount which is due . . . ." CONN. GEN. STAT. § 52-228 (1995).

97. *See, e.g.*, Alfano v. Insurance Ctr. of Torrington, 203 Conn. 607, 614, 525 A.2d 1338, 1342 (1987).

98. Bennett v. Automobile Ins. Co. of Hartford, 230 Conn. 795, 805, 646 A.2d 806, 811 n.19 (1994).

99. *Alfano*, 203 Conn. at 614, 525 A.2d at 1342; *Bennett*, 230 Conn. at 805, 646 A.2d at 811 n.19; Goral v. Kenney, 26 Conn. App. 231, 239-41, 600 A.2d 1031, 1035-36 (1991); A-G Foods, Inc. v. Pepperidge Farm, Inc., 216 Conn. 200, 218, 579 A.2d 69, 78 (1990).

100. *Bennett*, 230 Conn. at 805, 646 A.2d at 811 n.19.

101. CONN. GEN. STAT. § 52-216a (1995).

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The intent behind the statute was to prevent prejudicing the jury with knowledge of any settlement agreement.[102]

Before section 52-216a was enacted, juries did have knowledge of settlement agreements before deliberating on damages. Courts discovered, however, that the knowledge tended to prejudice the jury.[103] Thus, the better policy was to keep the information from the jury to remove "whatever possibility for prejudice [that] may exist."[104] The court in *Bennett*, therefore, held that since the knowledge of Bennett's settlement had to be kept from the jury, the defendant was not required to plead the Bennett settlement as a special defense.[105]

The court's reasoning could be extended one step further into the realm of a policy limit special defense. If the jurors knew that only a certain amount could be awarded because that was the policy limit, they might feel inclined to award that amount regardless of whether they actually believed that damages should be awarded in that amount. As a result, if the jury had knowledge of the limit, it could be "more prejudicial than probative," and "of questionable utility since the mathematical adjustment of the verdict could readily be effected by the court alone."[106] Despite its holding, the court in *Bennett* recognized the prejudicial quality of disclosing policy limits to the jury. The court believed that it could avoid this prejudice by keeping the policy limit special defense from the jury unless the facts required a jury determination.[107] The unanswered question still remains, however, as to what happens if the plaintiff disputes the amount of coverage. In that scenario, if it is sent to the jury for consideration and the jury determines the amount of coverage, it will once again be influenced by the knowledge that only a certain amount of coverage exists.

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102. Seals v. Hickey, 186 Conn. 337, 344, 441 A.2d 604, 608 (1982); Peck v. Jacquemin, 196 Conn. 53, 73, 491 A.2d 1044, 1044 (1985); *Bennett*, 230 Conn. at 804, 646 A.2d at 811; Civiello v. Owens-Corning Fiberglass Corp., 208 Conn. 82, 93, 544 A.2d 158, 163 (1988).

103. Fritz v. Madow, 179 Conn. 269, 273, 426 A.2d 268, 269 (1979); *see also* Belanger v. Village Pub I, Inc., 26 Conn. App. 509, 514, 603 A.2d 1173, 1176; *Seals*, 186 Conn. at 345, 441 A.2d at 608.

104. *Seals*, 186 Conn. at 344, 441 A.2d at 608 (citing Kosko v. Kohler, 176 Conn. 383, 387, 407 A.2d 1009 (1978)).

105. *Bennett*, 230 Conn. at 804-05, 646 A.2d at 810-11.

106. *Fritz*, 179 Conn. at 273, 426 A.2d at 269; *see also* TAIT & LAPLANTE, *supra* note 53, at 227; *Peck*, 196 Conn. at 59, 491 A.2d at 1047.

107. *Bennett*, 230 Conn. at 803-04 n.17, 646 A.2d at 810.

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VI. THE TREATMENT OF THE POLICY LIMIT AS A SPECIAL DEFENSE IN OTHER JURISDICTIONS

A few other jurisdictions have addressed the issue of mandating a policy limit special defense. The jurisdictions that decided against a policy limit special defense raised many of the same concerns mentioned above.

In *Allstate Insurance Co. v. Miller*,[108] the Maryland Court of Appeals considered the question of whether the trial court should reduce the jury verdict to keep it within the contractual limits of the policy. Miller, a passenger injured in a car accident, brought suit against the tortfeasor and the insurer of the vehicle in which she was riding for uninsured motorist benefits. The jury, with no knowledge of the policy limit, awarded $120,000, but the uninsured motorist coverage was only $50,000.[109] Allstate requested a remittitur, contending that a jury verdict in excess of uninsured motorist coverage policy limits should be reduced by the judge to bring it within the contractual limits. Miller, on the other hand, argued that since Allstate had the burden of pleading and proving the limits of liability to the jury, it had to bring the policy limits into evidence at trial, not in a post-trial motion.[110] The court noted that the question sent to the jury was one of damages which sounds in tort and not contract. While knowledge of insurance cannot be kept from the jury in that jurisdiction, the amount of uninsured motorist coverage should not be disclosed unless the coverage is in controversy.[111]

The court concluded by stating that the amount of uninsured motorist coverage should not be presented to the jury because it is irrelevant and unduly prejudicial.

> [A]ll the jury was directed to consider, was the issue of damages in a tort case. In this posture of the case, and under these circumstances, rather than require a party to establish uninsured motorist policy limits as an affirmative defense or as a limitation of exposure, the better rule is to allow the jury to make its decision on the issue of damages without being informed of the amount of coverage available. Therefore, the admission of unin-

108. 553 A.2d 1268 (Md. 1989).
109. *Id.* at 1268-69.
110. *Id.* at 1271.
111. *Id.* at 1271-72.

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> sured motorist coverage amounts should not be a tactical decision left to the parties' discretion. The fact of the limit of uninsured motorist coverage is irrelevant to the issue of the amount of tort damages. Here, no jury issue was presented concerning the $50,000 uninsured motorist coverage. Both the parties and the court were aware of the insurance policy limits. Under these circumstances, the jury's verdict should not have been influenced by extraneous factors such as the prospect of recovery or of the availability of a specific sum of uninsured motorist coverage.[112]

The same reasoning applies to *Bennett*. Once again liability was admitted, and the only issue for the jury was damages. As in *Miller*, the requirement of a policy limit special defense would create the need for a tactical decision by the parties. The amount of the injured party's damages could be less than the policy limit. Thus, if the jurors did not know of the policy limit, they would award only what they considered to be appropriate damages. If the jurors knew the amount of the policy limit, they might be inclined to award the entire amount of the policy regardless of what they considered to be the appropriate amount of damages. As a result, the insurance company may decide for tactical reasons to not plead the policy limit because by not pleading the limit, the amount of liability might be significantly reduced.

Alabama adopted the *Miller* rule in two cases: *Preferred Risk Mutual Insurance Co. v. Ryan*[113] and *Alfa Mutual Insurance Co. v. Moreland.*[114] In *Preferred Risk*, the court addressed the question of whether the trial court erred in admitting evidence of the limits of uninsured motorist coverage. The court held that evidence of the limits of an insurance policy is not relevant in tort cases and is not to be admitted.[115] In *Alfa Mutual*, the court addressed the additional question of whether the insurance company may seek remittitur when the jury verdict exceeds the limits of the uninsured motorist coverage. The court held that absent bad faith or fraud the court may reduce the verdict upon proper post-trial motion.[116]

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112. *Id.* at 1273.
113. 589 So. 2d 165 (Ala. 1991).
114. 589 So. 2d 169 (Ala. 1991).
115. *Preferred Risk*, 589 So. 2d at 166.
116. *Alfa Mutual*, 589 So. 2d at 171.

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The Wisconsin Court of Appeals in *Price v. Hart*[117] declined to adopt the *Miller* rule, even though the court considered it to be the better rule of law. In this case, Price was a passenger in a van owned by Duranso Transfer. Fireman's Fund provided uninsured motorist coverage to Duranso Transfer in the amount of $750,000. Fireman's Fund did not plead or prove the policy limit. A jury verdict was subsequently returned for Price in the amount of $4,795,552.[118]

In Wisconsin, whether an insurer is required to plead the policy limit is a question of law.[119] The burden of proof is on the insurer to plead and prove the policy limit.[120] If the insurer pleads and proves the policy limit, the trial judge has the discretion to reduce the verdict to the policy limit.[121] However, if the insurer fails to plead and prove the policy limit, it is liable for the full amount of the jury's verdict.[122]

The appellate court agreed that the holding in *Miller* was the better rule of law but declined to change the rule in Wisconsin and left any change up to the state supreme court. In dicta referring to *Miller*, the appellate court stated:

> Although this case has no precedential value in Wisconsin, we believe it is the better rule because insurance policy limits are available to the parties through discovery and cannot be presented to the jury. Furthermore, unless policy limits are in issue, they have no bearing upon the jury's consideration of damages and they are irrelevant until after verdict. Thus, to require an insurer to prove its policy limits at trial when they are not in issue is a formality that serves no purpose. The result in this case is a good example of why Wisconsin's procedure on this issue should be reexamined. It places form over substance.[123]

The rule in *Bennett* also places form over substance. Insurers will plead the policy limit for no reason because the plaintiff already has notice of the policy limit through discovery.

117. 480 N.W.2d 249 (Wis. Ct. App. 1991).
118. *Id.* at 251.
119. *Id.*
120. *Id.* at 252.
121. *Id.*
122. *Id.*
123. *Id.* at 253.

Louisiana is another jurisdiction that requires the insurance company to plead and prove the policy limit at trial in order to have the jury verdict reduced to the policy limit. In *Williams v. Bernard*,[124] the court wrote: "The jury's failure to be aware of the policy limit was attributable to the defendant. After coverage has been stipulated, an insurer cannot remain silent on extent of coverage and then complain when a jury awards an amount in excess of the policy limit."[125]

With the *Bennett* decision, the rule in Connecticut lies somewhere between the Maryland rule and the strict Louisiana rule. The goal in *Bennett* is clearly to provide notice and preserve the rights of all the parties. However, the *Bennett* decision is still problematic. If the plaintiff disputes the amount of coverage, the unanswered question is whether or not the jury will have to decide the amount of coverage as a question of fact. If so, then the jury has knowledge of the policy limits which can be prejudicial to either the plaintiff or the defendant. On the other hand, pleading the policy limit for the sake of pleading seems illogical because the limit is irrelevant to the amount of damages. Thus, pleading the policy limit seems to "place form over substance," in the words of the Wisconsin Court of Appeals.[126]

VII. Discovery of Insurance Policy Limits

If the primary goal of the special defense rule for policy limits is to provide notice to opposing counsel and the judge, it seems that modifying the discovery rule might provide better notice. After all, insurance policies are already discoverable under Connecticut Practice Book section 230.[127] When insurance policy information has been disclosed

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124. 413 So. 2d 198 (La. Ct. App. 1982), *aff'd*, 425 So. 2d 719 (La. 1983).

125. *Id.* at 200.

126. *Price*, 480 N.W.2d at 253.

127. Conn. Prac. Book § 230 (1995); *cf.* Fed. R. Civ. P. 26(b)(2) (requiring the disclosure of the existence and contents of insurance agreements in general). Discovery of insurance policies is also governed by state statute. General Statutes § 52-200a provides:

> Defendant's Insurance Liability Policy Limits and Insurer's Duty to Indemnify Subject to Discovery. In any civil action founded upon negligence, both the defendant's insurance liability policy limits and whether or not the insurer has disclaimed its duty to indemnify shall be subject to discovery upon written motion of the plaintiff. Any such motion and disclosure shall be excluded from the file submitted to the jury.

Conn. Gen. Stat. § 52-200a (1995).

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through discovery, opposing counsel is already on notice, and the only party that must be notified is the judge.

Traditionally, discovery of insurance coverage has been quite controversial.[128] Part of the conflict over discoverability of insurance coverage is that insurance is not itself admissible in court.[129] However, insurance may be relevant to issues such as ownership and control of premises or credibility of witnesses.[130]

Today, insurance coverage is discoverable. Connecticut Practice Book section 230 provides:

> DISCLOSURE OF AMOUNT AND PROVISIONS OF INSURANCE LIABILITY POLICY. In any civil action the existence, contents and policy limits of any insurance policy under which any insurer may be liable to satisfy part or all of a judgment which may be rendered in the action against any party or to indemnify or reimburse any defendant for payments made to satisfy the judgment shall be subject to discovery by any party by interrogatory or request for production under Secs. 222 and 226. Information concerning the insurance agreement is not by reason of disclosure admissible in evidence at trial.[131]

Further, the Advisory Committee for the Federal Rules of Civil Procedure stated that the reason in favor of discoverability is that

> [d]isclosure of insurance coverage will enable counsel for both sides to make the same realistic appraisal of the case, so that settlement and litigation strategy are based on knowledge and not speculation. It will conduce settlement and avoid protracted litigation in some cases, though in others it may have the opposite effect. The amendment is limited to insurance coverage, which should be distinguished from any other facts concerning defendant's financial status (1) because insurance is an asset created specifically to satisfy the claim; (2) because the insur-

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128. *See generally* Ralph R. Williams, *Discovery of Dollar Limits in Liability Policies in Automobile Tort Cases*, 10 ALA. L. REV. 355 (1958); Joseph N. Fournier, *Pretrial Discovery of Insurance Coverage and Limits*, 28 FORDHAM L. REV. 215 (1959); John P. Frank, *Discovery and Insurance Coverage*, 1959 INS. L.J. 281.

129. *See* FED. R. CIV. P. 26(b)(2) (advisory committee's note at 280-81); FED. R. EVID. 411; TAIT & LAPLANTE, *supra* note 53, at 267.

130. FED. R. EVID. 411; TAIT & LAPLANTE, *supra* note 53, at 267.

131. CONN. PRAC. BOOK § 230 (1995).

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> ance company ordinarily controls the litigation; (3) because information about coverage is available only from defendant or his insurer; and (4) because disclosure does not involve a significant invasion of privacy.[132]

Since the parties already know the extent of the policy limit through discovery, it seems that if the discovery rule was amended to require the parties to notify the judge of the policy limit and of the intent to seek remittitur when the jury verdict exceeds the policy limit, the goals of the *Bennett* decision would be satisfied. All of the parties would be on notice and the defendant's rights under General Statutes section 38a-336(b) would be preserved. Instead, under the complicated rule of *Bennett*, the insurer must plead the policy limit as a special defense, assume the burden of proof on the issue, and face the possibility that the plaintiff may dispute the amount of the policy limit, thereby making it a question of fact for the jury. Once the policy limit becomes a jury question, the old fear of prejudice returns. As a discovery rule, the jury would never need to hear about the policy limit and all of the parties that need to know the limit would receive notice.

