

CONNECTICUT INSURANCE LAW JOURNAL

Volume 14, Number 1
Fall 2007



University of Connecticut School of Law
Hartford, Connecticut

Connecticut Insurance Law Journal (ISSN 1081-9436) is published at least twice a year by the Connecticut Insurance Law Journal Association at the University of Connecticut School of Law. Periodicals postage paid at Hartford, Connecticut. Known office of publication: 55 Elizabeth Street, Hartford, Connecticut 06105-2209. **Printing location: Western Newspaper Publishing Company, 537 East Ohio Street, Indianapolis, Indiana 46204.**

Please visit our website at <http://www.insurancejournal.org> or see the final page of this issue for subscription and back issue ordering information.

Postmaster: Send address changes to Connecticut Insurance Law Journal, 55 Elizabeth Street, Hartford, Connecticut 06105-2209.

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A LICENSE TO BET: LIFE INSURANCE AND THE GAMBLING ACT IN THE BRITISH COURTS

Timothy Alborn

More directly than any other enterprise apart from slavery, life insurance set a price on human life. As it evolved in Britain during the nineteenth century, the insurance industry introduced a dizzying number of variations on this theme. For the individual purchasing an insurance policy, the value of life was translated into the sum required to care for dependents, loss of access to a wife's inheritance should she die before her father, the sum lost to a creditor in the event of death occurring prior to repayment, and the loss of livelihood suffered by a tenant whose lease ended with the life of a third party. All these reasons for buying insurance established an equivalence between mortality and monetary value—a "death nexus" that precisely and morbidly expressed the "cash nexus" derided by Thomas Carlyle as the moral failing of British society. Insurance companies were fond of reminding people that this sort of commodification was often productive of much social and even moral good, and it indisputably met a growing economic demand. But since nobody knew for certain when they would die, a life insurance policy was also, by definition, a wager. And since wagers occupied a quite different category—"intensely selfish in [their] action, and therefore anti-social and anti-christian," as one insurance writer called them in 1891—there was always at least the potential for the life office to take on the darker colors of the gambling den.¹

Lawmakers first became concerned about the slippery slope between life insurance and gambling during the third quarter of the eighteenth century, when the industry still catered to a relatively small, mostly aristocratic market.² Their concern grew out of a rash of cases in which people had taken out policies on the lives of perfect strangers, often celebrities, on the morbid chance that they would die prematurely.³ As Geoffrey Clark has noted, the Hanoverian gentry preferred this form of

1. C. Little, *Fire Insurance: Is It a Species of Gambling?*, NORWICH UNION MAGAZINE, 1891, at 2-3.

2. See GEOFFREY CLARK, *BETTING ON LIVES: THE CULTURE OF LIFE INSURANCE IN ENGLAND 1965-1775*, 49 (Manchester University Press 1999).

3. *Id.* at 49-53.

gambling over nearly all other varieties; a quarter of all bets in one gentleman's club in the 1770s was on the death of a third party, compared to only 2.5% on horse races.⁴ Prior to 1750 gambling on human life was only condemned on account of accompanying criminal acts, such as poisoning a man to collect on his life policy; after that time the wager itself came under increased scrutiny.⁵ Clark has plausibly linked this development to growing unease over slavery, since both "threatened to shatter the emerging free-market ethos that individuals should have the liberty to engage in a commerce of things, but not of each other."⁶ In the event, Parliament intervened much earlier in the former case, with the passage of the Gambling Act of 1774.⁷

The Gambling Act worked by requiring claimants to have a legitimate financial interest in the life of the insured.⁸ To prevent the "mischievous kind of gaming" that had arisen in the previous half-century, it declared all other insurances on human life "null and void, to all intents and purposes whatsoever."⁹ After 1774, it was only legal to collect on an insurance policy if a person (typically a wife or child) relied on the insured for income or was a creditor who stood to lose if the insured died before repaying the loan.¹⁰ Clark has argued that although the Act "was fairly successful at suppressing outright wagers, it could not uniformly segregate the prudential motives prompting proper, indemnifying insurance from the uninterested passions fueling speculation."¹¹ Even so, this statute remained on the books as the official dividing line between life insurance and gambling for the next 135 years, leaving judges, customers and life offices to make do with its uncertain provisions as best they could.¹²

The Gambling Act's ambiguity recurrently threatened to impede the expansion of life insurance throughout the nineteenth century. As Clark indicates, the chief problem in this case lay in life insurance's dangerous commingling of things and people.¹³ The challenge for judges and insurance companies alike was to keep those two categories as separate as

4. *Id.* at 50.

5. *Id.* at 51-53.

6. *Id.* at 62-63.

7. *See id.* at 9.

8. *Id.*

9. DERMOT MORRAH, A HISTORY OF INDUSTRIAL LIFE ASSURANCE 74 (1955).

10. *See* Clark, *supra* note 2, at 9.

11. *Id.* at 26.

12. It was modified in the 1909 Life Assurance Companies Act, which is discussed below.

13. CLARK, *supra* note 2, at 53.

possible without overly hindering the growth of the industry. Their efforts were tolerably successful in the case of upper-class life insurance.¹⁴ The increasingly impersonal and standardized nature of these transactions allowed judges to come to terms with the fact that many life policies, though formally instruments of gambling, were largely irrelevant to the moral issues raised by the specter of betting on human life. The result was that judges followed companies in adopting a set of principles which rendered the Act all but a dead letter after mid-century.

The case was far different once life insurance spread from the upper-class market to working-class customers after 1850. For one thing, the primary reason working people bought life insurance—to pay for a relative's funeral costs—did not formally qualify as an "insurable interest" under the Gambling Act; hence at least half of the tens of millions of such policies issued between 1850 and 1909 were technically illegal.¹⁵ Adding to the problem, judges doubted the companies' ability to deter their customers' alleged passion for gambling; company directors doubted their ability to prevent salesmen from attracting business by taking bets on neighborhood fatalities; and customers soon realized that the formal illegality of their policies entitled them to a refund if the life insured failed to die soon enough to "pay."¹⁶ The result was that companies sporadically appealed to the Gambling Act to quash what they saw as egregious cases of black-market wagering, while customers increasingly sued for back premiums.¹⁷ In response, late-Victorian judges wavered between punishing working-class "gamblers" for their depravity in treating neighbors like race horses, and punishing the companies for encouraging (through their agents) such allegedly immoral behavior.¹⁸

This article begins by recounting the relative ease with which companies and judges stabilized the meaning of "insurable interest" in the case of upper-class insurance, by examining the two leading cases of *Godsall v. Boldero*¹⁹ and *Dalby v. India and London Life*.²⁰ It then turns to the more complex case of working-class life insurance, by sampling a

14. I use the term "upper-class" in this chapter to connote the aristocrats, professionals, and merchants who comprised the primary market for life insurance up to the 1850s, as distinct from the working-class or "industrial" customers discussed below.

15. See MORRAH, *supra* note 9, at 75.

16. See *infra* notes 81-88 and accompanying text.

17. See *infra* notes 70-73 and accompanying text.

18. See *infra* notes 87-92 and accompanying text.

19. (1807) 103 Eng. Rep. 500 (K.B.).

20. (1854) 139 Eng. Rep. 465 (C.P.).

succession of trials which exhibited a variety of appeals to the Gambling Act. Finally, it briefly discusses efforts by companies to clarify the Act in 1909 by lobbying legislators to revise the meaning of "insurable interest" for working-class customers, by increasing supervision over agents and customers, and by introducing new forms of marketing which sought to teach their customers to associate insurance with financial security rather than gaming. What was at stake in each of these cases was the determination of a boundary between legitimate and illegitimate insurance, in an insurance market which appealed to all social classes because of—not in spite of—the fact that it often shaded imperceptibly into gambling.