VIII. CONCLUSION

In *Bennett v. Automobile Insurance Co. of Hartford*, the Supreme Court of Connecticut attempted to clarify the law of uninsured and underinsured motorist coverage. Instead, the court made this area of insurance coverage more complicated. The intent of the opinion in *Bennett* was to provide notice to all parties so that the insurance company's rights under General Statutes section 38a-336(b) could be preserved. However, if the plaintiff disputes the amount of the policy limit, the unanswered question remains whether the amount of coverage becomes a jury question. If it does, then the possibility of prejudice to the plaintiff or defendant arises because the jury decides the amount of the policy limit and knows that the amount of damages will be limited to that amount. Additionally, if the defendant fails to plead the policy limit as a special defense, the defendant could be forced to pay a jury verdict above the policy limit despite the statutory limitation of section 38a-336(b). Thus, the anomalous situation where an injured party could

132. FED. R. CIV. P. 26(b)(2) (advisory committee's note at 280-81).

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recover more from his or her own insurance company than from the inadequately insured tortfeasor is re-created.

Other questions also arise with the policy limit special defense. Since settlement payments and set-off could also limit an insurance company's liability, must they also be specially pleaded? In light of *Bennett*, the better rule for attorneys seems to be: "when in doubt, plead a special defense." Yet this rule gets away from the theories behind a special defense. Facts that must be specially pleaded are matters of discharge or matters of justification or excuse. A policy limit special defense does not fit into either of those categories because the insurance company has admitted liability, but only up to the amount for which the parties contracted. In addition, insurance companies will be forced to plead the policy limit, which is generally not at issue, for no reason. As a result of this rule, form is placed over substance.

The *Bennett* decision is beginning to have an effect in the lower courts.[133] As lower court cases similar to *Bennett* are appealed, it will be interesting to see how the state supreme court attempts to resolve these issues. The opinion in *Bennett* had good intentions, however, the issues left unresolved will only further complicate the quagmire of uninsured motorist coverage in Connecticut.

133. *See, e.g.*, Mayers v. Allstate Ins. Co., 9 CSCR 398 (April 18, 1994, Sylvester, J.) (referring to the Connecticut Appellate Court in *Bennett*).

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INTRODUCING MARKET DISCIPLINE INTO THE FEDERAL DEPOSIT INSURANCE SYSTEM: *O'MELVENY & MYERS V. FDIC*

*Jerrie L. Chiu**

I. INTRODUCTION

In recent years there has been a great deal of discussion on the need for reforms in the federal deposit insurance system, and a number of possibilities have been suggested. Starting with the Banking Act of 1933,[1] Congress established the Federal Deposit Insurance Corporation (FDIC), which is responsible for the nation's system of insurance for bank deposits.[2] This system was maintained until the early 1990s when the near insolvency of the Bank Insurance Fund (BIF), which finances federal deposit insurance, forced Congress to consider revamping the system.[3] A new system of federal deposit insurance was introduced in the Federal Deposit Insurance Corporation Improvement Act (FDICIA) of 1991,[4] which significantly reformed the old system through the adoption of risk-adjusted premiums for member institutions.

This Note discusses a recent case, *O'Melveny & Myers v. FDIC*,[5] and how it may affect the FDIC's determinations of risk-adjusted premiums. In this case, the FDIC took over as receiver of a California bank that had engaged in illegal practices and subsequently failed. The FDIC sued the bank's law firm, O'Melveny & Myers, for breach of

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* J.D., University of Connecticut School of Law, expected May 1996. B.S. Chemistry, Indiana University, 1990. The author would like to thank Professor Nicholas Georgakopoulos for his invaluable assistance in preparing this Note.

1. Ch. 89, 48 Stat. 162 (1933) (codified as amended in scattered sections of 12 U.S.C.).

2. JONATHAN R. MACEY & GEOFFREY P. MILLER, BANKING LAW AND REGULATION 22 (1992).

3. Stephen K. Huber, *The Federal Deposit Insurance Corporation Improvement Act of 1991*, 109 BANKING L.J. 300, 301 (1992).

4. Pub. L. No. 102-242, 105 Stat. 2236 (1991) (codified in scattered sections of 12 U.S.C.).

5. 114 S. Ct. 2048 (1994).

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fiduciary duty, because O'Melveny & Myers had not discovered the bank's fraud. In response, O'Melveny & Myers asserted state law defenses. The issue before the United States Supreme Court was whether state law or federal law should determine the law firm's duties toward the bank in a suit involving the FDIC as receiver.

In deciding that California law should apply, the United States Supreme Court reinforced a market discipline approach to the federal deposit insurance system. Throughout most of the FDIC's history, deposit insurance was provided to banks without consideration for the differences that state law or other local factors might have on the bank's likelihood of failure. Since the adoption of the FDICIA, the FDIC now adjusts the insurance that a particular bank pays on its deposits according to the risk of failure that the bank poses. The laws of the state in which the bank is located may contribute to the riskiness of insuring that bank, so, in order for the FDIC to correctly determine the rate to charge a bank, it must consider the laws of the state. If a state's laws make deposit insurance too expensive for its banks, the state may be forced to change its laws in order to remain competitive for banking business. The laws eventually adopted by the state may be determined by market forces and should, therefore, be more likely to represent the optimal level at which to engage in the activities governed by those laws. With market forces regulating the activities of banks, federal regulation may eventually become less stringent.

Part II of this Note presents some background information necessary to understanding risk and how risk influences an individual's need for insurance. This part further discusses the special problems that banks face in their operation. Part II also explains the new system of risk-adjusted premiums and how it is superior to the system in place prior to 1991, because it introduces a level of market discipline into the federal deposit insurance system. Part III elaborates on the facts of the case of *O'Melveny & Myers* and explains the rulings of the Ninth Circuit Court of Appeals and the United States Supreme Court. Part IV provides an analysis of how the Supreme Court's ruling in the case will affect the new system of risk-adjusted premiums. This Note concludes that the new system may allow market forces to determine the optimal levels of fiduciary liability, eventually reducing the need for cumbersome state and federal regulation of bank activities.

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II. BACKGROUND

Before beginning a discussion on the risk-adjusted insurance premium system of the FDICIA, it is beneficial to understand the concept of risk and how it influences the need for insurance. The uncertainty of the outcome in any undertaking contributes to the risk of engaging in that activity. When confronted with a risk of loss, most people take steps to avoid the risk. One method for avoiding risks is to buy insurance, which will compensate the insured should such loss occur. One special risk associated with banks, the risk of failure, contributes to the need for federal deposit insurance. In addition, certain key features of banks, such as fractional reserves and demand deposits, make them susceptible to runs and panics. Prompted by a series of runs and panics, the most injurious of which occurred in the late 1920s, the federal government instituted the system of federal deposit insurance.

The original system of federal deposit insurance, however, presented moral hazard problems, because it charged all member banks the same fee for coverage.[6] In 1991 this flat-fee system was changed to the current system of risk-adjusted premiums, in which banks are charged fees for deposit insurance based upon their individual chances of success or failure. The system of risk-adjusted premiums is more favorable, because it makes deposit insurance similar to market transactions. Without risk-adjusted premiums, there would be very little market discipline in the federal deposit insurance system. Neither bank shareholders nor bank depositors would have any incentive to monitor the behavior of bank managers to ensure that the risks the managers take are not excessive.

A. *Risk Aversion and Insurance*

In any undertaking, there is always a possibility that one may lose something of value, whether it be a portion of an investment or physical ability. If one invests in the stock market, one runs the risk of losing money. If one drives a car, one runs the risk of being injured in an accident. With respect to risk, people can be risk neutral, risk preferring or risk averse. A risk-neutral person will only consider the

6. Moral hazard refers to the tendency of one who does not bear the consequences of a loss to fail to take steps to avoid that loss. *See infra* note 21 and accompanying text.

expected return[7] of an undertaking in deciding whether to be involved in that activity and will not be deterred from engaging in that activity merely by the possible risk associated with it.[8] For example, a risk-neutral person will prefer the outcome of a $100 bet on a roulette table (which pays $3600 with a 1/38, or 2.63%, probability, and, therefore, has an expected value of $94.73) over a guaranteed cash payment of $80 (which has a probability of 100%, and, therefore, an expected value of $80). A risk-preferring person, on the other hand, will choose the activity that poses the greatest risk. In general, however, people are neither risk neutral nor risk preferring, but are instead risk averse.[9] A person who is risk averse considers the magnitude of the risk involved as well as the expected return in determining whether to accept a certain risk.[10]

An understanding of why people are risk averse can be gained by considering utility (happiness) as a function of wealth.[11] An individual's utility function (U) expresses the value that the individual attaches to a particular level of wealth (W).[12] As wealth increases so does utility, but utility does not continue to increase as rapidly as wealth. (See Figure 1.) This phenomenon is referred to as the *diminishing marginal utility of wealth* and is considered to reflect risk aversion.[13] One is averse to accepting the risk of even a fair bet, because doing so may decrease one's wealth and a decrease in wealth leads to a disproportionate decrease in utility. Even though the possible decrease in wealth may be canceled out by the chance for an equivalent increase in wealth, the same does not hold true for a decrease in utility. A decrease in wealth results in a greater decrease in utility than an equivalent increase in wealth would cause an increase in utility.

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7. The expected return is the probability of receiving the return multiplied by the amount of the return.

8. LEWIS D. SOLOMON ET AL., CORPORATIONS LAW AND POLICY 16 (3d ed. 1994).

9. *See infra* note 13 and accompanying text discussing diminishing marginal utility of wealth as the source of risk aversion.

10. A. MITCHELL POLINSKY, AN INTRODUCTION TO LAW AND ECONOMICS 51 (1983); SOLOMON ET AL., *supra* note 8, at 16.

11. As used here, wealth refers to anything possessed by an individual that is of value to that individual.

12. *See* Lawrence Blume & Daniel L. Rubinfeld, *Compensation for Takings: An Economic Analysis*, 72 CAL. L. REV. 569, 600-02 (1984).

13. *Id.* at 602.

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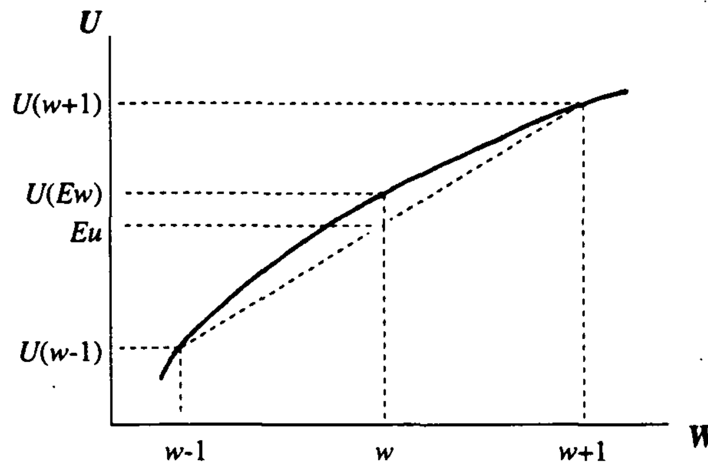
Figure 1



This graph illustrates the relationship between wealth (W) and utility (U) for a risk-averse individual faced with a risk that will result in a wealth of either $w + 1$ or $w - 1$ with equal probability. Notice that the utility of expected wealth, $U(Ew)$, is greater than the expected utility, Eu.

Insurance is a means of shifting the risk of loss in a particular situation to one who is better able to bear it. One method of shifting the risk of loss is to pool it so that risk is borne as a group instead of individually. Although some members of the group will experience the loss, the chance of the loss occurring to everyone in the group is low. By pooling their assets, everyone in the group can be assured of protection against the risk of loss without having to self-insure.

Since people are generally risk averse, they are willing to pay in order to reduce a particular risk—i.e., they are willing to buy insurance.[14] The amount that one is willing to pay to avoid a risk is called the *risk premium*[15] and depends on the size of the risk and the degree of risk aversion of the individual. In the roulette example, a risk-averse individual would be willing to give up $14.73 (the difference between taking the expected return of $94.73 on the bet and taking the $80) in order to receive the guaranteed payment of $80. This $14.73 is the risk

14. *See* POLINSKY, *supra* note 10, at 51-54. "One common way of eliminating risk is through insurance." *Id.* at 53.

15. SOLOMON ET AL., *supra* note 8, at 16; Blume & Rubinfeld, *supra* note 12, at 603.

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premium. With insurance, the individual is willing to pay a particular sum to ensure that a certain level of utility is maintained.[16]

Figure 1 illustrates the example of a risk-averse individual facing a situation that may lead to his wealth being maintained at $w + 1$ or reduced to $w - 1$ with equal probability. The individual's utility is represented by $U(w + 1)$ at a wealth of $w + 1$, whereas the individual's utility is represented by $U(w - 1)$ at a wealth of $w - 1$. Since the individual does not yet know the outcome of the situation, his expected utility is, in this case, the average of $U(w + 1)$ and $U(w - 1)$, or Eu. Notice that the utility of the expected wealth, $U(Ew)$, is greater than the expected utility, Eu.[17] If an individual who possesses a wealth of $w + 1$ is willing to pay an insurance premium of 1 $[(w + 1) - 1 = w]$, he can assure himself of maintaining a utility level equal to that of his expected wealth, $U(Ew)$. If the individual pays the premium of 1 and a loss of 2 occurs, the insurer will pay the individual a compensation of 2. The compensation paid by the insurer brings the individual back to a wealth of w, which still corresponds to a utility level equal to $U(Ew)$. If the loss does not occur, the individual has paid the premium of 1 and is also at $U(Ew)$. The individual is, therefore, assured of maintaining a level of utility equal to $U(Ew)$ rather than taking the risk that his utility may be reduced to $U(w - 1)$.

The above examples assume that insurance cannot be obtained at an actuarially fair price, which is one where "the premium equals the expected payment."[18] Private insurance is never actuarially fair, since part of the premium must necessarily be used to offset administrative costs and to ensure profits.[19] If insurance is actuarially fair, one will always fully insure. Since private insurance is in reality not actuarially fair, an individual will never fully insure against possible losses.[20] The amount the individual is willing to pay will be determined by the degree to which the money paid goes to a return on the risk and the utility function of that particular individual.

16. Blume & Rubinfeld, *supra* note 12, at 602.
17. *See supra* text accompanying note 13.
18. Blume & Rubinfeld, *supra* note 12, at 602.
19. *Id.* at 602-03.
20. *Id.*

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B. Moral Hazard in Insurance

When one who is fully insured no longer has any incentive to take steps to avoid the risk of loss, a *moral hazard* problem arises.[21] If one bears the risk of a particular loss, that person will be more likely to take steps to avoid the risk either by being more careful or by reducing the level of that activity to an efficient degree.[22] In the case where one is fully insured against a particular loss, however, there is no incentive to take such steps to avoid it. This situation is termed moral hazard. Private insurance companies have developed a number of methods for reducing their exposure to moral hazard, such as risk-adjusted premiums, co-insurance, and partial insurance.[23] These methods all involve putting some of the risk of loss back onto the insured.

Risk-adjusted premiums result in higher rates to those who have shown that they represent a greater risk. An automobile insurer charges higher rates to a driver who has received a number of speeding tickets or has had accidents in the past and charges lower rates to those drivers who have neither speeding tickets nor a record of accidents. Under a system of co-insurance, the individual serves as a self-insurer, because the insurance company pays only a percentage of the loss and makes the individual bear the risk on the difference. For instance, dental insurance plans may pay only 50% of the cost for repair work (such as fillings) and make the individual responsible for the other 50%. This encourages the individual to take preventive measures or bear 50% of the cost of the work. Finally, the insurer may offer only partial insur-

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21. POLINSKY, *supra* note 10, at 54; *see also* Krishna G. Mantripragada, *Depositors As a Source of Market Discipline*, 9 YALE J. ON REG. 543, 548 (1992) ("Moral hazard refers to the propensity of the insured institutions to disregard the risk consequences of their actions, if the costs of such actions are shifted to the insurer. This problem arises when actions of the insured that increase either the probability or the size of the losses to the insurer have no bearing on the premiums the insured pays.").

22. POLINSKY, *supra* note 10, at 54.

23. In theory, the only way to completely eliminate moral hazard is to adjust the insurance premium as the insured takes less care and, thereby, creates an increase in the expected loss. This would require the insurer to monitor the behavior of the insured to determine the degree of risk taken. This alternative is, however, infeasible, since the cost of monitoring would be high. The listed methods of reducing moral hazard, therefore, do not completely eliminate moral hazard but are a compromise between the insurer's need to keep cost low and avoid moral hazard and the insured's desire to avoid risk. *Id.* at 54-55.

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ance. Partial insurance can take the form of deductibles or exclusion of payment in certain situations. For example, an insurer on a life insurance policy may refuse to make payment in the case of a suicide.

C. Bank Failures and the Need for Deposit Insurance

Banks serve as financial intermediaries in that they allow the small investor to pool his money with other small investors and to engage in transactions in which he could not participate on his own. Banks use the money from deposits to finance large-scale investments and investments in which the assets are highly illiquid.[24] These types of investments may be in the form of real estate mortgages or secured loans to small businesses. Such investments would be out of reach for the average bank depositor working on his own. But when a depositor's money is pooled with that of others, the bank can then make such investments on the depositor's behalf. When a bank's ability to serve as a financial intermediary is combined with the manner in which it carries debt (as demand deposits), its susceptibility to runs and panics, and its interest-rate risk, a special risk of failure is created.[25]

While the debt of most institutions comes due at scheduled times, the debt of a bank is in the deposits owed to its customers. The majority of these deposits are payable by the bank immediately upon demand, and these are aptly referred to as *demand deposits*.[26] However, a bank never has enough money in hand on any given day to pay out all of its deposits. The bank's role as financial intermediary means that it must take portions of the deposits it acquires and use them to finance other investments, usually in the form of loans. Therefore, a bank main-

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24. MACEY & MILLER, *supra* note 2, at 37.

25. Under customary economic theory of business failure, there are two reasons why a firm fails: (1) the firm has not "responded to market forces with a satisfactory mix of price and product performance relative to its competitors in the industry," or (2) there is insufficient demand for the product. In either of these cases, the failure is desirable, because the resources the failed firm previously used can be put to more efficient use. If there is a reason to be concerned over bank failures, it must be because there is something unusual about banks that alters this customary view of the benefits achieved through business failure. Reasons for thinking that a bank failure is undesirable include the fear of runs and panics, loss of depositor wealth, and the cost of bank failures to the federal deposit insurance system. Jonathan R. Macey & Geoffrey P. Miller, *Bank Failures, Risk Monitoring, and the Market for Bank Control*, 88 COLUM. L. REV. 1153, 1155 (1988).

26. MACEY & MILLER, *supra* note 2, at 43.

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tains only a fraction of its total deposits at any given time on the accurate assumption that the total deposited funds will not be necessary to satisfy requests for funds on any given day. These are a bank's *fractional reserves*.[27] When the concepts of demand deposits and fractional reserves are considered together, the problem that banks may encounter becomes evident. In the event that all or a substantial portion of depositors demand payout of their deposits at the same time, a bank will be unable to repay the depositors. Likewise, since most of the bank's assets are relatively illiquid, a bank will be unable to sell any of its assets quickly enough to settle the debts it owes to its depositors.

The combination of demand deposits and fractional reserves makes banks susceptible to runs and panics. Since no bank has sufficient assets on hand to satisfy all of its deposits at once, depositors will make a run on a particular bank in order to avoid the risk of losing their savings. If a depositor waits, there may not be any money left, so it is in each individual's best interest to attempt to get to the bank before the other depositors.[28] A run on one bank can lead to a systemwide panic, a series of runs on individual banks.[29] When people hear of the failure of one bank, they begin to worry that their banks are also not safe and demand payment of their deposits. As the situation snowballs, more and more banks become victims of a run. Such behavior was demonstrated in the United States during the banking crisis of 1929-1933, when over 5000 banks failed within a three-year period.[30] The public confidence in the banking system became so low that a large number of bank runs and panics occurred, until March of 1933, when President Roosevelt was forced to declare a complete cessation of banking activities in the United States in order to stop the panic.[31]

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27. *Id.* at 45.

28. This type of situation is commonly referred to as a "collective action problem" or the "prisoner's dilemma." The individual must act to gather his own deposit from the bank or risk losing it entirely, because all of the bank's funds have already been paid to other bank depositors. Macey & Miller, *supra* note 25, at 1157.

29. Runs can spread and cause even solvent banks to fail. In order to prevent the collapse of the banking system, a mechanism to avoid runs on any bank is needed. Kenneth E. Scott, *Deposit Insurance and Bank Regulation: The Policy Choices*, 44 BUS. LAW. 907, 910 (1989); *see also* Macey & Miller, *supra* note 25, at 1157.

30. 1,345 banks failed in 1930, 2,298 banks failed in 1931, and 1,456 banks failed in 1932. MACEY & MILLER, *supra* note 2, at 21.

31. *Id.*

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A bank's asset-liability structure also makes it particularly susceptible to failure. A bank often has long-term assets and short-term debts. The long-term assets are in the form of mortgages, the interest rates of which may remain fixed for a number of years.[32] In contrast, a bank's debt is in the form of short-term demand deposits, on which the interest rates frequently change.[33] If the interest paid on demand deposits rises suddenly, but the interest rate on mortgages remains the same, the bank may be paying more for deposits than it is receiving on its loans. Such a situation erodes the bank's equity, causing the bank to fail. This is known as a bank's *interest-rate risk*.[34] If a bank is already failing, it may be willing to expose itself to interest-rate risk in the hope that rates on deposits will fall and it then will profit.[35]

A healthy bank, however, will be more likely to engage in a number of tactics to avoid interest-rate risk. Methods of reducing interest-rate risk include procuring loans that pay at adjustable rates, decreasing the duration of loans, and increasing the duration that fixed interest rates are paid on deposits.[36] By securing loans that pay at adjustable rates, the bank can increase the interest rate of a loan as interest rates paid on deposits increase. This will keep the profit made on loans from falling below the amount paid for deposits. By decreasing the duration of the loan, the bank shortens the length of time for which it earns a fixed interest rate on loans. This lowers the risk that a significant rise in interest paid on deposits will occur during the life of the loan. Finally, a bank can lower its risk by keeping the interest rate on deposits fixed for a guaranteed period of time, such as by selling certificates of deposit (CDs). A bank will reduce its interest-rate risk by applying any one of these three tactics or a combination of them.

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32. *Id.* at 58.

33. *Id.*

34. *Id.*

35. This is a source of moral hazard. With deposit insurance a bank will take greater risk, because there is no risk to depositors of losing their funds. Because of the government guarantee, banks can continue to raise funds through insured deposits and can then use those deposits to invest in risky loans and other investments. *See* Scott, *supra* note 29, at 910.

36. MACEY & MILLER, *supra* note 2, at 58.

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D. Federal Deposit Insurance

In the past, the market failed to provide insurance against the loss of bank deposits. Presumably, in an efficient market, insurance would be provided by the private sector when necessary.[37] Yet, despite the banking crisis of 1929-1933, the market never introduced insurance for bank deposits. Because the private sector failed to provide such insurance, one can say that there was a market failure in terms of insurance for bank deposits. To fill the gap left by the market, the federal government stepped in and set up a system of insurance for bank deposits under the Banking Act of 1933 (the Banking Act).[38]

The Banking Act was intended to be a solution to the collective action problem of bank runs and panics. The Banking Act established the FDIC, which currently provides insurance on deposits up to $100,000.[39] By insuring deposits, the Banking Act solved the problem of bank runs and panics. Each depositor no longer has to be one of the first to reach a bank in order to be assured of receiving his funds. Deposits are now insured by the federal government, which pays on the deposits if the bank fails to do so.

While the Banking Act adequately addressed the problem of bank runs and panics, it did little to guard against moral hazard.[40] Those who bore the risk of loss in a bank failure (the depositors) had no incentive to reduce the risk of that loss. Since most deposits were fully insured, depositors had no incentive to monitor bank managers.[41] If the bank managers poorly managed the bank and the bank lost all its money, the depositors were unaffected, since the federal government would return all of the depositors' money regardless.[42] Likewise, bank managers and shareholders had little incentive to manage the bank efficiently, because all banks were charged the same flat-rate premiums for FDIC coverage.[43] A bank with a bad record of business practices was

37. Blume & Rubinfeld, *supra* note 12, at 599.

38. Ch. 89, 48 Stat. 162 (1933).

39. 12 U.S.C. § 1821(a)(B) (Supp. V 1993).

40. *See* Lissa Lamkin Broome, *Redistributing Bank Insolvency Risks: Challenges to Limited Liability in the Bank Holding Company Structure*, 26 U.C. DAVIS L. REV. 935, 949-51 (1993).

41. *See infra* text accompanying note 57.

42. *See infra* note 60 and accompanying text (explaining that the FDIC often paid on uninsured deposits as well as insured ones).

43. Because all banks were charged the same fee for deposit insurance, some

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charged the same rate for insurance of its accounts as a bank with an excellent record. (Contrast this to the automobile insurance discussed above, where those who pose a greater risk of loss are charged higher premiums for insurance.) These factors may have contributed to the insolvency of the Bank Insurance Fund (BIF), since there was little incentive for any group in the market to ensure that banks were managed efficiently.

E. FDICIA: Risk-Adjusted Premiums

The system of flat-rate premiums for federal deposit insurance coverage was changed in 1991 when Congress passed the FDICIA.[44] The FDICIA appears to make federal deposit insurance more analogous to private insurance by charging banks risk-adjusted premiums.[45] A bank is no longer charged the same rate as a neighboring bank that may have a better record for safety. Instead, the bank with the better business record is rewarded with lower premium payments to maintain its federal deposit insurance coverage. As such, the FDICIA seeks to address both the collective action and the moral hazard problems in insuring bank deposits. Overall, the system may have greater efficiency, thereby avoiding any future insolvency on the part of the BIF.

Risk-adjusted premiums can be compared to bonds, which monitor corporations through their covenants. Risk-adjusted premiums are a necessary source of market discipline for banks, correcting for the lack of market discipline provided by bank shareholders and bank depositors in the prior system.

Federal deposit insurance with risk-adjusted premiums more closely mimics private insurance and still serves the purpose of providing security for bank deposits. For example, the risk-adjusted premiums charged

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banks that did not engage in risky practices were overcharged for deposit insurance. This created a subsidy which the banks could take advantage of by engaging in riskier activities. Kenneth E. Scott, *Deposit Insurance—The Appropriate Roles for State and Federal Governments*, 53 BROOK. L. REV. 27, 33 (1987); *see also* Broome, *supra* note 40, at 950. This system actually created an incentive for banks to engage in risky activities. Macey & Miller, *supra* note 25, at 1162-65.

44. Pub. L. No. 102-242, 105 Stat. 2236 (1991) (codified in scattered sections of 12 U.S.C.).

45. *See* 12 U.S.C. § 1817(b)(1)(A) (Supp. V 1993) ("The Board of Directors shall, by regulation, establish a risk-based assessment system for insured depository institutions.").

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to riskier banks are analogous to the higher automobile insurance rates a private insurer charges to drivers who pose greater risks of accidents. As already discussed, insurance for bank deposits is necessary in order to avoid bank runs and panics and to avoid a collapse of the financial system.[46]

Risk-adjusted premiums can also be viewed as equivalent to rate monitoring in corporate finance theory.[47] Just as bondholders charge higher interest rates to loan their money for riskier investments, the FDIC now charges higher insurance premiums to riskier banks. Even prior to the FDICIA, the bank regulatory system had in place restrictions on bank activity that are similar to covenants.[48] Bank regulations such as limitations on activities,[49] limitations on investments,[50] and capital adequacy requirements[51] serve the same purpose as restrictive covenants in bond agreements—to restrict the activities of the debtor to activities the debtholder believes to be within an acceptable level of riskiness. Risk-adjusted premiums add another level of control to guard against the moral hazard that was inherent in the federal deposit insurance system prior to the adoption of the FDICIA.

Shareholders and creditors of a firm typically provide market discipline. However, prior to adoption of the FDICIA, the Banking Act provided for little market discipline through either of these parties. The risk-adjusted premiums can, however, serve as a substitute for these forms of market discipline.

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46. *See supra* note 29 and accompanying text.

47. MACEY & MILLER, *supra* note 2, at 266.

48. These restrictions are designed to eliminate bank risks. Macey & Miller, *supra* note 25, at 1165.

49. Banks must keep their activities limited to those that one typically considers to be related to banking. For instance, it has been held that a bank may not provide travel agency services. Arnold Tours, Inc. v. Camp, 472 F.2d 427 (1st Cir. 1972).

50. Examples of bank investments which are not permitted include direct equity investments in real property and certain forms of securities investments. MACEY & MILLER, *supra* note 2, at 173-78.

51. Capital adequacy regulations require banks to maintain sufficient levels of capital against their assets. Two methods for determining if the requirement has been met include leverage ratios and risk-adjusted capital ratios. The leverage ratio method simply compares a bank's assets to its liabilities. The risk-adjusted capital ratio method, however, also considers the risk associated with the particular investments the bank has made in determining whether capital is adequate. MACEY & MILLER, *supra* note 2, at 284-87.

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Shareholders usually have a greater interest in a firm taking large risks, because larger risks may lead to greater gains for them. Shareholders only receive dividends if the firm's income exceeds its payments on debt for a given period. If the firm undertakes a venture that is too risky, the shareholders stand to lose only their initial investment due to the corporation's limited liability. Especially as the firm approaches insolvency, the shareholders have greater incentives to encourage the firm's managers to take larger risks.[52] If the firm is near insolvency, the shareholders probably will not receive anything upon liquidation. Therefore, the greater the risks the shareholders undertake the greater the possibility that they will receive some money, and the risk of losing their initial investment is no longer a concern.