I. GAMBLING AND LIFE INSURANCE, 1807-1854

The branch of upper-class life insurance that did most to expose the Gambling Act's ambiguous language concerned policies taken out by creditors against the contingency of debtors dying before they could repay the loan. To guarantee the legality of such policies, life offices routinely ascertained the fact of the loan; as long as the insurance did not exceed the sum of money that was lent, the lender could not be said to be speculating on the death of the debtor. Once such policies had been in force a few years, however, their legal status became more difficult to determine. What happened if a creditor continued to keep up the insurance policy after the debt had been repaid? Or what if the debt was repaid in installments, but the creditor kept up the original level of coverage? Such questions raised the distinct possibility that many, perhaps the majority, of such policies were technically illegal when the claim was actually paid. And the legality of third-party policies was a major issue in the early nineteenth century, when roughly a third of all policies, and probably half of the sums assured, were of this variety.²¹

Lord Ellenborough clarified these legal questions at King's Bench in 1807, although he did so in a way that would create intolerable levels of

21. Between 30% and 47% of clerical, medical & general policies issued between 1824 and 1895 were on third parties, as were 34.4% of legal and general policies in force in 1870. Renewal Ledgers, Clerical, Medical and General Life Assurance Society (unpublished manuscript, on file with Clerical Medical Group Archives, Edinburgh); Life Policy Registers, Legal and General Life Assurance Society (unpublished manuscript, on file with Guildhall Library, MS 18,473, London).

unpredictability for prospective third-party insurers.²² The decisive case, *Godsall v. Boldero*, concerned a seven-year term policy for £500 on the life of William Pitt, which was taken out from the Pelican life office as security against a debt.²³ The Pelican had resisted the claim on the grounds that by the time it was ready to pay, the debt had already been canceled by means of a special Parliamentary grant which cleared the former Prime Minister's outstanding commitments.²⁴ When Godsall sued for his £500, the company's lawyer invoked the Gambling Act, arguing that "if this policy may be enforced... every creditor may gamble upon the life of his debtor by way of insurance, ... and upon his death he would be entitled to double satisfaction of his debt."²⁵ He also compared the case to that of a marine policyholder who claimed a total loss even though he had already been indemnified by means of salvage.²⁶ Godsall's lawyer countered that the Pelican should pay the claim since they had been fairly compensated for the risk, urging that in such contracts "the premium is not calculated upon the risk of the insolvency of the person whose life is insured, but solely on the probability of the duration of the life."²⁷ Ellenborough sided with the Pelican, ruling that the policy was "in its nature a contract of indemnity, as distinguished from a contract by way of gaming or wagering."²⁸

By restricting third-party life policies to the indemnification of remaining sums owed by insured debtors after they died, Ellenborough endowed life offices with blanket deniability in the event of such policies falling due. Companies soon discovered that such power was double-edged, since they threatened to dissuade creditors from taking out policies for fear that a company would postpone payment until other means of securing the debt had been exhausted. After the Asylum Life Assurance Company successfully appealed to the Gambling Act to dispute a child endowment policy in 1830, insurers "received applications for written acknowledgments that the Directors will not avail themselves of any such advantage, in cases which bear a great analogy to that which has just been decided against the public."²⁹ A typical company response to this sort of

22. This was in keeping with Ellenborough's wider pattern of decisions which "barred the way repeatedly to attempts to modernize the law." P.S. ATIYAH, *THE RISE AND FALL OF FREEDOM OF CONTRACT* 422 (1979).

23. (1807) 103 Eng. Rep. 500 (K.B.).

24. *Id.* at 500-02.

25. *Id.* at 503.

26. *Id.* at 502-03.

27. *Id.* at 502.

28. *Id.* at 504.

29. H.B. & Co., *To our Subscribers*, 94 CIRCULAR TO BANKERS 329, 330 (1830).

fear was by the Alliance, which spent a decade pondering the proper course to take when "the Assured has a shifting interest in the Life" after first learning in 1827 that it could challenge any policy that failed Ellenborough's strict standard.³⁰ Eventually its board decided that it was not worth the trouble to determine the technical legality of the insurance beyond its initial issue.³¹ Other offices followed a similar trajectory, first disputing claims in isolated cases, then eventually guaranteeing customers that *Godsall* would have no impact on their decision to meet an initial obligation.

In *Dalby v. India and London Life Assurance Company* (1854), the Court of Common Pleas caught up with the life offices' practice, deciding (in the words of Justice Parke) that a "much more reasonable construction" of the Gambling Act was "that, if there is an interest at the time of the policy, it is not a wagering policy, and that the true value of that interest may be recovered, in exact conformity with the words of the contract itself."³² The case involved an attempt by the India and London to deny payment on a policy which it had originally accepted as a reinsurance from the Anchor life office, but which had subsequently been taken over by an Anchor director who kept the policy in force.³³ In ordering the India and London to pay, Parke appealed both the customer's right to know the exact value of his purchase and to the fact that *Godsall* had been "universally disregarded" by nearly all life offices.³⁴ The lawyer who argued the Anchor's case, George Bramwell, repeated the earlier claim in *Godsall*'s defense that a life policy was "a simple and absolute contract to pay a given sum of money on the death of the life," and hence did not qualify as an indemnity.³⁵ He added that Ellenborough had bestowed powers on life offices that they had, in practice, been unwilling to exercise: for instance, the right "to demand the money back, if the debtor's executors,—say, ten years after his death,—become possessed of funds wherewith to pay the debt."³⁶

30. *Id.*

31. Alliance Assurance Company board minutes (May 23, 1827, Feb 22, 1837 and July 10, 1839), unpublished manuscript, on file with Guildhall Library, MS 12, 162, London).

32. (1854) 139 Eng. Rep. 465, 476 (C.P).

33. *Id.* at 466-69.

34. *Id.* at 473-76.

35. *Id.* at 469. Bramwell went on to be a leading architect of "freedom of contract" doctrine in English law. See ATIYAH, *supra* note 22, at 374-80.

36. *Dalby*, 139 Eng. Rep. at 469-70.

Parke's decision in *Dalby*, closely following Bramwell's arguments, firmly established that the payment of a life claim was not the same as an indemnification for a loss. To this extent, his reasoning was sound.³⁷ What his ruling overlooked, however, was the fact that any insurance policy that professed to do more than indemnify against a contingent loss is, by definition, equivalent to a wager. This had been Ellenborough's point when he implied that life insurance was *either* "a contract of indemnity" *or* "a contract by way of gaming or wagering."³⁸ Judges in the *Dalby* case claimed that their decision left the Gambling Act intact as a secure protection against "colourable insurances" such as when a "man might lend another 5l., to enable him to insure for 10,000l."³⁹ But this example was no different from lending a man £10,000 for a few weeks, then keeping all but £5 of that sum in force as a life policy—which is exactly what *Dalby* legalized. Parke's contrary claim notwithstanding, it was illogical to assert that an insurable interest at the outset necessarily meant that it was "not a wagering policy."⁴⁰

The fact of the matter was that few people by the mid-nineteenth century were concerned about the possibility that life insurance might qualify as a subset of "wagering." Hence the mathematician Augustus De Morgan, in an 1838 critique of *Godsall*, argued that "the contract of insurance, be it gambling, or be it not, rests entirely upon the permission given by the law to consider a high chance of a small sum as good consideration for a low chance of a large sum."⁴¹ A half-century later, industry spokesmen were even more brazen in their identification of life insurance and gambling, as when the Law Union's medical officer urged that his line of work was "a very moral thing, and is very charitable; but there is no doubt it is a form of gambling... and we all go to the office, and

37. See VIVIANA A. ROTMAN ZELIZER, *MORALS AND MARKETS: THE DEVELOPMENT OF LIFE INSURANCE IN THE UNITED STATES* 71-72 (1979) (describing the influence of the insurable interest doctrine on the relationship between pecuniary loss and emotional loss).

38. *Godsall v. Boldero*, (1807) 103 Eng. Rep. 500, 504 (K.B.).

39. *Dalby*, 139 Eng. Rep. at 473.

40. On the *Godsall* and *Dalby* cases, and their impact on American life insurance practice. See Sharon Ann Murphy, "Security in an Uncertain World: Life Insurance and the Emergence of Modern America" (Ph.D. dissertation, University of Virginia), 145-159 (2005).

41. AUGUSTUS DE MORGAN, *AN ESSAY ON PROBABILITIES, AND ON THEIR APPLICATION TO LIFE CONTINGENCIES AND INSURANCE OFFICES* 247 (London: Longman, Orme, Brown, Green, and Longmans, 1838).

back lives instead of horses."⁴² One reason for this departure from earlier efforts to segregate insurance and gambling into two distinct categories is that late-Victorians had started to distinguish between different sorts of gambling, some of which were apparently good for society. Viviana Zelizer's comments regarding American life insurance in the late-nineteenth century are just as relevant to British opinion at the time: "as risk increasingly became an integral part of the... economic system, certain forms of risk taking and speculation assumed new respectability. Rational speculation that dealt with already existent risks was differentiated from pure gambling which created artificial risk."⁴³

Alongside such shifts in perception had evolved changes in the practice of life insurance, which erased many of its earlier overlaps with "pure gambling." One of these was a new willingness by most offices after 1850 to offer standardized "surrender values" to parties who wanted to drop their policies—a category of people which included many creditors whose debts had been repaid.⁴⁴ This practice superseded the previous course taken by customers in such cases, which was to auction off the policy to the highest bidder, who would continue to pay the premiums then collect the claim when the insured party died.⁴⁵ Hence a precisely calculable, private and wholly impersonal transaction took the place of an unseemly public spectacle, one which the insurance reformer Elizur Wright pointedly compared to slavery.⁴⁶ Once such changes were underway, upper-class customers and companies benefited equally from the predictable playing field which was achieved by pretending that the Gambling Act did not apply to them, and neither side had an incentive to take the other to court as a means of resolving their grievances.