The federal deposit system prior to the adoption of the FDICIA actually encouraged shareholders to take greater risks.[53] Under the old system, all banks were charged at a flat rate. A bank with a reputation for bad business practices would probably underpay for deposit insurance, while a bank with a good reputation would overpay.[54] Since the FDIC would pay all of the deposits upon failure of the bank, and since the banks were already paying for the protection, shareholders had an incentive to take greater risks. Prior to the passage of the Banking Act there was a double liability system, which allowed the bank assessor to charge the shareholders up to the par value of their stock in order to satisfy the debts of an insolvent bank.[55] This system gave bank shareholders an incentive to more closely monitor bank managers, but it was

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52. *See* Scott, *supra* note 43, at 33; *see also* Broome, *supra* note 40, at 968 ("In a limited liability system, as a bank's capital declines, its shareholders have little left to lose from the bank's insolvency. Consequently, they may encourage bank managers to engage in increasingly risky activities which, if successful, will return value to their shares, and, if unsuccessful, will result in little or no further loss to them.").

53. Since the bank was charged a flat fee for deposit insurance, the risk to shareholders was lower, so one could expect the shareholders to take greater risks. Macey & Miller, *supra* note 25, at 1162-65; *see also supra* note 43 and accompanying text.

54. This created the subsidy discussed earlier. *See supra* note 43 and accompanying text.

55. The shareholders could then be responsible for twice their initial investment, once when the stock was bought and a second time when the debts of the failed bank had to be settled. The threat of having to pay twice for bank stock provided an incentive for bank shareholders to monitor the behavior of bank managers. For further information on the double liability system, see Jonathan R. Macey & Geoffrey P. Miller, *Double Liability of Bank Shareholders: History and Implications*, 27 WAKE FOREST L. REV. 31 (1992).

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slowly abolished after Congress passed the Banking Act.[56] The absence of any kind of incentive for shareholders to be careful, coupled with the existence of guaranteed coverage by the FDIC, created a moral hazard problem with bank shareholders.

Without risk-adjusted premiums, depositors have very little incentive to monitor bank managers. Small depositors (accounts under $100,000) are fully covered by the FDIC. As discussed above, when one does not bear the risk of loss, one has no incentive to take steps to avoid that risk.[57] Arguments have been presented in favor of a system of co-insurance, where depositors must pay a deductible and assume responsibility for some of the loss of a failed bank. These arguments have been criticized, however, on the basis that such a system would disproportionately disadvantage small depositors.[58] For example, if deposit insurance did not pay for the first $5000, but paid the remaining amount of the deposit up to $100,000, small depositors would be likely to lose all of their money, while large depositors would lose only a small portion. Likewise, the same reasons that large uninsured depositors do not serve as a good source of market discipline would apply to a system of co-insurance.[59]

Large uninsured depositors (with more than $100,000 in deposits) have been shown to have little incentive to monitor bank managers, and, therefore, they also do not serve as a good source of market discipline. In the past, the FDIC was known to pay uninsured depositors an average of 99.5% of their funds regardless of the amount of their deposit,[60] so in reality the risk of loss to uninsured depositors was very

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56. The Banking Act implemented the federal deposit insurance system, which was believed to be superior to the double liability system. At the time the Banking Act was written, there was much criticism of the double liability system on the grounds that it had failed to protect creditors and had failed to maintain the public's confidence in the banking system. *Id.* at 37-39.

57. *See supra* note 21 and accompanying text.

58. MACEY & MILLER, *supra* note 2, at 270.

59. For a discussion of the ability of uninsured depositors to serve as a source of market discipline, see *infra* text accompanying note 64.

60. Macey & Miller, *supra* note 25, at 1192. In the past, 75% of bank failures have been resolved through purchase and assumption transactions, in which another bank agrees to purchase the assets of the failed bank and to assume its liabilities as well. Assumption of liabilities includes covering uninsured deposits. When a purchase and assumption transaction occurs, the FDIC has to pay the acquiring bank the difference between the assets of the failed bank and the liabilities of the failed bank. Since the acquiring bank also assumes the liability of uninsured deposits, this method

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slight. Since uninsured depositors knew that their losses would be paid by the FDIC regardless of the size of their deposits, there was no incentive for them to monitor.[61]

Brokered deposits have also served to relieve large depositors from having to monitor bank managers.[62] A brokered deposit is one in which the depositor places his funds with a brokerage house, which then divides the money into smaller amounts and places them into a number of different banks that pay the highest interest rates.[63] In this way, the deposits in each individual bank are small enough that they are fully covered by federal deposit insurance. The FDIC will insure funds in each bank up to the $100,000 limit and does not add up the total of funds in a number of different banks. A depositor with $100,000 in a number of different failed banks will receive the entire $100,000 from each bank through the FDIC.

There are additional reasons that large uninsured depositors are not an effective source of market discipline.[64] Uninsured depositors will only monitor up to the point that it is efficient for them to monitor. This level of monitoring will not be sufficient to take into account the total risk, such as the risk that insured deposits may also be lost. Another problem with uninsured depositor monitoring is a lack of information.[65] Without the appropriate information the degree or type of monitoring will be inefficient. The free-rider problem is an additional concern commonly encountered when considering market discipline.[66] Free-riding occurs when all depositors do not monitor bank managers because they are relying on the efforts of others. Therefore, not enough monitoring occurs. A final problem is that the form of market discipline

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of resolution shifts the risk of loss from the uninsured depositor to the FDIC. Broome, *supra* note 40, at 943-45.

61. The FDICIA, however, prohibits payments over $100,000 after December 31, 1994, if such payments would have the effect of increasing the losses in any insurance fund. 12 U.S.C. § 1823(c)(4)(E) (Supp. V 1993).

62. Macey & Miller, *supra* note 25, at 1194.

63. *Id.*

64. There have, however, been arguments that interest rates paid on uninsured certificates of deposit (CDs) can serve as a source of market discipline. Higher interest rates on uninsured CDs are given by banks in which it is riskier to invest. Higher CD rates reflect higher capital costs to shareholders, so shareholders will have an incentive to reduce risk in order to keep the cost of capital low. *See id.* at 1197.

65. Helen A. Garten, *Banking on the Market: Relying on Depositors to Control Bank Risks*, 4 YALE J. ON REG. 129, 139-141 (1986).

66. Macey & Miller, *supra* note 25, at 1203.

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that uninsured depositors may provide is exactly the problem that deposit insurance seeks to avoid—runs and panics on banks.[67]

F. Determination of Insurance Premiums Under the FDICIA

Under the FDICIA, the FDIC is instructed to calculate risk-adjusted premiums based on such factors as the "categories and concentrations of assets," the "categories and concentrations of liabilities," and the "revenue needs of the deposit insurance fund."[68] Other factors that can be considered include interest-rate risk, credit risk, diversification risk, operation risk, risk of fraud or insider abuse,[69] and, as the *O'Melveny & Myers v. FDIC* case shows, the risk of inability to recover under state law.

The FDICIA involves both the federal government and the private sector in determining the rates for insurance, since a system in which either sector acted alone would be unacceptable.[70] The federal government may not be able to judge on its own whether deposit insurance is correctly priced, because it is not in a position of bargaining such as that of a buyer or seller in the private market.[71] Experience with other government programs has shown that the federal government would overprice such insurance.[72] On the other hand, experiences with state-

67. Garten, *supra* note 65, at 156, 160.

68. 12 U.S.C. § 1817(b)(1)(C) (Supp. V 1993).

69. MACEY & MILLER, *supra* note 2, at 276.

70. If the federal government is left to determine risk-adjusted premiums, the judgments may be politically influenced. Concern over allowing the private sector to insure bank deposits, though, stems from the financial requirements of covering bank deposits nationwide. A private insurer is unlikely to have the financial capability to manage deposit insurance systemwide. The federal government, however, can cover the cost through tax revenues. Public confidence in the ability of a private insurer to handle deposit insurance may be weak, leading to bank runs and panics. Scott, *supra* note 43, at 34-36, 40-41. Also, since the banks would have no recourse if they felt the government's assessments were incorrect, the federal government may be "overly sensitive" to overpricing the cost of the deposit insurance. This would result in too low a price for deposit insurance. Herbert Baer, *Private Prices, Public Insurance: The Pricing of Federal Deposit Insurance*, 9 ECON. PERSP. FED. RES. BANK CHICAGO 45, 47 (1985).

71. Baer, *supra* note 70, at 46-47.

72. Federal Crop Insurance has "created incentives to bring low quality land into production" by basing its assessments on average county yields rather than individual farm yields. Publicly operated water projects have underpriced water, "leading to excess demand, water shortages, rationing, and overproduction of certain agricultural

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sponsored private deposit insurance have shown that a private insurance scheme cannot protect against systemwide catastrophes.[73] The FDICIA, therefore, allows the FDIC to acquire private reinsurance[74] for up to 10% of the probable losses of a particular institution.[75] Furthermore, the FDIC may base the rates it charges wholly upon the cost of obtaining the reinsurance.[76] Through this method, the private sector can be used to determine the market rate charged to each institution while keeping federal protection systemwide.

Although the FDICIA was passed in 1991, the FDIC has only recently begun taking steps toward implementing the new risk-adjusted premium system. The FDIC has announced that it will lower the insurance premiums for bank deposits, but will maintain higher rates for savings and loan associations (S&Ls). The premiums paid by most banks will be $.04 per $100 in deposits.[77] S&Ls, in contrast, continue to pay $.23 per $100 in deposits.[78] For banks that pose strong risks of failure, the rate will be $.31 per $100.[79] This action by the FDIC will pose "a competitive problem"[80] for S&Ls. These "competitive problems" will serve as the source of market discipline necessary to lower the riskiness of thrift institution activities. If the riskiness of S&Ls is lowered, the market discipline instituted through this difference in insurance premiums may accomplish the goals of the FDICIA—to reduce the number of failures and to recapitalize the deposit insurance fund.[81]

Private reinsurance may reduce the need for other forms of regulation.[82] Forms of regulation such as limitations on entry, limitations on

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products." *Id.* at 47.

73. *Id.*; *see also* Scott, *supra* note 43, at 40.

74. Reinsurance is a method by which the insurer contracts with a third party (the reinsurer) to insure itself in whole or in part against the contingency that it may have liability on the original insurance contract with the insured. *See generally* Baer, *supra* note 70.

75. 12 U.S.C. § 1817(b)(1)(B)(i) (Supp. V 1993).

76. 12 U.S.C. § 1817(b)(1)(B)(ii) (Supp. V 1993).

77. Albert R. Karr, *FDIC Proposes to Cut Banks' Premiums for Deposit Insurance but Not Thrifts'*, WALL ST. J., Feb. 1, 1995, at A2.

78. *Id.*

79. *Id.*

80. *Id.*

81. In the case of S&Ls, this fund is the Savings Association Insurance Fund (SAIF), which is separate from the BIF, but which is also managed by the FDIC. *See* MACEY & MILLER, *supra* note 2, at 61.

82. Broome, *supra* note 40, at 958.

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activities, limitations on investments and capital adequacy requirements may not be necessary if market forces in the form of risk-adjusted premiums discourage banks from engaging in regulated activities. There would be little incentive to engage in behaviors that increase the bank's insurance premiums. Further, if a bank engages in activities that are too risky, the FDIC may not be able to obtain private reinsurance for that institution.[83] This could be a warning signal to the FDIC that such an institution is engaging in unsound business practices or is already insolvent. Federal regulation may become less stringent, since the private insurance market could take over the task of monitoring bank behavior in determining insurance rates. Market forces could then be used to determine when a bank should cease operating.[84]

Now that the background material on risk and the need for federal deposit insurance has been discussed, the facts and ruling in the case of *O'Melveny & Myers v. FDIC*[85] will be examined. Following this, the Note will proceed to an analysis of the case and its impact on the administration of federal deposit insurance.

III. *O'MELVENY & MYERS v. FDIC*

A. *Facts and Procedural History*

American Diversified Savings Bank (ADSB), a California-chartered and federally insured savings and loan association, was owned by Ranbir Sahni and Lester Day, who served as ADSB's chief executive officer and president, respectively.[86] The principal business of ADSB was the purchase, development and sale of real estate through limited

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83. Baer, *supra* note 70, at 53.

84. Some commentators have argued that this would be superior to the present system, because it would close banks that are in serious financial difficulty before they become insolvent. Under the current regulatory system, the shareholders have an incentive to keep the bank running as long as possible in the hope of regaining some of their investment. This is undesirable because it keeps the bank running beyond the point when it could be profitable and dissipates assets, so that the FDIC has to pay more to satisfy deposits. Under the private reinsurance system, a bank can be closed when it can no longer receive reasonable insurance, while the assets of the bank can still be used efficiently. *Id.* at 53-55.

85. 114 S. Ct. 2048 (1994).

86. FDIC v. O'Melveny & Myers, 969 F.2d 744, 746 (9th Cir. 1992), *rev'd*, 114 S. Ct. 2048 (1994).

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partnerships sponsored by ADSB.[87] These transactions were financed through ADSB's deposits, which were insured by the Federal Savings and Loan Insurance Corporation (FSLIC).[88]

In September of 1985, ADSB retained the law firm of O'Melveny & Myers to assist with the Wells Park and Gateway Center real estate transactions.[89] O'Melveny & Myers was retained in order to prepare "private placement memoranda" (PPMs), which were designed to encourage outside investors to become limited partners in these real estate ventures. O'Melveny & Myers was responsible for writing portions of the PPMs, editing other portions, and performing due diligence review of these documents to confirm their accuracy and completeness of disclosure.[90] The PPMs also included representations of the financial and regulatory health of ADSB. The facts as stipulated at the trial level revealed that Sahni, Day and ADSB's executive vice president, Wyn Pope, had manipulated the books of ADSB in order to fraudulently misrepresent the value of ADSB's assets. They had also made a pretense of sales of assets in order to inflate profits and to mask ADSB's dwindling performance.[91]

During the preparation of the documents designed to lure investors into the real estate ventures, O'Melveny & Myers never communicated with any accounting firm retained by ADSB, any of ADSB's federal or state regulators, or ADSB's chief financial officer.[92] Within a span of only seven months (April 1985 through October 1985), ADSB had retained three different accounting firms.[93] The third firm was engaged after its predecessor, Arthur Young & Company, began to express concerns about ADSB's financial condition.[94] In addition, ADSB's first accounting firm, Touche, Ross & Company, had informed federal regulators and ADSB's previous attorneys, Rogers & Wells, that it believed

87. *Id.*

88. *Id.* Congress passed the Financial Institutions Reform, Recovery and Enforcement Act (FIRREA) of 1989, Pub. L. No. 101-73, 103 Stat. 183 (1989), which abolished the FSLIC and transferred the FSLIC's responsibilities to the management of the FDIC. The FDIC was substituted for the FSLIC as a party to this case under FIRREA § 401(f)(2). FDIC v. O'Melveny & Myers, 969 F.2d at 746 n.2.

89. FDIC v. O'Melveny & Myers, 969 F.2d at 746.

90. *Id.*

91. *Id.*

92. *Id.* at 747.

93. *Id.* at 746.

94. *Id.*

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ADSB's net worth to be less than zero within the five months before the private placement offerings were made.[95] Despite such activity, O'Melveny & Myers never checked with any of these parties to question the representations that ADSB made to the law firm concerning its financial status. The real estate transactions were completed, however, on December 31, 1985.[96]

On February 14, 1986, after determining that ADSB was insolvent, the FSLIC stepped in as conservator.[97] The FSLIC found that ADSB had violated laws and regulations and had engaged in unsafe and unsound business practices resulting in a dissipation of ADSB's assets.[98] The FDIC, after stepping in as conservator, filed suit against Sahni and Day, in the United States District Court for the Central District of California, alleging breach of fiduciary duty.[99] After the FDIC took over as receiver, it began receiving complaints from investors involved in the Wells Park and Gateway Center deals alleging that the PPMs misled them into investing.[100] The FDIC ordered the partnerships to rescind the deals and to return the investors' money.[101] In exchange, the investors assigned their claims to the FDIC.[102] The FDIC subsequently brought suit against O'Melveny & Myers, charging the firm with professional negligence, negligent misrepresentation and breach of fiduciary duty for failing to make efforts to discover ADSB's fraudulent conduct and for failing to protect the investors.

On a motion for summary judgment, O'Melveny & Myers argued that the conduct of ADSB's officers must be imputed to ADSB. The firm asserted that the FDIC, as receiver, now stood in the shoes of ADSB and that, as an ordinary assignee, the FDIC was barred from bringing a claim against O'Melveny & Myers.[103] The district court

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95. *Id.*

96. *Id.* at 747.

97. *Id.* See *supra* note 88 for an explanation of the impact of FIRREA on this case. The FDIC was later appointed as receiver under FIRREA § 104(f)(2).

98. FDIC v. O'Melveny & Myers, 969 F.2d at 747.

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. Under California law, an attorney has a duty to make an independent investigation into information supplied by the corporation that is intended to be used by investors. Koehler v. Pulvers, 614 F. Supp. 829 (S.D. Cal. 1985). Also, under California law, a "corporation is a distinct legal entity separate from its stockholders and from its officers." Maxwell Cafe v. Department of Alcoholic Beverage Control, 298

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granted summary judgment in favor of O'Melveny & Myers on the ground that it found no genuine issue of material fact.[104] The FDIC appealed this ruling to the United States Court of Appeals for the Ninth Circuit.

B. Opinion of the Ninth Circuit Court of Appeals

The Ninth Circuit Court of Appeals reversed the district court's summary judgment ruling on the ground that federal common law, not California law, should apply to a dispute involving the FDIC as receiver. The court held that even if the knowledge of Sahni and Day could be imputed to ADSB, making it impossible for ADSB to bring suit against O'Melveny & Myers, such a rule does not necessarily extend to the FDIC.[105] Following precedent in *D'Oench, Duhme & Co. v. FDIC*[106] and *FDIC v. Bank of San Francisco*,[107] the court held that

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P.2d 64, 68 (Cal. Dist. Ct. App. 1956). But, the corporation is presumed to have knowledge of all facts known to its managing officers. Blue Diamond Plaster Co. v. Industrial Accident Comm'n, 205 P. 678 (Cal. 1922). In this case, O'Melveny & Myers argued that ADSB was barred from bringing a malpractice claim against the firm due to equitable principles. O'Melveny & Myers argued that it was inequitable for ADSB, to which the knowledge of its officers is imputed, to bring a claim against the law firm for ADSB's own wrongdoing. The firm also argued that the FDIC, as receiver, likewise should have been barred from bringing the claim, because California law holds that a receiver

> occupies no better position than that which was occupied by the person or party for whom he acts and the receiver takes the property and the rights of one for whom he was appointed in the same condition and subject to the same equities as existed before his appointment and any defense good against the original party is good against the receiver.

Allen v. Ramsay, 4 Cal. Rptr. 575, 583 (Cal. Dist. Ct. App. 1960). Under this principle, if the knowledge of Sahni and Day could be imputed to ADSB, it would also be imputed to the FDIC as receiver.

104. FDIC v. O'Melveny & Myers, 969 F.2d at 747.

105. *Id.* at 751.

106. 315 U.S. 447 (1942). In *D'Oench, Duhme & Co.*, the FDIC sued for payment on a demand note. The central issue in the case was which law should be applied in deciding liability under the note. The Court held that federal law should apply, because the FDIC is a federal corporation acting under an act of Congress.

107. 817 F.2d 1395 (9th Cir. 1987). In *Bank of San Francisco*, the FDIC brought suit against the issuer of a letter of credit. The issuing bank had refused to pay, because the institution for which the FDIC was acting as receiver had fraudulently secured the letter of credit. The court held that federal common law was to govern the decision in a suit brought by the FDIC, because such a suit arises under the

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federal, not state, law should govern the application of defenses against the FDIC specifically. The court also held that, while it may look to state law to fashion the federal law, it does not have to do so.[108] The court decided not to follow California law on this issue and instead fashioned a federal law that was more "equitable."[109]

In fashioning this "equitable" law, the court held that, under federal common law, "the equities between a party asserting an equitable defense and a bank are at such variance with the equities between the party and a receiver of the bank that equitable defenses good against the bank should not be available against the receiver."[110] The court reasoned that a receiver does not voluntarily "step into the shoes" of the failed institution, but is forced into the position.[111] Since the FDIC did not voluntarily assume its position as receiver, it should not be subject to the same equitable defenses as the failed institution. The Ninth Circuit stated that allowing such defenses against the receiver would frustrate the federal regulatory scheme designed to protect third parties against the bank's wrongdoing.[112] In light of these findings, the court reversed the summary judgment ruling of the district court and remanded the case for further consideration consistent with its opinion. O'Melveny & Myers appealed to the United States Supreme Court.

C. Opinion of the United States Supreme Court

The United States Supreme Court reversed the Ninth Circuit's decision on the grounds that state law, not federal common law, should govern the dispute. The Court stressed that the cause of action at issue was created by California law, and California, therefore, should have the authority to determine the attributes of that law.[113] Under the precedent of *Erie Railroad Co. v. Tompkins*,[114] the Court flatly stated that there is no general federal common law. The Court held that the FDIC in its position as receiver only succeeded to the rights of the failed

laws of the United States.

108. FDIC v. O'Melveny & Myers, 969 F.2d at 751.

109. *Id.*

110. *Id.* at 752.

111. *Id.* at 751.

112. *Id.* at 752.

113. O'Melveny & Myers v. FDIC, 114 S. Ct. 2048, 2052-54 (1994).

114. 304 U.S. 64 (1938).

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institution.[115] If ADSB would have been subject to the laws of California on imputation of knowledge, then so too should the FDIC in its position as receiver. The Court found support for this position in the subsection captioned "Powers and Duties of [the FDIC] as . . . Receiver,"[116] which states that the FDIC as receiver shall "by operation of law, succeed to—all rights, titles, powers, and privileges of the insured depository institution." Since the FDIC as receiver "steps into the shoes" of the failed institution, it obtains the rights and liabilities of that failed institution as they existed prior to the receivership. Unlike the Ninth Circuit, the Supreme Court found no conflict between federal policy and state law strong enough to warrant the application of a federal common law rule to such a dispute.[117] The Supreme Court, therefore, reversed the Ninth Circuit Court of Appeals and remanded the case for determination consistent with its decision.

IV. ANALYSIS

The Supreme Court's decision in *O'Melveny & Myers v. FDIC*[118] supplements the reformed federal deposit insurance system by fostering the development of market discipline. When ADSB's officers engaged in their illegal acts, the FDIC still operated under the flat-fee system, but when the case was decided by the Supreme Court the new system of risk-adjusted premiums was in place. Even though the FDIC could not have avoided the losses incurred in this case, the decision may affect the manner in which such institutions will be dealt with by the FDIC in the future.

The effect of the decision in *O'Melveny & Myers* is more significant now that the FDIC operates under a risk-adjusted premium system. Specifically, this decision may force the FDIC to consider the impact of the laws of the state in which the insured institution resides on the risk associated with insuring that institution. If state law is applicable in determining the defenses available against the claims brought by the FDIC in any given dispute, then consideration of state law may have an effect on the rate of deposit insurance charged to any bank within that particular state. In this case, since the FDIC is unable to recover from

115. O'Melveny & Myers v. FDIC, 114 S. Ct. at 2054.
116. 12 U.S.C. § 1821(d)(2)(A)(i) (Supp. V 1993).
117. O'Melveny & Myers v. FDIC, 114 S. Ct. at 2055-56.
118. 114 S. Ct. 2048 (1994).

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O'Melveny & Myers under California law, the FDIC will have to add that possibility to its risk in insuring deposits in other California banks.

Having risk-adjusted premiums makes federal deposit insurance more analogous to private insurance, which also guards against moral hazard by charging higher premiums for increased risk. Without risk-adjusted premiums, there was little market discipline for deposit insurance. With risk-adjusted premiums in place, depositors are still fully insured and, therefore, will not be a source of market discipline, but shareholders may want bank managers to keep risks low in order to reduce costs. If a state has laws that increase the risk to the FDIC in insuring an institution within that state, the state may be motivated to change the law or else all of its banks may face higher costs.

The Supreme Court's decision in *O'Melveny & Myers* allows states to set their own requirements for fiduciary liability, but still allows market forces to influence each state's decision in setting that liability standard. Allowing states rather than the federal government to set their own fiduciary standards seems preferable, since the states may have better knowledge of their own needs. The individual states may be more qualified to evaluate their risks than the federal government. The states may be more familiar with local markets and economies and may be in a better position to evaluate the methods for dealing with those local market forces. Nevertheless, allowing individual states to set their own standards for fiduciary liability could result in a *race to the bottom.*[119] That is, as states continue to compete for business, they must continue to lower their regulatory standards in order to remain attractive to business. Therefore, to be more competitive, states may lower their standards for fiduciary liability. In the absence of risk-adjusted premiums, there would be little incentive for the states to have fiduciary liability, since the federal government through deposit insurance will be the one to bear the cost of poor monitoring by fiduciaries.

With risk-adjusted premiums, however, market forces may guide the states in determining the appropriate level of fiduciary liability in any given situation. Banks in states in which fiduciary standards are lower may be subjected to higher insurance premiums for deposit insurance. Higher insurance premiums could result in higher operating costs, higher interest rates on loans or lower interest rates on deposits. This may

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119. This phrase (originally termed "the race for the bottom") was invented by Professor William L. Cary in William L. Cary, *Federalism and Corporate Law: Reflections Upon Delaware*, 83 YALE L.J. 663, 666 (1974).

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give depositors and those looking to borrow money an incentive to go to out-of-state banks, causing in-state banks to lose business. In order to lower their costs and regain some business, the in-state banks may be forced to make contracts with fiduciaries concerning their level of fiduciary liability. Through these interactions market forces may be allowed to determine the optimal level of fiduciary liability for any given situation. This optimal level of fiduciary liability may differ from state to state or from bank to bank. If transaction costs involved in making these contracts with fiduciaries become too expensive for banks, the states could step in and set an optimal level of fiduciary liability. This level of liability may be determined, however, by market forces through the risk-adjusted premiums, not from a race to the bottom, which could result in the federal government bearing the cost.

V. CONCLUSION

The United States Supreme Court's decision in *O'Melveny & Myers v. FDIC*[120] supplements the move toward introducing risk-adjusted premiums into the federal deposit insurance system. Prior to the adoption of the FDICIA, the federal deposit system lacked sufficient market discipline. The concept of risk-adjusted premiums, however, may serve as a substitute for market discipline in the system. Determining the optimal level of fiduciary liability for law firms such as O'Melveny & Myers can become a function for the market if states compete to lower their banks' federal deposit insurance premiums. This may be superior to allowing the federal government to set the standards for fiduciary liability, because the federal government is not in as good a position as the individual states or the market to determine the appropriate level of liability for any given state. States are more capable of assessing their own needs. By allowing the states to set the standard of liability, and by introducing market forces through private reinsurance, the optimal level of fiduciary liability can be set by the market and the need for the federal government to assess the risk of insuring any particular institution may be reduced.

While it is difficult to know the exact effects that the system will have on the banking industry once it is fully in operation, some reasonable predictions can be made. The system of private reinsurance and risk-adjusted premiums may decrease the degree of federal involvement

120. 114 S. Ct. 2048 (1994).

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in the banking industry. Market forces could determine optimal levels of activity in many areas besides fiduciary activities. With the private market influencing the activities of banks, the federal system of bank regulation may become less cumbersome, without risking an increase in the number of bank failures. The states may also be able to lessen their regulations of banks within the state because of this change in insurance. Furthermore, the states may be forced to change a number of their laws in order to make banks within their state more competitive. This will not necessarily lead to a set of uniform laws surrounding the banking industry, since each state's laws may differ based on factors which increase the risk of deposit insurance within that particular state. *O'Melveny & Myers*, therefore, might be viewed as expressing the Supreme Court's faith that a race to the bottom may not occur and that regulatory competition between the states may provide the best banking system.

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LIAR'S POKER: THE EFFECT OF INCONTESTABILITY CLAUSES AFTER *PAUL REVERE LIFE INSURANCE CO. V. HAAS*

Katherine Cooper[*]

I. INTRODUCTION

Incontestability clauses have long been used in insurance contracts to provide customers with a sense of security that their claims will be paid. Generally, the clauses operate as a bar to the insurance company's defenses against payment after a specific period of time has passed. In most states, incontestability clauses are required in life, health and disability insurance policies in order to encourage consumer confidence and reduce insurer contests to the policies based on information given in the application form.[1]

In *Paul Revere Life Insurance Co. v. Haas*,[2] the Supreme Court of New Jersey addressed the question of whether a statutorily required incontestability clause should be interpreted to override the effect of fraudulent misstatements made by the insured when he applied for disability insurance coverage. The answer given was no. This Note will address why that decision was wrong.[3]

In *Haas*, the plaintiff-appellant, Paul Revere Life Insurance Company (the insurance company), had a choice of using one of two statutorily required incontestability clauses in the policy purchased by defendant-respondent Gilbert K. Haas (Haas). One of the clauses included a provision that voided the incontestability clause if fraudulent misrepre-

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1. Such contests were often made for frivolous reasons, thereby unfairly canceling an insured's policy at the time the benefits were needed. This frequently occurred after the insured had paid premiums for many years. See discussion *infra* pp. 228-29.

2. 644 A.2d 1098 (N.J. 1994).

3. This Note does not address the issue of prior manifestation.

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sentations were made on the application form. However, the insurance company chose the other option, which had no such provision for fraud. By choosing the second option, the insurance company had fair warning that it could not use fraudulent misrepresentation as a defense to payment. Prior to underwriting the contract, the insurance company had the opportunity to weigh the risk of misrepresentation against the marketing benefits presumably gained from using the more restrictive clause. Thus, when the insurance company determined that Haas had misrepresented information on his application form, it should have paid the benefits promised by the contract.

By allowing the insurance company to contest the validity of the contract, the court in *Haas* erroneously interpreted the incontestability clause contained in the contract. This interpretation destroyed the meaning of the New Jersey incontestability statute and undermined the ordinary intent of incontestability clauses.