42. R. Hingston Fox, "The Assurance of Impaired Lives, Chiefly with Reference to Special Forms of Assurance," *Clinical Journal* 6 (1895), 258.

43. Zelizer, *supra* note 3, 86. See also G.R. SEARLE, *MORALITY AND THE MARKET IN VICTORIAN BRITAIN* 78-86 (1998).

44. *ECONOMIST*, June 18, 1892 at 789.

45. Until the Insurance Policies Act of 1867 officially legalized such purchases (assuming the title to the policy was properly assigned to the purchaser), such auctions were technically illegal under the Gambling Act. But, as in the case of creditors collecting claims despite the cancellation of the debt, the Act was seldom applied to them. See CORNELIUS WALFORD, *INSURANCE CYCLOPEDIA* 203 (London, Layton) (1871).

46. William Clendenin, *A Brief Sketch of the Life and Works of Elizur Wright*, in *THE BIBLE OF LIFE INSURANCE* 66, 67 (1932).

II. THE GRAY MARKET IN WORKING-CLASS LIFE INSURANCE

When companies started to extend life insurance to a working-class market after 1860, they opened the way for a whole new crop of technically illegal third-party policies. The main contingency which these "industrial" offices guarded against, in exchange for weekly premiums of several pence, was the cost associated with providing a "proper" burial for a family member.⁴⁷ Unlike third-party policies involving loans, however, which were at least legal at the outset of the contract, the Gambling Act did not recognise liability to pay funeral expenses as an "insurable interest" in another person's life. The only exception was when the family member was an adult male who took out the policy in his own name, since the benefit (usually between £10 and £50) could be said to be used to support the man's dependents. No such "interest" existed in the millions of cases in which husbands wanted to take policies out on their wives, parents on their children, and on through the family tree to grandchildren, cousins and in-laws.⁴⁸ Most of these people could usually find a company willing to sell them a policy on someone else's life, but until 1909 they could not find a statute declaring its legality.⁴⁹

Beyond buying policies that were merely technically illegal, many working-class policyholders broke the spirit as well as the letter of the Gambling Act—although the extent to which this happened is difficult to determine. At the very least, reported cases indicate that conditions existed for this sort of street betting to flourish.⁵⁰ When a Bradford poor law guardian told of a man suffering from "cancer in the mouth" who died with twelve policies on his life, the guardian observed that "[t]he agent insured the man without ever seeing him, but his friends knowing that it was cancer, knew it would be fatal in the end."⁵¹ Many court cases similarly told of people dying prematurely with several policies on their lives, implying that customers took advantage of their superior knowledge of

47. LAURIE DENNETT, *A SENSE OF SECURITY: 150 YEARS OF PRUDENTIAL* 5-9 (1998).

48. MORRAH, *supra* note 9, at 74-76. Partial legal recognition of the widespread practice of insuring children's lives was achieved in the 1875 Friendly Society Act. This Act allowed families to insure up to £6 per child. While this formally extended only to mutual "collecting societies," the courts soon extended this provision to joint-stock companies under common law. See Sidney Webb, *The Working of the Insurance Act*, *NEW STATESMAN* 2 (1914 & Supp.).

49. See MORRAH, *supra* note 9, at 74-75.

50. *Id.* at 74.

51. SELECT COMMITTEE ON CHILDREN'S LIFE INSURANCE BILL, REPORT, 1890, H.L. 70.

sickly neighbors to profit at the distant office's expense. The agents who sold such policies were either assumed to be overly lax (as in the Bradford case) or complicitous.⁵² Companies were usually willing to fight such claims in court, often with a successful outcome, although even here they needed to keep one eye fixed on the tender subject of public relations. Hence when Sophie Haberschitz of the East End was found burned to death in 1909 with ten policies on her life, the implicated offices decided to pay the claims on the grounds that "it was undesirable lest the world know that such a thing was possible."⁵³

If industrial life offices were sometimes reluctant to challenge claims that they assumed to be guilty of criminal intent, they were even less likely to resist "legitimate" claims on third-party policies just because the Gambling Act said they could. Although any office might, in theory, cart out the Act whenever a claim by a nephew or grand-daughter involved it in a loss, they did no such thing, for the same reason that upper-class offices ignored *Godsall*: it would have driven away half their business. Unfortunately for the companies, the same reasoning did not work in reverse. The Gambling Act enabled people who held "legitimate" but illegal policies to exercise an especially brutal form of selection against industrial offices, by suing for a refund when their premiums had exceeded the value of the claim. The associated legal costs were enough to restrict the number of such cases until around 1900, but after this time lawyers started to appear on the scene who were willing to try them on a contingency basis.⁵⁴ These lawyers, Edwardian cousins of the ambulance chaser, naturally earned the wrath of industrial insurance managers, as when Alfred Henri of the Liverpool Victoria railed against, "solicitors of a certain type . . . who were willing to take up these cases for what they might get out of them."⁵⁵ Their reputation was substantially higher among the large number of working-class policyholders who were stuck in what had become an unprofitable contract. Yet even customers who won their suits learned that illegal insurance economics came with troubling fine

52. *See, e.g.*, 19 ASSURANCE AGENT'S REVIEW 42-43 (1906).

53. Industrial Life Offices Association Minute Book (July 13, 1909) (unpublished manuscript, on file with Guildhall Library, MS 29,802, London).

54. Officially, Edwardian lawyers were barred from charging contingency fees. The legal challenges described below, however, would only have been feasible on such a basis; hence it seems likely that lawyers informally accomplished this, for instance by voluntarily foregoing their fee in the event of a negative verdict. I am grateful to Joshua Getzler for pointing out this problem.

55. Industrial Life Offices Association Minutes Book (unpublished manuscript on file with Guildhall Library, London) MS 29,802.

print: legal fees could run nearly as high as the claim, once lawyers averaged in their time from cases they lost.⁵⁶

As *Dalby* demonstrates, the prevalence of business-friendly, judge-made law often allowed Victorian markets to operate quite efficiently despite statutory obstacles.⁵⁷ Yet no judge delivered a *Dalby*-style ruling in the late-nineteenth century which clearly stated that working-class "life-of-another" policies were not equivalent to wagers. There are several reasons for this, relating to distinctive traits of industrial insurance, popular assumptions about working-class gambling, and conflicting views held by different judges. First, the large scale and unpopular reputation of industrial insurance companies, affected both sides of the blurry line separating "pure gambling" from "rational speculation." The three largest industrial offices, the Prudential, Refuge, and Pearl, dominated their competitors, and each were writing millions of new policies a year by 1910.⁵⁸ The companies' size and central organization rendered them vulnerable to losses to parties whose local knowledge was an advantage in insurance wagers; but it also made them more capable of surviving an expensive court battle if they chose to resist payment. The companies' unpopular reputation, especially that of their salesmen, gave customers a fighting chance to convince a judge that they had been hoodwinked into buying an illegal policy and deserved to get a refund. Part of this reputation was derived from the assumption that burial insurance qualified as illicit "gambling" on the deaths of neighbors and relatives; but much of it also stemmed from the assumption that even the "bona fide" service offered by the companies—financial security against the cost of burial—encouraged needlessly lavish funerals among the poor.⁵⁹

Assuming that burial insurance did qualify as gambling, people who bought it, and companies that sold it, were far more likely than upper-class customers to be viewed by the rest of society to be practicing "pure gambling" instead of "rational speculation." Gambling of any variety appeared darker to Victorians whenever the gamblers were poor people.⁶⁰

56. DENNETT, *supra* note 47, at 403 n.15.

57. See *Dalby v. India & London Life Assurance Co.*, 15 C.B. 365 (1854).

58. Timothy Alborn, *Senses of Belonging: The Politics of Working-Class Insurance in Britain, 1880-1914*, 73 J. MOD. HIST. 561, 576 (2001).

59. Alborn, *supra* note 58, at 579.

60. This may very well be due to the fact that "already existent risks"—for instance, a joint-stock company's financial future—were off limits to working-class gamblers, who lacked the requisite capital to become shareholders. They did, in contrast, have access to "artificial risks" such as the outcome of card games, lotteries, or horseraces. See SEARLE, *supra* note 43, at 232.