This erroneous interpretation also places the judiciary in a position to determine the level of risk to be assumed by insurance companies. This is not the proper role of the judiciary. It is the responsibility of the legislature, as it regulates agencies, and each insurance company to determine the level of risk that will be assumed in an insurance policy. The *Haas* decision allows the judiciary to improperly usurp the role of the legislature in regulating insurance practices.

The precedent established by *Haas* has the potential to eliminate the protection that all incontestability clauses are intended to provide. As explained below, incontestability clauses are required by statute in most states because they fulfill numerous public policy goals. Overriding the incontestability clause ignores the benefits such clauses provide to individual consumers, insurance companies and society at large. Although it is logical to argue that incontestability clauses should not be used to benefit people who intentionally defraud insurance companies, there are many cases in which it is unclear whether fraud took place or an honest mistake was made. In enacting required incontestability clauses, state legislatures have weighed the risk of fraud against the risk of unfair, anticonsumer results, and have determined that requiring the clauses achieves the greater good. In addition, the incontestability statute in New Jersey, like that of most states, allows insurers to choose an option that makes fraud an exception to incontestability. Thus, a provision that allows for stricter control of fraud is available within the statute.

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The insurance company in *Haas* should have been required to fulfill its obligation under the contract as provided by the incontestability clause that it chose to include in the policy.

II. Background: History, Public Policy and Methods of Interpreting Incontestability Clauses

A. *The Evolution of Incontestability Clauses*

1. The Meaning of "Incontestable"

An incontestability clause operates like a statute of limitations to restrict the grounds of contest available to insurance companies.[4] It prevents the insurance company from denying a claim by invalidating portions of the policy or by rescinding the whole contract. After a specified period of time,[5] the insurer may not raise any defenses to a claim based on material misrepresentations made by the insured at the time of application for coverage. Incontestability clauses allow the insurer time to investigate the information given by the insured if the insurer wishes to deny coverage based on such information contained in the application form.[6] During the investigation period allowed by the statute, all defenses are available to the insurer.[7]

Although incontestability clauses are found most commonly in life insurance policies, they are also used frequently in disability insurance contracts.[8] When a disability policy contains an incontestability clause, the insurer's defenses are limited to challenges related to the particular disability, rather than the validity of the contract itself, once the contestable period ends.[9]

4. V.G. Lewter, Annotation, *Construction of Incontestable Clause Applicable to Disability Insurance*, 13 A.L.R.3d 1383, 1384 (1967).

5. Most incontestable clauses specify a period of two years in which the insurance company may contest information given in the application form. MURIEL L. CRAWFORD & WILLIAM T. BEADLES, LAW AND THE LIFE INSURANCE CONTRACT 423 (6th ed. 1989).

6. 18 GEORGE J. COUCH, COUCH CYCLOPEDIA OF INSURANCE LAW § 72:2 (Ronald A. Anderson ed., 2d ed. 1984).

7. *Id.* § 72:16.

8. Lewter, *supra* note 4, at 1384.

9. *Id.* at 1386.

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2. History

Incontestability clauses have been used in the insurance industry for more than 100 years to encourage customers to purchase insurance.[10] At first, insurers offered incontestability clauses in life insurance policies in an effort to counter public distrust of insurance companies.[11] Eventually, state legislatures began to require the clauses. These state laws were enacted in an attempt to protect the average consumer from the power discrepancy that existed between large corporations and individual consumers.[12] Before incontestability clauses were used, the insured would commonly pay premiums for a long period of time only to have the insurance company void the contract for some minor reason when it came time to pay benefits.[13] The early incontestability clauses were designed to protect consumers from the "greed and ruthlessness of insurers" who "too often . . . resisted liability stubbornly on the basis of some misstatement made by the insured at the time of applying for the policy."[14]

Today, most states have statutes requiring such clauses in life, health and disability insurance policies.[15] Most of these statutes exist

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10. Erik K. Fosaaen, *AIDS and the Incontestability Clause*, 66 N.D. L. Rev. 267, 267 (1990). By 1905, the majority of American insurers offered policies containing incontestability clauses. An English insurer, London Indisputable Life, was the first insurer on record to include an incontestability clause in an insurance contract. In the United States, the Manhattan Life Insurance Company was the first company to offer a policy containing an incontestability clause. CRAWFORD & BEADLES, *supra* note 5, at 424.

11. CRAWFORD & BEADLES, *supra* note 5, at 424.

12. Fosaaen, *supra* note 10, at 268-70. Most early incontestability clause statutes were spurred by the actions of the Armstrong Commission, a committee headed by Senator William W. Armstrong, which conducted an in-depth investigation of the entire insurance industry in 1905. As a result of its investigation, the committee drafted model insurance policies and included incontestability clauses in its model life insurance policies. The standards set by the Armstrong Commission were adopted by many state legislatures.

In 1946, the National Association of Insurance Commissioners (NAIC) drafted a model incontestability clause statute. This model statute for life insurance policies has been adopted by at least 47 states. *Id.*

13. CRAWFORD & BEADLES, *supra* note 5, at 424.

14. 7 SAMUEL WILLISTON, A TREATISE ON THE LAW OF CONTRACTS § 912, at 394 (Walter H.E. Jaeger ed., 3d ed. 1963).

15. *See generally* Lewter, *supra* note 4.

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to promote certainty of payment and reduce litigation.[16] However, the specific function of incontestability clauses has at times been the subject of debate. The generally accepted view is that an incontestability clause removes all misstatements, including fraud, as the basis for a coverage defense after the contestable period expires.[17] Thus, unless an incontestability clause contains an exception for fraud, the insurer may only assert the defense of fraud during the contestable period.[18]

3. Public Policy

Incontestability clauses "are generally regarded as valid, being neither unreasonable nor against public policy."[19] In fact, strong public policy reasons exist for the enforcement of incontestability clauses. In the words of Chief Justice Oliver Wendell Holmes, "The object of the [incontestability] clause is plain and laudable—to create an absolute assurance of the benefit, as free as may be from any dispute of fact except the fact of death, and as soon as it reasonably can be done."[20]

Incontestability clauses put a "checkmate" on litigation, reducing costs to insurance companies, insureds and society.[21] The clauses also avoid the problem of having to rely on stale evidence in a contract dispute by preventing battles over information provided by the insured years before coverage was claimed.[22] Incontestability clauses provide insurers with a substantial amount of time to investigate the information provided in the application form, yet prevent them from "lulling the insured into a sense of security, only to litigate the issue later."[23]

The most important public policy reason for the inclusion of incontestability clauses in insurance contracts is to protect insureds from the consequences of unintentional misrepresentation and to increase the security of the policy.[24] "[I]t is generally agreed . . . that life insurers

16. Wischmeyer v. Paul Revere Life Ins. Co., 725 F. Supp. 995, 1000 (S.D. Ind. 1989).

17. *See* Fosaaen, *supra* note 10, at 272 nn.32-35.

18. *Id.* at 272.

19. COUCH, *supra* note 6, § 72:3.

20. Northwestern Mut. Life Ins. Co. v. Johnson, 254 U.S. 96, 101-02 (1920).

21. 1A JOHN ALAN APPLEMAN & JEAN APPLEMAN, INSURANCE LAW AND PRACTICE § 311, at 311 (1972).

22. *Id.* at 306.

23. Maxwell v. Cumberland Life Ins. Co., 748 P.2d 392, 395-97 (Idaho 1987).

24. Strawbridge v. New York Life Ins. Co., 504 F. Supp. 824, 829 (D.N.J. 1980).

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originally included the incontestable clause as a waiver of their right to contest the policy for misstatements by the applicant."[25] In this manner, insurers provided insureds with peace of mind that their policies would be honored when benefits were needed. The clauses effectively balance the interests of both the insured and the insurer by adding to the security of the policy while still providing ample time for the insurer to investigate information contained in the application.

The validity of these public policy objectives has been recognized and accepted in most jurisdictions. In *Wischmeyer v. Paul Revere Life Insurance Co.*,[26] it was noted that:

> [the statute] clearly reflects a legislative mandate that if an insured is not disabled for two years after issuance of the policy, then his claim for benefits cannot be denied on the grounds that he had a pre-existing condition . . . . By use of this precise language, the legislature struck a balance. The clause protects an insured who is healthy enough to work throughout the two-year period from losing the security of disability insurance because of some prior condition that might eventually disable him. On the other hand, the insurer is protected in that it is not precluded from denying benefits to an applicant whose pre-existing condition is so bad that he becomes disabled during the two-year period.[27]

This greater level of security provides an incentive to consumers to purchase insurance. Society benefits from this incentive because private individuals who have insurance for their life, health and disability needs are less likely to become a financial burden on the community.[28]

Life, health and disability insurance policies enable people to invest over the long term in order to support themselves when they face financially difficult times. The inclusion of incontestability clauses in insurance policies is justifiable because insurance contracts have this

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25. CRAWFORD & BEADLES, *supra* note 5, at 425.

26. 725 F. Supp. 995 (S.D. Ind. 1989).

27. *Wischmeyer*, 725 F. Supp. at 1001-02 (construing a statute similar to the one at issue in *Haas*).

28. The public policy objective of encouraging citizens to privately insure against future financial needs was confirmed in Strawbridge v. New York Life Ins. Co., 504 F. Supp. 824 (1980). The *Strawbridge* court stated: "In view of the unequal bargaining position of applicants and insurance companies, the State has enacted protective legislation to limit this power of rescission." *Id.* at 829.

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unique nature. "Insurance is affected with a public interest, and is therefore . . . subject to reasonable control for the public good."[29] Adequate insurance is a necessity to maintaining financial solvency through many life crises. Society's need for such products, combined with the insurance industry's history of contesting policies for minor, technical reasons,[30] makes incontestability clauses a reasonable and necessary requirement.

Although incontestability clauses may be considered beneficial to society overall, insurance companies have valid concerns about fraud and abuse. As discussed in Appleman's treatise on insurance law, the type of incontestability clause contained in most policies does present an opportunity for abuse.[31] If an applicant chooses to gamble by giving false information when purchasing a policy, he or she will usually succeed in obtaining benefits if the insurance company does not discover the misrepresentation until after the contestable period has passed.[32] However, as Appleman points out, "only a minuscule percentage of the population ever resorts to such devious conduct, and it is considered desirable to have a cutoff time as to ordinary misrepresentations."[33]

It is important to note that an incontestability clause does not entirely relieve either party from the consequences of fraud. Rather, an incontestability clause fixes "a reasonable time within which the defense of fraud may be successfully urged."[34] As explained in *Couch*:

> The opportunity and facility afforded the insurer for investigating and discovering fraud within the time prescribed, by a clause making the policy incontestable for any cause after one year, is not contrary to public policy as tending to condone or promote fraud, even though construed as a bar to the defense of fraud in obtaining the policy.[35]

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29. Foster v. Washington Nat'l Ins. Co., 192 A. 59, 61 (N.J. 1937).

30. CRAWFORD & BEADLES, *supra* note 5, at 424.

31. APPLEMAN & APPLEMAN, *supra* note 21, § 311 at 305-06.

32. *Id.* at 305.

33. *Id.*

34. COUCH, *supra* note 6, § 72:15.

35. *Id.* § 72:4. Couch points out that even an incontestability clause that goes into effect on the date of purchase, thereby eliminating the insurance company's opportunity to search for fraudulent misrepresentation, may still be valid and not contrary to public policy. *Id.* § 72:5.

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While there is awareness of the potential for abuse, most state legislatures require that insurance companies take this risk because the loss incurred through occasional fraud is outweighed by the overall gains to society achieved by using incontestability clauses.

Furthermore, by requiring incontestability clauses, legislatures have created an incentive for the insurance company to investigate an insured's history before obligating itself to cover the applicant.[36] This pressure to investigate sooner rather than later acts to quickly curb fraud before substantial time or money is invested in the policy by both the insurer and insured.

B. *The Statutory Requirement for the Incontestability Clause in* Paul Revere Life Insurance Co. v. Haas

1. The Mandate of the New Jersey Legislature

New Jersey law requires insurance companies that write disability policies to include an incontestability clause in each policy sold. Insurance companies may choose one of two incontestability clauses for their policies.

The relevant statute reads:

> There shall be a provision as follows:
> Time limit on certain defenses:
> a. After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 2-year period.
> . . . .
> (2) A policy . . . [such as Haas's] may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption
> "INCONTESTABLE":

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36. Velez Gomez v. SMA Life Assurance Co., 793 F. Supp. 378, 382 (D.P.R. 1992).

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> After this policy has been in force for a period of 2 years during the lifetime of the insured, (excluding any period during which the insured is disabled) it shall become incontestable as to the statements contained in the application.
>
> b. No claim for loss incurred or disability (as defined in the policy) commencing after 2 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss and [sic] existed prior to the effective date of coverage of this policy.[37]

In *Wischmeyer v. Paul Revere Life Insurance Co.*,[38] the United States District Court for the District of Indiana interpreted a similar statute and found the mandate of the clause to be as follows:

> 1. If an insured files a claim for disability;
> 2. And, if that disability began after two years from the date of issue;
> 3. Then the insurer *cannot* deny the claim because of a pre-existing condition.[39]

The court went on to say that "[a]lthough the same provision could have been drafted with more clarity, this is the only possible construction of the particular clause in question."[40]

2. Paul Revere's Choice

Paul Revere Life Insurance Company chose the incontestability clause option that did not contain extended insurer protection against fraudulent misstatements. Assuming that the insurance company used an average level of diligence in designing its policy, it is reasonable to assume that the insurance company chose the second incontestability option for a reason. Increased marketability is the most likely reason.

Incontestability clauses are generally "included in the policies to affect their saleability."[41] Even when such clauses are required by stat-

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37. N.J. STAT. ANN. § 17B:26-5 (West 1985).

38. 725 F. Supp. 995 (S.D. Ind. 1989).

39. *Id.* at 1001.

40. *Id.*

41. Malloy v. New York Life Ins. Co., 103 F.2d 439, 445 (1st Cir. 1939), *cert. denied*, 308 U.S. 572 (1939).

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ute, insurance agents undoubtedly point out the clause to potential buyers and explain that coverage may not be denied after a period of time.[42] Thus, it follows that when given the choice between two clauses, an insurance company would choose the clause that would result in increased sales or in some other benefit to the company. If potential fraud was enough of a threat to the insurance company, the company could have chosen the option that offered long-term protection against fraud. Accordingly, it is likely that Paul Revere knowingly took on the risk of fraud in exchange for the marketing benefits provided by the incontestability option it chose.

C. *Interpreting Incontestability Clauses*

Straightforward interpretation of incontestability clauses is difficult because the clauses have an effect that is counterintuitive to traditional legal principles. Incontestability clauses directly oppose the basic rule of contract law that fraud vitiates a contract. When an incontestability clause is present in an insurance contract, that basic tenet of contract law must be revised to say that fraud vitiates a contract *unless* the contract contains an incontestability clause and the incontestable period has expired.[43]

In construing incontestability clauses, there has been debate over whether the clauses protect only the validity of the entire policy, or if the clauses may prevent a defense to specific claims. Generally, courts agree that the incontestability clause "relates to the validity of the contract and not to the construction of policy provisions."[44] Thus, an insurer may contest a claim if other portions of the policy support such a defense to payment. However, an insurer may not contend that the policy is entirely void.