The Gaming Act of 1845, as distinct from the Gambling Act which only applied to insurance, was mainly enforced among the poor.⁶¹ Hence, private clubs and racetracks remained effectively legal, while off-course betting did not.⁶² This double standard reflected the middle classes' "paternalistic care for the poor who might be led astray by the machinations of bookmakers;" a sentiment that stood in clear tension with the contrary middle-class, "drive to cash in on the demand for gambling."⁶³ The result was that working-class gambling "inhabited a twilight world" in late-Victorian legal and moral discourse, not unlike that which enveloped industrial insurance at the same time.⁶⁴

The scale and reputation of industrial insurance helps to explain why companies and their customers took so many cases to court between 1880 and 1909.⁶⁵ But, it does not explain why judges had so much trouble discovering a "reasonable construction" of the Gambling Act that would settle the cases.⁶⁶ The problem was not that judges lacked opinions where industrial insurance was concerned; law's "hortatory aspect" was as much on display in this realm of insurance law as in any other.⁶⁷ The problem was that judges could not decide exactly what or whom they should be exhorting. To add to the confusion, a clear split developed after 1900 between the higher courts and the county courts. The higher courts became increasingly concerned with establishing "principles" that would allow the companies to get on with their business, and the county courts tended to ignore the higher courts rulings in order to "get at the agents" by forcing

61. See SEARLE, *supra* note 43, at 232 (mentioning the "widely held view that the operation of the law was being grossly distorted by class bias"). See also CLARK, *supra* note 2, at 22 (explaining that "The Gambling Act . . . introduced the first appreciable regulation of life insurance . . .").

62. See Roger Munting, *Betting and Business; the Commercialisation of Gambling in Britain*, 31 *Bus. Hist.* 67, 68 (1989). See also SEARLE *supra* note 43, at 232.

63. See Munting, *supra* note 62, at 68.

64. SEARLE, *supra* note 43, at 232. See also MORRAH, *supra* note 9, at 27-29 (discussing industrial insurance of the same time period, and comparing the advances made in mathematical and psychological analysis to the difficulties of the early companies).

65. See MORRAH, *supra* note 9 at 31 (talking about the difficulties with industrial insurance during this time period, and the increase in contracts issued).

66. See CLARK, *supra* note 2 at 26 (noting the "intractable problems that courts encountered in meaningfully distinguishing a legitimate insurable interest from an illegitimate gamble . . .").

67. ATIYAH, *supra* note 22, at 395 (talking about the "hortatory aspect" of law); see also MORRAH, *supra* note 9 at 24 (discussing the Select Committee being favorable towards industrial insurance).

companies to pay.⁶⁸ The result was a patently uncertain legal framework, which industrial life offices ultimately found to be intolerable.

III. THE GAMBLING ACT ON TRIAL

In their respective battles to stack the deck in their favor, working-class customers and companies told stories at trial in order to convince judges that the Gambling Act entitled them to gain at the other's expense. When policyholders sued for a return of premiums, they presented themselves as victims of the insurance agent's misleading claim that such policies were legal. In their defense, depending on the circumstances of the case, life offices tried to shift blame back onto the policyholder or the agent. The insurance agent, who received so much of the blame in these trials, was the least likely to be asked to testify, lest he refute the other parties' professions of innocence.

When a Liverpool woman sued the Refuge in 1903 after paying £82 on two policies worth £72, she argued that the agent had told her "it would be all right—she could draw the money!"⁶⁹ The judge agreed that this was tantamount to fraud on the company's part, and awarded her £34—ruling that the rest of the payment lay outside the statute of limitations.⁷⁰ Alice Crosty used the same argument to win £53 back from the Scottish Temperance life office in 1909, on a policy she had taken out on her aunt's life.⁷¹ With less success, Johanna Butt of Swansea tried to claim that "people came and asked her to pay premiums" in a case where she was accused of taking out fifteen policies on the same man's life.⁷² For the most part, the fact that all these allegations of misrepresentation were made by women simply reflects the economic reality that buying insurance—like pawning, food shopping, and rent payment—qualified as "women's work"

68. See PATRICK POLDEN, *A HISTORY OF THE COUNTY COURT, 1846-1971*, 68-69, 94 (1999) (discussing the difference in treatment of creditors and debtors between the two courts, and how the county court judges sought to "impose a paternalist regime on the improvident and incompetent"). This work also discusses the relationship between county courts and high courts in the late nineteenth century.

69. Industrial Life Offices Association Minute Book (unpublished manuscript, on file with Guildhall Library, MS 29,802, London). In this and subsequent cases, monetary sums are rounded to the nearest pound.

70. *Id.*

71. 47 *Ins. Rec.* pg. #, 529 (1909).

72. *Id.* at 336.

in the working-class division of household labor.⁷³ Yet probably it also indicated a conscious strategy by such women and their lawyers to capitalize on the middle-class assumption, shared by many working men, that insurance salesmen habitually took advantage of their female customers' naiveté as they made their way from the doorstep into the front room.⁷⁴

Life offices tried to counter such claims by insisting that their customers, far from being innocent victims, were seasoned veterans at the "game" of demanding back premiums when the life they had "gambled" on refused to die in a timely fashion. When two Walworth women sued the Liverpool Victoria in 1909 for £26 in back premiums after their father died, claiming "misrepresentation of one of their agents," the society's lawyer countered that it had offered the women the £10 due at the death, "but it had been refused by them because their father lived longer than they expected, and the transaction had been unprofitable to them."⁷⁵ Although successful in the Liverpool Victoria case, such reasoning proved to be a risky legal strategy since companies could all too easily incriminate themselves along with their customers. Hence, a judge found against the Royal Liver in 1903 when it refused to refund Mary Wilson of Padiham £36 in premiums paid on a policy on her father-in-law's life, despite its lawyer's argument that she "had been speculating in insurance for a considerable time, and... was prepared to take the risk." The judge was not impressed by the society's efforts to counter Wilson's charge of misrepresentation with the claim that "many insurance companies took and honoured those wagering policies, as the Royal Liver was prepared to do in the case."⁷⁶

In responding to these stories, late-Victorian judges sent a decidedly mixed set of messages to customers and companies alike. Some, especially at the county level, blamed the companies for making a mockery of the Gambling Act and punished them by requiring them to return the premiums paid for illegal policies.⁷⁷ Others did not accuse the directors of

73. See ELLEN ROSS, *LOVE AND TOIL: MOTHERHOOD IN OUTCAST LONDON, 1870-1918* 193(1993).

74. See, e.g., the Trades Union Congressional resolution from 1909 which states that "[u]nfair advantage is often taken [by insurance salesmen] of the womankind when the husband is away": *reprinted in* Industrial Life Offices Association Minute Book (unpublished manuscript, on file with Guildhall Library, MS 29,802, London).

75. 47 INS. REC. 25 (1909).

76. 41 INS. REC., 509 (1903).

77. 8 ASSURANCE AGENTS' REV. 147 (1895); 9 ASSURANCE AGENTS' REV. 62 (1896).

encouraging gambling, but did fault their agents. For example, a Swansea judge forced the Royal Counties Friendly Society to refund a collier's premiums with costs in 1902. Although the judge claimed that he "would not think of blaming the directors," he did feel the need to "warn people about this, so that they will not enter into these contracts," and he concluded: "These agents behave so badly. I should like to hit some of these societies through their agents."⁷⁸ Another judge allowed the Liverpool Victoria to deny five claims on the short life of a girl who died of tuberculosis in 1906, but required it to pay £20 in costs, arguing that "[s]o long as there are agents who lend themselves to this trafficking... there will always be found people weak enough or greedy enough to listen to the tempters."⁷⁹ A third set of judges similarly blamed the agents, but had ample suspicion left over for the policyholders as well. Hence the judge in the Walworth case admitted that "canvassers for insurance companies were apt to misstate things," but also offered this taunt to the allegedly victimized sisters: "The whole mischief is that your father lived too long. Is that not it?"⁸⁰ A Bristol judge similarly denied £25 in back premiums for a £19 policy against the death of "an elderly man called Mark Barnes," appending to his ruling the wry observation that "[o]wing to Mr. Barnes's perversity in continuing to live, poor Mr. Tilley had overpaid."⁸¹

Harse v. Pearl (1904) held that policyholders should be assumed to be parties to illegal insurances unless fraud on the part of the agent could be proven.⁸² In that case, the Court of Appeals did make some strides towards stabilizing the meaning of the Gambling Act in application to working-class insurance.⁸³ Lord Mathew, expressly grounded his ruling in *Harse* on the principle that life offices were, "entitled to the administration of the law on fixed principles."⁸⁴ The Court arrived at these "fixed principles" in *Harse* by invoking the legal fiction that insurance salesmen could not be expected to understand how the Gambling Act had defined insurable interest; and hence could not be guilty of misrepresentation.⁸⁵ That case

78. 40 INS. REC. 174 (1902).

79. 19 ASSURANCE AGENTS' REV. 42-43 (1906).

80. 47 INS. REC. 25 (1909); 70 POST MAG. 53 (1909).

81. 47 INS. REC. 593 (1909).

82. *Harse v. Pearl*, (1904) 1 Eng. Rep. 558, 560-61 (K.B.).

83. *See id.* at 560, 564. *See also* 70 Post Mag. 207 (1909). In a second ruling, *Griffiths v. Fleming*, the court was able to accomplish greater levels of certainty for the narrower category of husbands taking out policies on their wives. *See Griffiths v. Fleming*, (1909) 1 Eng. Rep. 805, 808 (K.B.).

84. 70 POST MAG. 207 (1909).

85. *Harse*, 1 Eng. Rep. at 560-61.

was a typical one: Harse had taken out policies on his parents' lives and then demanded back premiums from the Pearl once his payments had exceeded his claim.⁸⁶ The trial jury had found for the Pearl on the grounds that the Agent represented that the Policy would be valid and did not know that what he was saying was untrue.⁸⁷ The Court of Appeals confirmed this verdict, on the assumption that salesmen's claims regarding the validity of third-party policies were statements of the general law of the land in relation to insurance, which were made innocently to a person who was most desirous of entering into an illegal Contract.⁸⁸

In reaching its verdict, the judges offered a unique twist on the usual brand of moralizing about dodgy agents preying on innocent, or even not-so-innocent, working-class victims.⁸⁹ The court argued that most industrial insurance salesmen were cut from the same cloth as their customers, and hence were unlikely to be in a position to lead their customers too far astray.⁹⁰ This corresponded with the socioeconomic reality of most insurance salesmen at the time, and it certainly corresponded with the agents' self-ascribed mission to put themselves, "on a level with all the policy-holders, no matter how humble their position in life may be."⁹¹ From this premise, the judges concluded that customers and agents were similarly *ignorant* of the Gambling Act—hence relieving insurance salesmen of any "greater obligation to know the law than the persons they approach for the purpose of effecting policies." Since the Pearl was not "in any way bound to appoint Agents with some special knowledge of law," it stood to reason that *caveat emptor*, not the Gambling Act, was the relevant "general principle" in such cases.⁹²

Unfortunately for the life offices, *Harse* was only partially successful at putting an end to the rising tide of litigation that had been such a problem since 1900. This was especially the case in county courts,⁹³ where judges were often determined to punish the industrial offices by assuming fraud on

86. *See id.* at 558.

87. *See id.* at 559.

88. *See id.* at 563-64. *See also* Industrial Life Offices Association Minutes Book, Law Reports (unpublished manuscript, on file with Guildhall Library, MS 29,802, London).

89. Industrial Life Offices Association Minutes Book, Law Reports (unpublished manuscript, on file with Guildhall Library, MS 29,802, London).

90. *Harse*, 1 Eng. Rep. at 564.

91. FREDERICK H. GISBOURNE, *HOW TO CONDUCT AN AGENCY* 5 (1895).

92. Industrial Life Offices Association Minutes Book, Law Reports (unpublished manuscript, on file with Guildhall Library, MS 29,802, London).

93. *See* POLDEN, *supra* note 68, at 94 (stating that cases heard by judges in the county court rose from 1,046 in 1900 to 5,289 in 1913).

the part of their agents. Hence when Hannah Brown sued the Britannic life office in 1907 in the Preston County Court to recover premiums for a policy on her mother's life, the office failed in its attempt "to prove that both the Company and the assured were in *pari delicto*, as in the Harse case."⁹⁴ Instead, the judge sternly insisted that the Britannic was responsible for its agents' actions: "The policy was signed by five officials, including two directors, yet not a single one thought it incumbent upon him to consider whether the insurable interest was valid under an Act 125 years old."⁹⁵ Although *Brown* was subsequently reversed on appeal, as were a number of similar lower court rulings, the trickle of such rulings grew to a flood in 1909.⁹⁶ A November 1909 editorial in the *Insurance Record* entitled "Trouble in the Industrial Assurance World" cited the case of a Welsh district in which "one company alone has had no fewer than one hundred and forty County Court actions brought against it in about two months, for the return of premiums on alleged illegal assurances."⁹⁷ It was the Edwardian equivalent of a class-action suit: "In several districts during the past six weeks circulars confidently believed to emanate from a firm of solicitors, have been distributed, inviting policyholders to take proceedings for the recovery of premiums; and in Lancashire certain solicitors, have called and addressed public meetings with the same object."⁹⁸ As with many modern class-action suits, new legislation soon followed to prevent the recurrence of such alarming disruptions to business as usual.

After 1909: From Judgment to Surveillance

The new law in question was the Assurance Companies Act of 1909⁹⁹, most of which had to do with upper-class life insurance business.¹⁰⁰ As the Act was making its way through Parliament, the industrial offices lobbied strenuously to include a provision that would prevent customers from being able to cite "the old Act of George III" in order to recover their premiums.

94. Industrial Life Offices Association Minutes Book, Law Reports (unpublished manuscript on file with Guildhall Library, MS 29,802, London).

95. 45 INS. REC. 564 (1907).

96. 70 POST MAG. 53-54 (1909).

97. INS. REC. (1909).

98. 47 INS. REC. 567 (1909).

99. 9 Edw. 7, c. 49 (Eng.).

100. MORRAH, *supra* note 9, at 73 (1955) (emphasizing that "[t]he main purpose of the Act was to strengthen the statutory guarantees for the security of the insuring public" and similarly to "the Act of 1870 life assurance did not begin until the insurers had deposited £20,000 ... with no power of withdrawal,").

Their preferred solution, endorsed in section 37 of the Act, was to legalize retroactively all existing "bona fide" third-party policies, "having regard to the change in the social condition of the people, and to the obligation which the law has placed upon the children and grandchildren since 1774."¹⁰¹ A different clause dealt with future insurances by legalizing "life of another" policies on parents, grandparents, grandchildren, brothers and sisters.¹⁰² These modifications left some legal uncertainty intact, mainly because they defined the amount of a "bona fide" policy (whether issued before or after 1909) as the sum which "the relative reasonably might expect" to pay for a funeral. "Reasonable" funeral expenses remained a bone of contention, with some trial judges setting the bar as low as £10 and companies issuing policies up to £25, and nobody was too sure what to do about people who took out several policies from different offices.¹⁰³ Furthermore, the new law's extended definition of legitimate kinship still excluded thousands of step-children, half-siblings, and cousins who continued to buy third-party policies after 1909, and hence continued to provide fodder which enterprising attorneys could use to initiate new litigation.¹⁰⁴

To prevent these remaining issues from becoming a commercial liability, life insurance offices began to pay more attention to their agents' methods of attracting business. Sidney Webb reported in 1915 that they had started to "scrutinize closely all policies purporting to be on the 'life of another,'" to require signatures from lives insured, and to fine agents who exceeded the cap on policy size although he doubted that this was enough to rein in agents' bad behavior.¹⁰⁵ More significant than these partial concessions to the spirit of the 1909 Act was the increasing tendency after 1918 to extend middle-class marketing devices to their customers.¹⁰⁶ Although "surrender values" for such policies continued to be rare, owing to the fees involved, companies like the Prudential began awarding "free policies" and bonuses to customers after several years.¹⁰⁷ They also started

101. Industrial Life Offices Association Minute Book, unpublished manuscript, on file with Guildhall Library, MS 29,802, London.

102. The Assurance Companies Act, 1909, 9 Edw. 7, c. 49, § 36 (Eng.).

103. Webb, *supra* note 48, at 28. See, e.g., *Tofts v. Pearl Life Assurance Co.* (1913) 110 LT 190; *aff'd* [1915] 1 KB 189 (rejecting Pearl's claim that £40 covering the deaths of Tofts' mother and father constituted, "an unreasonable amount for mourning.").