The difficulty in interpreting incontestability clauses arises from the fact that exceptions and limitations to incontestability clauses, such as exceptions for deaths that occur during war or airplane crashes, should

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42. Plotner v. Northwestern Nat'l Life Ins. Co., 183 N.W. 1000, 1003 (N.D. 1921). For example, in Provident Life & Accident Insurance Co. v. Altman, 795 F. Supp. 216 (E.D. Mich. 1992), the insurance company admitted that it did not include an exception for fraud (although allowed to do so by the Michigan statute) because "the omission made the policy 'more marketable.'" *Id.* at 222.

43. CRAWFORD & BEADLES, *supra* note 5, at 423.

44. Button v. Connecticut Gen. Life Ins. Co., 847 F.2d 584, 588 (9th Cir. 1988) (applying Arizona law), *cert. denied*, 488 U.S. 909 (1988).

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not logically be honored if the clause makes the contract truly incontestable. These exceptions muddy the waters of interpreting incontestability clauses because a plain reading of an incontestability clause is that it prohibits all defenses to the contract's validity that may be made by the insurer. When exceptions are allowed, it becomes unclear what the insurer means by the words "contest" and "defense," because if a circumstance falls under one of the exceptions, the insurer still may successfully contest the policy or defend against the claim.[45]

Yet such exceptions have been accepted by the courts.[46] If these exceptions had not been honored by the courts, incontestability clauses would likely be strictly enforced and given their intended effect—as absolute waivers, after a period of time, of any legal right to challenge a contract's validity.[47] However, exceptions to incontestability clauses do exist; thus, the clauses are subject to various degrees of enforcement and methods of interpretation.

1. Applying a Plain Meaning Reading

In interpreting the language of an insurance policy, the court should seek to effectuate the expectations of the average policy buyer.[48] In reaching this goal, the intent of the parties must be ascertained from the document itself,[49] and the insurance policy should be read as an ordinary policy holder would understand it.[50] Thus, a traditional "plain meaning reading" should be given to insurance contracts.

The reasons for using a plain meaning reading apply specifically to incontestability clauses.[51] Incontestability clauses should be given

45. CRAWFORD & BEADLES, *supra* note 5, at 426.

46. *Id.* at 425. For example, in Metropolitan Life Ins. Co. v. Conway, 169 N.E. 642 (N.Y. 1930), the insurance company won a dispute against the Superintendent of Insurance of New York. New York required incontestability clauses in all life insurance contracts. Metropolitan wanted to write a policy, containing the standard two-year incontestability clause, but creating an exception for any death occurring as a result of an aviation accident. The Superintendent argued that this rider was inconsistent with the incontestability clause. The insurer maintained that it had a right to specify precisely which risks it would assume. The Court of Appeals of New York, Cardozo, C.J., held for the insurer, arguing that the presence of an exception was not inconsistent with the legislature's intent to provide incontestability policies.

47. CRAWFORD & BEADLES, *supra* note 5, at 425.

48. Kievit v. Loyal Protective Life Ins. Co., 170 A.2d 22, 30 (N.J. 1961).

49. APPLEMAN & APPLEMAN, *supra* note 21, § 311, at 313.

50. Kissil v. Beneficial Nat'l Life Ins. Co., 319 A.2d 67, 70 (N.J. 1974).

51. APPLEMAN & APPLEMAN, *supra* note 21, § 311, at 313. Old rules of construc-

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"commonsense construction," that is, a meaning that a reasonable person would understand, not what the insurer may have intended the contract to mean.[52] Such a rule of interpretation is appropriate because incontestability clauses affect the salability of the policy,[53] giving a marketing benefit to insurance companies. Thus, because insurers use the clauses to encourage laypeople to enter into complex insurance agreements that are beneficial to the insurance company, it is appropriate to apply a commonsense construction when interpreting the contract. Thus, any ambiguity in the contract should be resolved against the insurer, provided that the resolution is consistent with the insured's reasonable expectations of the coverage purchased.[54] In general, disputes over the language of an insurance contract are resolved in favor of the insured on the grounds that insurance policies are contracts of adhesion.[55] Thus, the insured's interpretation, which is also the plain meaning, prevails.

The courts must also guard against infusing an incontestability clause with meaning that is not clearly spelled out in the clause. For example, courts should not interpret "incontestable" in a manner that creates exceptions not clearly provided for in the policy.[56] To do so abandons the plain meaning reading that should be applied when construing incontestability clauses.

2. The Impact of a Statutory Mandate

In some jurisdictions, a distinction has been drawn between incontestability clauses that are included voluntarily by insurance companies and those that are required by statute. Although insurance contracts are normally construed against the insurer,[57] it is generally agreed that in-

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tion apply to incontestability clauses, and the intent of the parties must be ascertained from the document itself. Any ambiguity "must be resolved against the insurer and in favor of the insured. . . . " *Id.*

52. COUCH, *suprà* note 6, § 72:9.

53. Malloy v. New York Life Ins. Co., 103 F.2d 439, 445 (1st Cir. 1939), *cert. denied*, 308 U.S. 572 (1939).

54. Voorhees v. Preferred Mut. Ins. Co., 607 A.2d 1255, 1260 (N.J. 1992).

55. Six states strictly follow this principle. Lewter, *supra* note 4, at 1386. Iowa and Georgia have decided that this principle extends to any vagueness in interpreting the language of incontestability clauses as well. *Id.* at 1387.

56. COUCH, *supra* note 6, § 72:9.

57. Because insurance contracts are contracts of adhesion, courts generally resolve ambiguities against the insurer. *Voorhees*, 607 A.2d at 1260; *see also* Equitable Life

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contestability clauses required by statute should not be automatically construed against the insurer.[58] Because the statute requires the clause, that portion of the insurance contract is not a true adhesion contract since the clause does not arise from the insurer's superior bargaining ability and the clause is not drafted by the insurance company. Thus, the advantage in interpretation that is usually given to the insured in a traditional insurance adhesion contract is not necessarily granted when a dispute arises over a statutorily required contract provision. Instead, courts adhere to the ordinary rules of statutory construction.[59]

In interpreting a statutorily required incontestability clause, courts generally refuse to automatically construe the incontestability clause in favor of the insured and instead rely on legislative intent.[60] The court will rely only on "the plain and ordinary meaning of the clause's language, mindful that the clause was the result of a specific statutory directive."[61] It is necessary to compare the statute with the clause included in the policy and to evaluate the intent of the statute, regardless of the impending outcome. "A court may not disregard the plain words of a statute merely because they occasionally lead to an unhappy result."[62] Because the intent behind incontestability statutes is clearly established, developing exceptions that are not clearly stated in the statute creates the risk that the true intent of the legislature will be undermined. A court should not make a ruling based on what it thinks the statute ought to mean, unless the actual words of the statute support that meaning.

In *Foster v. Washington National Insurance Co.*,[63] the New Jersey Supreme Court held that fraud could not be used to bar payment in the presence of a statutorily required incontestability clause because the clause, upon a plain meaning reading, did not contain an exception for fraud or misstatements.[64] Thus, the New Jersey Supreme Court con-

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Assurance Soc'y of the United States v. Bell, 818 F. Supp. 245, 249 (N.D. Ind. 1993), *aff'd*, 27 F.3d 1274 (7th Cir. 1994).

58. APPLEMAN & APPLEMAN, *supra* note 21, § 332, at 384.

59. *Equitable Life*, 818 F. Supp. at 249; Lewter, *supra* note 4, at 1387.

60. Lewter, *supra* note 4, at 1387.

61. Wischmeyer v. Paul Revere Life Ins. Co., 725 F. Supp 995, 1001 (S.D. Ind. 1989).

62. Massachusetts Mut. Life Ins. Co. v. Manzo, 584 A.2d 190, 194 (N.J. 1991).

63. 192 A. 59 (N.J. 1937).

64. *Id.* at 60-61.

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cluded that a clause such as the one contained in Haas's contract should be interpreted using a plain meaning reading.

In addressing the impact of a statutory mandate, it is important to note that a statutorily required incontestability clause does not necessarily bar the insurer from adding other protective provisions to the contract.[65] Insurance companies may build specific exceptions or bars to coverage into contracts that contain incontestability clauses provided that the exceptions do not override the effect of the incontestability statute.[66] Thus, insurance companies cannot accurately claim that they have their hands tied when faced with a statute requiring an incontestability clause.

3. The Interpretation of Incontestability Clauses with Respect to Fraud

It is a widely held view that an insurance policy containing an incontestability clause should not be voided for fraud unless the clause contains an exception for fraud. These opinions are generally held based on the premise that incontestability clauses cut off all defenses except those that are expressly excepted from the clause.[67]

In general, incontestability clauses are strictly enforced so that even if an incontestability clause goes into effect at the moment the policy is issued (thus, denying the insurer any time to investigate the insured's statements), the incontestability clause cuts off all defenses.[68] If fraud is at issue, the policy is not considered void unless the incontestability clause specifically excepts fraud from the defenses barred by the clause.[69] For example, in *Bankers Security Life Insurance Society v.*

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65. COUCH, *supra* note 6, § 72:27. "The existence of an incontestable clause statute does not bar the insurer from adding exceptions to such clause, but an exception will not be permitted to be made to an incontestable clause when the effect thereof is to conflict with the statutory form of the incontestability clause." *Id.* (footnotes omitted).

66. *See* Metropolitan Life Ins. Co. v. Conway, 169 N.E. 642 (N.Y. 1930); *see also supra* note 46 and accompanying text. See also the statute in question, which reads "No claim for loss incurred or disability . . . commencing after 2 years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition *not excluded from coverage by name or specific description effective on the date of loss* and [sic] existed prior to the effective date of coverage of this policy." N.J. STAT. ANN. § 17B:26-5(2)(b) (West 1985) (emphasis added).

67. COUCH, *supra* note 6, § 72:59.

68. *Id.* § 72:71.

69. *Id.* "Cases that have allowed insurance companies to rescind policies for fraud-

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Kane,[70] an insured in a witness protection program did not disclose his prior criminal record on his application for life insurance. The court held that the life insurer could not challenge the validity of the policy based on fraud, nor could it bring a tort suit against the insured for fraud, because fraud was not an exception to the incontestability clause.[71] Thus, the fact that the insured has lied and given false information does not render the incontestability clause inapplicable.[72]

This rule has been applied to disability policies as well as life insurance policies. Once a disability policy becomes incontestable, the insurer may not deny coverage based on a defense of fraud. Generally:

> In the absence of specific provisions to the contrary, the incontestable clause of a disability policy is ordinarily effective to deprive the insurer, after the passage of the stated period, of the right to declare the policy invalid on the ground that it was procured through fraud or misrepresentations by the insured.[73]

It is clear that a defense of fraud cannot be raised after the contestability period ends unless such a defense is clearly excepted from the incontestability clause.[74] States that have followed this reasoning include New York, Arizona, California, Georgia, Iowa, New Hampshire, North Carolina, and West Virginia.[75]

Provident Life & Accident Insurance Co. v. Altman[76] is an illustration of this principle. In *Provident*, the District Court for the Eastern District of Michigan, applying Michigan law, held that an insurer may not deny disability benefits based on misrepresentation in the application unless the incontestability clause contains an exception for fraud. Although the Michigan incontestability statute allowed an exception for

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ulent misrepresentation are either ones that had an exclusion for fraudulent misrepresentation in the incontestability clause or ones . . . where the claim was made before the maturation of the incontestability period." Manzella v. Indianapolis Life Ins. Co., 814 F. Supp. 428, 432 (E.D. Pa. 1993) (citation omitted).

70. 885 F.2d 820 (11th Cir. 1989) (applying Florida law).

71. *Id.*; *see also* Service Life Ins. Co. v. Weinberg, 81 F.2d 359 (7th Cir. 1936) (holding that fraud could not be used as an exception to an incontestability clause because this would defeat the purpose of the incontestability clause; fraud could only be used as a defense if the clause included a provision for fraudulent misstatements).

72. COUCH, *supra* note 6, § 72:71.

73. Lewter, *supra* note 4, at 1388 (footnote omitted).

74. COUCH, *supra* note 6, § 72:70.

75. Lewter, *supra* note 4, at 1389-92.

76. 795 F. Supp. 216 (E.D. Mich. 1992).

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fraudulent misstatements, the insurance company had not included such an exception in the contract.[77]

The court reasoned that since Provident failed to include the provision excepting fraudulent misrepresentations, it had agreed to extend the same coverage to insureds who fraudulently misrepresented as to those who innocently misrepresented. Provident could not expect the court to make its decision as though the policy had included "either the specific language [excepting fraudulent misrepresentations] or the public policy behind the language."[78] Thus, the court refused to add meaning to the policy that was not specifically spelled out in the contract.

4. The Impact of the Insurance Company's Ability to Choose

In interpreting the incontestability clause at issue in *Haas*, it is important to remember that the insurance company had the option of using a clause that would guard against fraudulent misrepresentations. The insurance company was not forced to use the particular clause at issue; it chose to use it. Therefore, it should be held to its choice.

This reasoning has been recognized with respect to the statute at issue in *Haas*.[79] In *Manzella v. Indianapolis Life Insurance Co.*,[80] the District Court for the Eastern District of Pennsylvania interpreted this statute using New Jersey rules of construction. The court concluded that whether intentional misstatements made by the insured on the application form will void the policy depends on which statutory incontestability clause the insurer chooses.[81] In *Manzella*, the insurer chose part (a)(2) (as did the insurance company in *Haas*). The *Manzella* court determined that the insurer could not raise the issue of fraudulent misstatements in the application after the contestability period had expired.[82]

The *Manzella* court pointed out that the defendant could have chosen the other incontestability option and protected itself from receiving fraudulent information, "but it did not, presumably to make its policies more attractive to prospective customers. It must live with the conse-

77. *Id.* at 218.
78. *Id.* at 222.
79. N.J. STAT. ANN. § 17B:26-5.
80. 814 F. Supp. 428 (E.D. Pa. 1993).
81. *Id.* at 430.
82. *Id.* at 432.

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quences of that choice."[83] Thus, in neither *Manzella* nor *Haas* should the insurance company be seen as a victim, in light of the fact that it gained a marketing advantage by choosing the clause in question.

III. *PAUL REVERE LIFE INSURANCE CO. V. HAAS* [84]

A. *Facts and Procedural History*

Defendant-respondent Gilbert K. Haas purchased a disability income policy from Paul Revere Life Insurance Company (the insurance company) in 1987. The policy contained an incontestability clause which provided that disability claims would not be challenged once the policy had been in effect for two years. The incontestability clause contained no exception for fraud.