104. MORRAH, *supra* note 9, at 75-76.

105. Webb, *supra* note 48.

106. PAUL JOHNSON, SAVINGS AND SPENDING: THE WORKING-CLASS ECONOMY IN BRITAIN, 1870 – 1939 39-43 (1985).

107. ARNOLD WILSON & HERMANN LEVY, INDUSTRIAL ASSURANCE: AN HISTORICAL AND CRITICAL STUDY 191-93 (1937).

to offer endowment insurances, which had already replaced whole-life coverage as the most popular middle-class policy around 1900.¹⁰⁸ Endowment insurance provided term coverage for ten to twenty years, then converted to an annuity if the policyholder was still alive to collect.¹⁰⁹ Industrial offices went from issuing 3.5 million endowment policies in 1912 to thirteen million in 1931, comprising a quarter of their sales.¹¹⁰ By offering free policies, and by combining life insurance with an old age pension, the companies gave customers a reason to hold onto their policies even after they survived their predicted time of death.

Legislative and administrative reforms solved most of the strictly economic problems that the Gambling Act had once put in the way of industrial insurance. The 1909 revisions greatly reduced the number of people who could claim that their policy was illegal, and the companies' new marketing methods greatly reduced their customers' incentive to sue.¹¹¹ Hence from the industrial insurance industry's perspective, it made sense to pretend, as their upper-class counterparts had been doing for a century, that "gambling" no longer had anything to do with their business. As J.A. Jefferson of the Britannic confidently assured Sir Benjamin Cohen's parliamentary committee on industrial insurance in 1931, "[t]he British working classes of to-day are not gambling and thinking only of having a bit on the old man";¹¹² the fact that nearly 80% of his company's business was comprised of "life of another" policies—all of which would have been technically illegal under the Gambling Act—was "all part and parcel of the assurance."¹¹³

Many social critics were not as willing to let the matter rest. In his 1915 Fabian Society report on industrial insurance, Webb scolded the companies for having gotten Section 37, "smuggled into the Life Assurance Companies Act almost without discussion," and called the companies' high caps on funeral expenses, "an abuse which calls for a remedy."¹¹⁴ Cohen accused the 1909 Act of giving "a right . . . to the poor man and not to the rich" and the Cohen Committee berated the companies for encouraging, if

108. JOHNSON, *supra* note 106, at 41.

109. ROBERT T. GREEN, LIFE INSURANCE BLINDNESS 132 (1929).

110. JOHNSON, *supra* note 106, at 41.

111. See DENNETT, *supra* note 47, at 173-74.

112. DEPARTMENTAL COMMITTEE ON THE LAW AND PRACTICE RELATING TO INDUSTRIAL ASSURANCE, MINUTES OF EVIDENCE, 1931, H.M.S.O. 233, 249.

113. *Id.*

114. Sidney Webb, *The Special Supplement on The Working of the Insurance Act*, THE NEW STATESMAN, Mar. 1914, at 27-28.

not gambling *per se*, "economic waste on expenses of every kind in connection with death in working-class homes."¹¹⁵ Once Parliament had solved the "gambling" problem to their own satisfaction, however, the industrial offices were just as successful at keeping these continuing "collectivist" criticisms at bay. Two interwar inquiries produced no significant new laws, and a further attempt to nationalize industrial insurance in 1950 came to nothing.¹¹⁶ One reason why companies were able to resist such reforms for as long as they did was because they had figured out when to move their problem out of the courts and back into the market, where "collectivist" judges could rarely touch them.

115. Wilson & Levy, *supra* note 107, at 141-42.

116. See Dennett, *supra* note 47, at 260-62, 294-99.

**INSURER-POLICYHOLDER INTERESTS,
DEFENSE COUNSEL’S PROFESSIONAL DUTIES,
AND THE ALLOCATION OF POWER TO
CONTROL THE DEFENSE**

*James M. Fischer**

[T]he ethical dilemma . . . imposed upon the insurer-employed defense Attorney would tax Socrates, and no decision or authority we have studied furnishes a completely satisfactory answer.**

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* Professor of Law, Southwestern Law School. I would like to thank Thomas Baker, David Hyman, and Charles Silver for their helpful comments and suggestions many years ago when this paper was in its infancy. I would also like to thank the anonymous reviewer who provided helpful comments for this paper during the selection process.

** Hartford Accident & Indemnity Co. v. Foster, 528 So.2d 255, 273 (Miss. 1988).

I. INTRODUCTION

The typical, and traditional, model of professional responsibility assumes one client and one lawyer. Within this binary model, which is largely governed by notions of agency law,¹ the lawyer's course of conduct is governed by a basic duty of loyalty.² Because there is only a single focus or object of the duty, the lawyer's ability to be loyal is usually not complicated. Indeed, the concerns here are more frequently directed toward excessive zeal rather than misdirected zeal.³

Many legal relationships do not, however, fit nicely into this binary model. Consider, for example, a scenario that is replayed hundreds if not thousands of times a day in the United States. A policyholder is involved in an automobile accident and is sued by the other driver ("claimant") for personal injuries. The policyholder is insured under a standard automobile liability insurance policy issued by an insurer. The policyholder requests that the insurer provide a defense as promised by the terms of the policy.⁴

1. *See* Westinghouse Elec. Corp. v. Kerr-McGee Corp., 580 F.2d 1311, 1316 (7th Cir. 1978). *See generally* L. RAY PATTERSON, LEGAL ETHICS: THE LAW OF PROFESSIONAL RESPONSIBILITY §2.01 (1989). *See infra* note 30, which states that under the law of agency, the lawyer may be characterized as either an agent or an independent contractor depending on the situation. Neither the Restatement of Law Governing Lawyers nor Agency Law identifies the lawyer-client relationship as specifically one of agency or independent contracting. RESTATEMENT (THIRD) LAW GOVERNING LAWYERS §14 (2000); RESTATEMENT (THIRD) OF AGENCY LAW §1.01 (2006).

2. CHARLES WOLFRAM, MODEL LEGAL ETHICS §4.1 (1986); RESTATEMENT (THIRD) OF LAW GOVERNING LAWYERS §16 cmts. b, e (2000); *Flatt v. Superior Court*, 855 P.2d 950, 957 (Cal. 1994) (describing lawyer's duty of loyalty to an existing client as "inviolable").

3. *See* Richard Wasserstrom, *Lawyers as Professionals: Some Moral Issues*, 5 HUM. RTS Q.1 (1975) (noting that lawyer's professional independence and the adversary culture encourages a "zealous" advocacy that is often socially disruptive). Wasserstrom's paper is enormously controversial, but nonetheless, the increased attention given to sanctions rules, such as Rule 11, Federal Rules of Civil Procedure, and civility codes supports a general agreement that advocacy can be, and often is, excessive. *See* WOLFRAM, MODEL LEGAL ETHICS §10.3, *supra* note 2, at 578-82.

4. Under the standard liability insurance policy, the insurer promises:

We will pay damages for "bodily injury" or "property damage" for which any "insured" becomes legally responsible because of an auto accident. Damages include pre-judgment interest awarded against the "insured." We will settle or defend, as we consider appropriate, any claim or suit asking for these damages. In addition to our limit of liability, we will pay all defense costs we incur. Our duty to settle or defend ends when our limit of liability for this

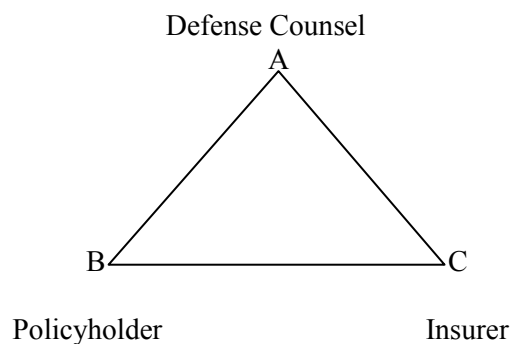
The insurer agrees and retains “defense counsel” to represent the policyholder in the litigation with the claimant.

The insurance model does not fit into the traditional binary model. The insurance model creates a multilateral relationship between the involved parties and this is reflected in the use of terms to describe it, such as triangular, tripartite, trilateral, or three cornered.⁵ The following schematic is frequently used to illustrate the parties’ relationship:

coverage has been exhausted. We have no duty to defend
any suit or settle any claim for “bodily injury” or “property
damage” not covered under this policy.

ROBERT E. KEETON & ALAN I. WIDISS, *INSURANCE LAW A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES*, 1216 (Practitioner’s ed. 1988). Similar obligations are found in other forms of liability insurance coverage, such as commercial general liability insurance, *Id.* at 1243, and homeowner’s insurance, *Id.* at 1227.

5. Articles and papers on the insurance model are legion. See Aviva Abramovsky, *The Enterprise Model of Managing Conflicts of Interest in the Tripartite Insurance Defense Relationship*, 27 CARDOZO L. REV. 193 (2005); Charles Silver and Kent Syverud, *The Professional Responsibilities of Insurance Defense Lawyers*, 45 DUKE L.J. 255 (1995); Symposium: *Liability Insurance Conflicts and Professional Responsibilities*, 4 CONN. INS. L. J. 1 (1997). See also John Larkin, *ETHICAL CONSIDERATIONS FOR ATTORNEYS ACTING AS INSURANCE DEFENSE COUNSEL*, 518 PLI/Lit. 381 (Feb.-March 1995); Michael A. Berch & Rebecca White Berch, *Will the Real Counsel for the Insured Please Rise?* 19 ARIZ. ST. L.J. 27 (1987); Karen O. Bowdre, *Conflict of Interest Between Insurer and Insured: Ethical Traps for The Unsuspecting Defense Counsel*, 17 AM. J. TRIAL ADVOC. 101 (1993); John A. Edginton, *Ethics at Sea: Ethics Issues for Maritime Lawyers and Insurers*, 70 TUL. L. REV. 415 (1995); Robert B. Gilbreath, *Caught in a Crossfire Preventing and Handling Conflicts of Interest: Guidelines for Texas Insurance Defense Counsel*, 27 TEX. TECH. L. REV. 139 (1996); Eric Mills Holmes, *A Conflict-of-Interest Roadmap for Insurance Defense Counsel: Walking an Ethical Tightrope Without a Net*, 26 WILLIAMETTE L. REV. 1 (1989); Ronald Mallen, *A New Definition of Insurance Defense Counsel*, 1986 INS. COUNS. J. 108; John K. Morris, *Conflicts of Interest in Defending Under Liability Insurance Policies: A Proposed Solution*, 1981 UTAH L. REV. 457 (1981); Thomas V. Murray & Diane M. Bringus, *Insurance Defense Counsel: Conflicts of Interest*, FED’N INS. & CORP. COUNS. Q. 283 (1991); Richard L. Neumeier, *Serving Two Masters: Problems Facing Insurance Defense Counsel and Some Proposed Solutions*, 77 MASS. L. REV. 66 (1992); Robert E. O’Malley, *Ethics Principles for the Insurer, the Insured, and Defense Counsel: The Eternal Triangle Reformed*, 66 TUL. L. REV. 511 (1991); Douglas R. Richmond, *Lost in the Eternal Triangle of Insurance Defense Ethics*, 9 GEO. J. LEGAL ETHICS 475 (1996); Mark Saxson, *Conflicts of Interest: Insurers Expanding Duty to Defend and the Impact of “Cumis Counsel,”* 23 IDAHO L. REV. 351 (1987); Debra A. Winiarski, *Walking the Fine Line: A Defense Counsel’s Perspective*, 28 TORT & INS. L.J. 596 (1993); Brooke Wunnicke, *The Eternal Triangle: Standards of Ethical Representation by the Insurance Defense Lawyer, For the Def.*, Feb. 1989.



The relationship illustrated by line BC is created by the insurance contract; the relationships AB and AC arise out of the insurance contract but are not created by it. The insurance contract is necessary to the formation of the subsequent professional relationships because it creates the legal obligation on the insurer's part to defend and indemnify the policyholder from claims within the coverage promised by the policy. Pursuant to the insurance contract the insurer will retain defense counsel to represent the policyholder. However, before a client-lawyer relationship in fact exists the policyholder will have to request a defense, the insurer will have to accede to the request, and counsel will have to agree to represent the policyholder. The relationships AB and AC involve a lawyer whose relationships also implicate professional codes and the rules and principles that govern a lawyer's relationship with a client. Problems arise when the binary model of the professional codes must be integrated into the multilateral world created by the insurance contract. There is a tendency to see the problem in terms that suggests a zero-sum bargaining process, i.e., gains for one of the parties at one point of the triangle must necessarily result in a loss to one of the other parties at another point of the triangle.⁶

Not surprisingly lawyers tend to see the proper resolution of the conflict through the lens of professional duty to the client while insurers see it through the rights conveyed to the insurer by the insurance contract. These polar opposites are usually advanced with a "take no prisoners"

6. See Geoffrey C. Hazard, Jr., *Triangular Lawyer Relationships: An Exploratory Analysis*, 1 GEO. J. LEGAL ETHICS 15 (1987); see also John Leubsdorf, PLURALIZING THE LAWYER-CLIENT RELATIONSHIP, 77 CORNELL L. REV. 825 (1992). Both articles address the complications introduced to the bipolar relationship assumed by professional codes when third parties with whom the client also has a relationship affect the lawyer's relationship with the client.

approach.⁷ Perhaps no issue so animates the legal profession today as the prospect of non-lawyers intruding into the domain and rules of lawyer professional conduct and deportment. As a consequence, the use of harsh terms to characterize the relationship is not unknown.⁸ Much of the decisional law dealing with the triangular relationship is written against a backdrop that evidences significant mistrust that defense counsel will act in a professionally proper manner.⁹ That attitude becomes dominant and

7. See Tennessee Supreme Court Board of Prof. Responsibility, Formal Op. 99-F-143 (June 14, 1999) (concluding that an insurer may not control a policyholder's defense to the extent it would undermine the lawyer's professional duties to the client-policyholder); Stephen L. Pepper, *Applying the Fundamentals of Lawyer's Ethics to Insurance Defense Practice*, 4 CONN. INS. L.J. 27, 51 (1997) (arguing that the preferred model is that defense counsel's duties are owed exclusively to the policyholder).

8. See *Longo v. Am. Policyholder's Ins. Co.*, 436 A.2d 577, 579-80 (N.J. Super. Ct. Law Div. 1981) (noting that the relationship is "fraught with real and potential conflicts of interest," that the relationship is "delicate," and that problems that inhere in the relationship are "particularly acute"); *Rose Med. Ctr. v. State Farm Mut. Auto. Ins. Co.*, 903 P.2d 15, 17 (Colo. Ct. App. 1994) (noting the "inherent tension" in the relationship). Analysis here tends towards metaphor. Thus the triangular relationship is analogized to "The Bermuda Triangle" or is characterized as a "tightrope", "crossfire", etc. See *supra* note 5.

9. See *CHI of Alaska, Inc. v. Employers Reinsurance Corp.*, 844 P.2d 1113, 1116-17 (Alaska 1993): Where there is a conflict between insurer and insured, appointed counsel may tend to favor the interests of the insurer primarily because of the prospect of future employment. *United States Fidelity & Guar. Co. v. Louis A. Roser Co.*, 585 F.2d 932, 938 n.5 (8th Cir. 1978) ("Even the most optimistic view of human nature requires us to realize that an attorney employed by an insurance company will slant his efforts, perhaps unconsciously, in the interest of his real client—the one who is paying his fee and from whom he hopes to receive future business—the insurance company."); *San Diego Navy Fed. Credit Union v. Cumis Ins. Soc'y, Inc.*, 162 Cal. App.3d 358, 208 Cal. Rptr. 494, 498 (1984) ("A lawyer who does not look out for the insurer's best interest may soon find himself out of work." (quoting the trial court); Michael A. Berch & Rebecca W. Berch, *Will the Real Counsel for the Insured Please Rise?*, 19 ARIZ. ST. L. J. 27, 29-30 (1987). ("[T]he attorney's economic interests weigh heavily in favor of the insurer, which, after all, may retain his services in other cases; yet the rules of professional responsibility tip the scales toward the insured."); Arthur P. Berg, *Losing Control of the Defense – The Insured's Right to Select His Own Counsel*, 26 FOR THE DEFENSE 10, 15 (July 1984) ("Although [some] courts seems to trust the insurer and the attorney to act in the best interests of the insured, the more common view is that the longstanding ties that defense counsel has with the insurer will inevitably influence his conduct of the case."); Sampson A. Brown and John L. Romaker, Cumis, *Conflicts and the Civil Code: Section 2860 Changes Little*, 25 CAL. W. L. REV. 45, 54 (1988) ("The attorney, wishing to maintain the insurer's business, does not want to aggravate the company."); Mark A. Saxon, *Conflicts of Interest: Insurers' Expanding Duty to Defend and the Impact of "Cumis" Counsel*, 23 IDAHO L. REV. 351, 353 (1987) ("Insurance counsel's relationship with the insurer is contractual, usually ongoing, supported by strong financial interests, and often strengthened by sincere friendships.").

controlling if the tendency is indulged in, as it often is, to focus upon relationships in isolation or to argue that one of the legs of the triangle should be preferred.¹⁰ The approach suggested in this paper is more contextual. Identifying a lawyer's duties within the triangular relationship requires that the whole "triangular" relationship be considered, not just in terms of the obligation imposed by the bilateral, professional model or by the insurance contract. This paper's central theme is that the basic, underlying relationships intended by the parties to the insurance contract is improperly devalued and as a consequence too much emphasis is placed upon the professional code's binary model to determine how defense counsel should identify her duties and responsibilities within the triangular relationship. By the same token, the insurance contract cannot be seen as the sole, conclusive determiner of the lawyer-client relationship. The insurer, having contracted to provide the policyholder with a lawyer, must accept that its promise may be subject to the rules that govern the lawyer's behavior. The task is to find a workable reconciliation of the two themes.