When applying for the disability insurance policy, Haas completed an application form. On the form, he claimed no prior medical condition or treatment of his eyes.[85] However, four years before applying for the policy, Haas had been diagnosed with retinitis pigmentosa, a progressively degenerative disease of the retina. He had been treated for the condition as recently as 1985.[86] Haas admitted that he intentionally concealed his condition in the application.[87]

In December 1990—more than two years after purchasing the policy—Haas notified the insurance company that he planned to make a claim for disability benefits. In January 1991, he filed for benefits claiming he was disabled by retinitis pigmentosa.[88] Haas received several disability payments, but the insurance company stopped paying him when it discovered that Haas had made false statements on his application form.[89]

The insurance company brought suit against Haas in October 1991 to rescind the disability policy.[90] The Superior Court, Law Division, of Bergen County, granted summary judgment in favor of Haas.[91] The

83. *Id.*
84. 644 A.2d 1098 (N.J. 1994).
85. *Id.* at 1101.
86. *Id.*
87. *Id.*
88. *Id.*
89. *Id.*
90. *Id.*
91. *Id.* at 1098.

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insurance company appealed. The Appellate Division of the Superior Court of New Jersey upheld the summary judgment in part, finding that the policy's incontestability clause overrode the insurance company's claim that Haas's fraud should void the policy.[92] The court mandated that the insurance company provide coverage to Haas for the disability caused by the retinitis pigmentosa.[93]

The Supreme Court of New Jersey reversed the appellate division decision. The supreme court held that the incontestability clause did not preclude the insurer from denying a claim when the insured intentionally included false information when applying for the policy.

B. The Appellate Division Decision

In *Paul Revere Life Insurance Co. v. Haas*,[94] the appellate division of the superior court upheld, in part, Haas's motion for summary judgment.[95] The court held that the incontestability clause barred an action to rescind the contract even though the insured gave false statements in his application form.

The decision was based on a determination that the insurance company had no right to rescind the policy based on fraud because it had opted for the incontestability clause lacking an exception for fraud.[96] To find otherwise, the court noted, would be to "contravene the clear meaning of the [legislature]."[97] Thus, the court recognized that it would be improper to make a decision as though the exception for fraudulent misrepresentations had been included in this incontestability clause when it clearly had not.[98]

As part of the reasoning for its decision, the appellate division cited two policy considerations. The first was a recognition that incontestability clauses reduce litigation because fraud must be proven within the

92. Paul Revere Life Ins. Co. v. Haas, 628 A.2d 772, 773 (N.J. Super. 1993).

93. *Id.* at 777.

94. 628 A.2d 772 (N.J. Super. 1993).

95. *Id.* at 778. The case was remanded in part for discovery on the issue of whether Haas's disability manifested itself prior to the commencement of the incontestability period. *Id.*

96. *Id.* at 775.

97. *Id.*

98. *Id.* "We would contravene the clear meaning of the policy, and indeed the statute, were we to graft the 'except fraudulent misrepresentations' phrase upon the clause pertinent here." *Id.*

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contestable period.[99] The reduction of litigation benefits insureds as well as insurers and is a clear underlying purpose of all incontestability clauses.[100] The second was the consideration that incontestability clauses strike a fair balance between providing adequate time for the insurance company to investigate the application and providing long-term peace of mind to the insured.[101]

The insurance company had argued that the court should rely on *Johnson v. Metropolitan Life Insurance Co.*[102] In *Johnson*, the insured failed to disclose on his application form that he suffered from coronary insufficiency. After he became disabled by Alzheimer's disease, the insurance company attempted to use the misstatement about the heart condition to void the policy.[103] The Supreme Court of New Jersey held that an insurer could not use a defense of equitable fraud to bar payment of benefits because the contract contained an incontestability clause.[104] The appellate division decided that reliance on *Johnson* would be misplaced because *Johnson* dealt with an older incontestability statute, one allowing an exception for fraudulent misrepresentations.

C. The Supreme Court Decision

The Supreme Court of New Jersey reversed the decision of the appellate division and held that an insured may not recover benefits if he intentionally provides misleading information in his application for insurance coverage.[105]

The opinion began with a discussion of whether the disability in question was covered by the policy and the incontestability clause. The court first addressed *Johnson v. Metropolitan Life Insurance Co.*[106] Haas had argued that under the interpretation of incontestability developed in *Johnson*, the insurance company was barred from rescinding the

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99. *Id.* at 777.
100. *Id.*
101. *Id.*
102. 251 A.2d 257 (N.J. 1969).
103. *Id.* at 259.
104. *Id.* at 267.
105. Paul Revere Life Ins. Co. v. Haas, 644 A.2d 1098 (N.J. 1994). The court also remanded to the New Jersey Superior Court, Law Division, to determine when Haas's disability manifested itself. *Id.* at 1101.
106. 251 A.2d 257.

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policy and from denying claims based on a fraud defense.[107] The court decided that this reasoning did not apply to the situation in *Haas* because the disability suffered by the insured in *Johnson* was unrelated to the condition about which the insured had provided false information on his application form.[108] The court decided that because the fraud and the disability in *Johnson* were unrelated, the *Johnson* decision did not juxtapose rescission of the policy and denial of the claim in a fashion that would allow its application to the situation in *Haas*. Instead, the court determined that denying Haas's claim would not require rescission of the entire policy. The court held that the insurance company was allowed to defend against Haas's claim, even if it were barred from rescinding the policy.[109]

The court also determined that *Lindsay v. United States Life Insurance Co.*[110] was not applicable to the *Haas* situation. In *Lindsay*, the issue was a statutorily required incontestability clause. The insurance company declined coverage, claiming that the insured intentionally misrepresented information on his application in order to conceal his wife's adverse medical condition.[111] The superior court, law division, concluded that the insurer was required to cover the preexisting condition once the contestability period expired.[112] The *Haas* court determined that the facts in *Haas* were different from those in *Lindsay* because in *Haas* the insurance company was merely trying to avoid covering a condition that the "insurer would not have covered if the insured had not concealed its existence."[113] However, the court recognized that in *Lindsay*, the court had interpreted the incontestability clause as requiring the insurer to cover a preexisting condition because the insurance company was attempting an unwarranted exclusion.[114]

After disposing of those cases, the court held that the insurance company could limit the scope of the policy's coverage to illnesses that manifest themselves subsequent to the policy being issued.[115]

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107. *Haas*, 644 A.2d at 1103-04.
108. *Id.*
109. *Id.*
110. 194 A.2d 31 (N.J. Super. 1963).
111. *Id.* at 32.
112. *Id.* at 35.
113. *Haas*, 644 A.2d at 1106.
114. *Id.*
115. *Id.*

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The court opined that the appellate division had been wrong to interpret the contract as an ordinary insured would understand it because the clause was legislatively mandated and therefore was not an adhesion contract.[116] Because the clause was included in the policy at the direction of the legislature, it was not in the policy due to the insurance company's superior bargaining power. Therefore, the clause was not part of an adhesion contract and did not deserve a presumption towards the insured's interests. In addition, the court determined that an ordinary insured could not reasonably expect the clause to shield him or her from the effects of his or her own fraud.[117]

Finally, the court addressed Haas's argument that his fraud was irrelevant because the insurance company could have selected the clause that would have guarded against fraudulent misstatements. The court opined that the legislature's enactment of insurance fraud prevention legislation was evidence of a general legislative mandate to guard against insurance fraud in all situations.[118] The court determined that simply because the legislature offered the second incontestability option did not mean that the legislature intended to allow recovery under coverage that was obtained through fraud.[119]

In a dissenting opinion, Justice O'Hern supported the decision of the appellate division. While admitting the difficulty of siding with a "liar,"[120] the dissent recognized that the legislature had valid reasons for mandating incontestability clauses and that there were valid reasons for enforcing such clauses. The dissent pointed out that the strength of the incontestability clause statute was undermined by the majority decision and that the majority decision destroyed the power balance that the incontestability clause was designed to achieve. Justice O'Hern explained:

> I do not object to an insurer's frank statement to its policyholders that it will contest any and all claims on a policy should it discover that the policyholder intentionally concealed medical history. After all, ours is a free-market society; we get only what we pay for. However, I disapprove of an insurance company's attempt to avoid providing the coverage for which it

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116. *Id.*
117. *Id.* at 1107.
118. *Id.* at 1107-08.
119. *Id.* at 1108.
120. *Id.* at 1109 (O'Hern, J., dissenting).

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> has freely chosen the terms and for which it has accepted premiums. That is the case here.[121]

The dissent concluded by urging that the insurance company be required to honor its promise. The dissent recognized that there is potential for many situations in which an innocent misrepresentation may be made[122] and that in those cases, innocent insureds will also have their benefits taken away.[123]

IV. ANALYSIS

The Supreme Court of New Jersey should have upheld the decision of the appellate division. Haas's disability insurance policy was a valid contract and he was entitled to the full protection of the incontestability clause contained in that contract. By denying Haas the protection of the statutorily required clause, the court superseded a legislative mandate that this disability policy become incontestable after two years.

When it enacted this statute, the New Jersey legislature was acting in its proper role as a regulator of the insurance industry. The insurance industry has long been regulated by state governments and by agencies established by the government for that specific purpose.[124] In overriding the legislative intent behind the statute at issue in this case, the court superseded the legislature, encroaching on its function as a regulator of the insurance industry.

This incontestability clause was enacted by the New Jersey legislature to perform precisely the function that it states—to make disability insurance contracts incontestable after two years. In rendering the *Haas* decision, the Supreme Court of New Jersey effectively grafted a fraud exception onto the clause in Haas's contract and, arguably, the incontestability statute. This was not an appropriate action in this case because incontestability clauses are firmly established as sound legislative acts designed to enforce certain power balances and to maintain con-

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121. *Id.* at 1109-10.

122. *Id.* Justice O'Hern used an example of a woman who is aware of a lump in her breast at the time she applies for insurance but is unaware that the lump is cancerous. In order to collect benefits, she may have to prove to her insurance company, likely through expensive and stressful litigation, that she did not intentionally conceal her cancer. *Id.* at 1109.

123. *Id.* at 1110.

124. *See generally* McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1012 (1988).

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sumer faith in the insurance industry. The court should not have created a meaning for the clause, or implied an intent to the statute, that was not spelled out by the legislature.

In overriding the incontestability structure established by the legislature, the court ignored the sound, underlying public policy that has existed for nearly 100 years. This public policy includes a desire to reduce litigation, provide for "fresh" evidence if litigation does take place, allow insureds to enjoy a greater measure of security in their policies, and encourage citizens to privately insure against future financial hardship. For the court to allow the insurer to defend against payment over the authority of an incontestability statute that does not specifically include fraud as a bar to payment is to disregard the public policy objectives set by the legislature.

The possibility of fraud—the downside to incontestability clauses—was a risk foreseeable by the legislature and the insurance company. The assumption the court made in its decision—that the legislature intended that fraud should override an incontestability clause—is faulty. Although general antifraud legislation had been passed, the court's assumption is faulty because it would mean that the legislature viewed fraud as an overriding concern with regard to all insurance policies. However, this does not follow because the legislature specifically addressed fraud in the incontestability statute.

The incontestability clause statute strikes a balance between giving the insurer a reasonable period of time to investigate and providing the insured with greater security that benefits will be paid when they are needed. Neither of the incontestability clause options offered by the New Jersey statute created an absolute waiver of the defense of fraud. Rather, both options recognize fraud—along with all other defenses—but provide a specific period of time within which those defenses may be established. Fraud is recognized by the incontestability statute, and insurance companies are given the option of choosing an incontestability clause that directly confronts the risk of fraud.

The court, however, determined that these protections against fraud were not sufficient. The court assumed that if the legislature were faced with fraud with respect to the second incontestability option, it would include a specific fraud exception for the clause. This assumption can be quashed using basic rules of statutory construction because the legislature illustrated, by including an option in the statute that protected against fraud, that fraud was a consideration. The statute is evidence of the ability of the legislature to address fraud and guard against it when

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necessary. By allowing insurers a choice of two clauses, one of which contained an exception for fraudulent misrepresentation, it is clear that the legislature knew how to create an exception for fraud when it so desired.

In reaching its decision, the court also employed improper methods of contract interpretation. A plain meaning reading, such as the one employed by the appellate division, should have been given to the clause, because the clause is unambiguous. When this incontestability clause is read plainly, it clearly bars a contest to coverage based on the insured's fraud once the contestability period has passed.

The statute from which the clause is derived is also clear. Even if the statute were ambiguous, no legislative history or conflicting statutory provisions are available that would make it possible to say that the legislature intended to create a meaning other than the one clearly stated in the statute. Therefore, the court should not have assumed that any other intent was present.

As a final point on the issue of fraud, it is important to recognize that this insurance policy was a valid contract between two parties. Working within the legislature's statutory requirements for incontestability, the parties themselves, by contract, chose to limit the time period during which fraudulent misstatements could void the contract. By "adding" an exception for fraud to this contract, the court has allowed the insurance company to avoid its bargained-for obligations simply because the court did not favor the consequences of the option that the insurance company chose to follow. Despite the fact that this was a valid, binding agreement, and that the insurance company likely received marketing benefits from making the choice it did, the court has decided to override the legislature and the contract itself.

Instead of overriding the statute, the court should have found for Haas. A finding for Haas would have forced the insurance company to adjust its contracting behavior to make its customers aware that their policies would be voided if their application form contained misstatements. This would force the insurance company to use the first statutory provision, which notifies the insured that the policy may be voided if false information is provided on the application form, in order to protect against fraudulent misstatements over the long term. It would not be unreasonable to require this of the insurance company; rather, it would ensure the formation of a valid contract.

In addition to being more straightforward and fair, maintaining the integrity of the incontestability clause option used in Haas's contract is

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prudent because the line between innocent and fraudulent misrepresentations is not always clear. Although the court appeared to say that its decision would have been different if Haas had not committed fraud, it is not always possible to tell if misrepresentations are intentional or not. This can be a difficult determination to make because, as Justice O'Hern pointed out in his dissent, people's memories fade, laypeople do not have medical expertise, and many questions on insurance application forms are vague or difficult to understand. The challenges of drawing lines between fraud and honest mistakes are part of the reason that most states require incontestability clauses in life, health and disability insurance contracts. As the law of New Jersey stands after *Haas*, even innocent misrepresentations could void the contract if the insured is not able to provide solid proof that the misrepresentation was unintentional.

In essence, this decision returns insureds to a time when incontestability clauses did not exist. This outcome is in direct opposition to the legislature's intent in mandating incontestability clauses. The balancing of interests between insurer investigation and insured peace of mind is a valid public policy goal, one that should not be disrupted because the court does not agree with the outcome of a specific case.

V. Conclusion

By finding for the insurance company, the Supreme Court of New Jersey erroneously interpreted the incontestability clause contained in the insurance policy. This interpretation destroyed the meaning of the incontestability clause and effectively overrode the intent behind the statute that required the clause to be included in the contract. This action undermines the ordinary intent of incontestability clauses and disrupts longstanding public policy goals achieved through incontestable insurance policies.

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