I shall concede at the outset that many of the approaches I suggest in this paper are counter to the law as it now is, or at least as it is interpreted to be. But this paper's approach, which places greater emphasis on the allocation of responsibility encompassed by the parties' relationship and joint goals, is preferable to a model which looks exclusively to the professional codes or to the insurance contract to resolve issues arising out of the triangular relationship.

The approach urged in this paper is that the law should, in a pragmatic, functional manner, integrate the insurance contract and professional obligations to enable counsel to interact with the insurer and the policyholder in a way consistent with the rights, duties, goals and obligations the parties envisioned and accepted in all the agreements that define their relationship. The current, most widely accepted model holds

Id. This mistrust is shared by some of the commentators. See Abramovsky, *supra* note 5, at 199 (comparing retained defense counsel to "house counsel" for criminal organizations and suggesting that the strict scrutiny applied to lawyer representation of members of the latter for conflicts of interest should be likewise applied to lawyer representation provided by insurers because in both cases the lawyer's financial interest are aligned with the fees payer rather than the client).

10. See Pepper, *supra* note 7, 27, 28-29 (1997) (criticizing commentators who argue that the policyholder-insurer leg of the triangle is dominant and arguing that policyholder-defense counsel leg is dominant). I do not mean to diminish by exclusion the insurer-defense counsel leg of the triangle; however, the focus of attention on this leg has been the relationship between these parties, i.e., is the insurer a client of defense counsel. See *infra* Part IV A-B.

that in the face of counsel's inability *ex post* to achieve an informed, consensual reconciliation of conflicting interests, as between all of the parties to the triangular relationship, defense counsel, policyholder, and insurer, defense counsel should withdraw from the relationship.¹¹ Conflicting interests can be broadly construed to involve any situation when defense counsel's general duty of loyalty to the client (the policyholder) may be compromised by counsel's wish to please the insurer, which is the party who selected counsel, pays the counsel's fees, and may be the source of future business for the counsel.¹² As a result, defense counsel is regularly confronted with situations, which, under the professional codes, are deemed to give rise to conflicts of interest pitting the lawyer's duty of loyalty against the lawyer's financial self-interest.¹³

The withdrawal approach has largely captured the attention of academics and practitioners but it is not a realistic option when the conflict is inherent to the relationship and reflects a recurrent problem that affects a significant number of the total cases. One practitioner observed the current approach has, "a ton of baggage associated with it," and should be replaced by an approach that identifies and spells out defense counsel's duties.¹⁴ "The fundamental question is who is entitled to what and why."¹⁵ That is a fair question. The short answer is that the lawyer, in representing the policyholder, should, as the policy holder's designee accept direction from the insurer, for the claim's defense to the extent the insurer is responsible for the consequences, such as when the claim is likely to be resolved within the policy's limits.¹⁶ While I do not argue that counsel owes a duty of

11. ROBERT H. JERRY & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW § 114 at 892-93 (4th ed. 2007) (However, the section goes on to note that there is some "disagreement among courts and commentators" as to the level of withdrawal necessary).

12. See *CHI of Alaska, Inc.* 844 P.2d at 1116-17 (explaining these concepts through citation of various cases and sources).

13. Pepper, *supra* note 7, at 46 (giving the general example of the attorney being pulled between the economic dependence on "much larger insurance companies" and the "unsophisticated insured," and explaining the relation to Rules 1.7, 1.4(b), and 1.2(c)).

14. See *Keeping an Eye on ALI*, 3 INS. LITIG. REP. (BNA) at 19 (July 5, 1996).

15. *Id.*

16. See *Davenport v. St. Paul Fire & Marine Ins. Co.*, 978 F.2d 927, 931, 933 (5th Cir. 1992) (noting that standard policy language gives the insurer the right to control the defense to the exclusion of the policyholder and that this right includes the selection of defense counsel); *Crist v. Ins. Co. of N. Am.*, 529 F. Supp. 601, 603 (D. Utah 1982) ("The insurer's duty to defend corresponds to the insured's duty to relinquish control of the defense, and one cannot arise without the other"); see *N. Y. State Urban Dev. Corp. v. VSL Corp.*, 738 F.2d 61, 65-66 (2d Cir. 1984) (holding that the court will recognize the right of insurers to select defense counsel as necessarily incident to the right to control the defense); *cf. In re*

loyalty to the insurer, counsel's duty of loyalty to the policyholder-client must be measured by three considerations: the policyholder's gain and surrender of rights by entering into the contract with the insurer; the contract with the insurer; and the policyholder's request that the insurer provide a defense as required by the insurance contract. The longer answer follows.

One important limit on the scope of this paper is the assumption that the insurer has accepted the tender of the defense by the policyholder "without reservation." This means that the insurer accepts that the claim is covered by the insurance contract. I do not address in this paper the rights of the parties when the insurer indicates that it is contesting coverage, i.e., accepts the tender of the defense under a "reservation of rights."

I also do not address whether an excess of limits exposure creates a conflict of interest.¹⁷ I assume for purposes of this paper that the claim will be resolved within policy limits.

II. THE STANDARD POSITION REGARDING THE TRIANGULAR RELATIONSHIP

The standard position regarding the insurer's defense obligations under standard liability insurance policies is well known. Insurers contractually have the right to control the litigation, and this includes the selection of defense counsel to represent the policyholder.¹⁸ When the rights of the

Preferred Acc. Ins. Co. of New York, 78 NYS.2d 674, 675 (N.Y. App. Div. 1948) (by tendering claim, policyholders impliedly authorized the insurer to select counsel to defend the policyholders in the action involving the tendered claim); *see generally* 7C JOHN ALAN APPLEMAN, INSURANCE LAW AND PRACTICE WITH FORMS § 4681 (WALTER F. BERDAL rev. vol. 1979).

17. The general view appears to be that it does not. *See* Hartford Acc. & Indem. Co. v. Foster, 528 So.2d 255, 269-70 (Miss. 1986). Yet, a damage claim beyond policy limits in and of itself presents no ethical problem to the lawyer employed to defend the case, because his employment is for one of two purposes: either win the case outright, or keep the damages as low as possible. Everything he does in fulfillment of either objective must of necessity benefit both clients. The lawsuit must be defended forthwith, professional decisions and actions must be timely made.

Id. (citation omitted). *See generally* Dale E. Hausman, *Conflict Issues in the Tripartite Relationship*, in H-741 PRACTICING LAW INSTITUTE, INSURANCE LAW 2006: UNDERSTANDING THE ABC'S 197, 207-08 (2006).

18. *See* Davenport v. St. Paul Fire & Marine Ins. Co., 978 F.2d 927, 931-32 (5th Cir. 1992) (discussing the right of the insurer "to assume control of the defense of an action against the insured to the exclusion of the latter" and "the same right that an insurer exercises in its settlement negotiations is exercisable by it in its choice of counsel.").

policyholder and insurer are in conflict, the courts consistently hold that counsel's duties to the policyholder trump counsel's obligations or desire to accommodate the insurer.¹⁹ Trumping occurs even when both the insurer and policyholder are deemed to be "clients" of defense counsel.²⁰

One difficulty with the "standard position" is that courts have not carefully distinguished cases where the "rights" of the insurer and the policyholder are in conflict from cases where only their "interests" diverge.²¹ What does it mean to say that the policyholder's interests should be preferred or deemed primary? If the policyholder is the sole client, then the statement states the obvious; if the policyholder and the insurer are both clients, the statement is inconsistent with the normal rules of joint representation.²² Courts have been unwilling to confront the issue directly.

19. See John A. Edginton, *Ethics At Sea: Ethical Issues For Maritime Lawyers and Insurers*, 70 TUL. L. REV. 415, 439-40 (1995): There is little doubt under any of the ethical systems in place in the United States that the lawyer's primary duty is to the insured in the tripartite relationship. In a typical insurance defense relationship the lawyer's ties with the insurer often are longer-standing and closer than the relationship with the insured client. The lawyer most often relies on the insurer rather than the insured client for future work. Whether under such circumstances the lawyer realistically can respect the primary duty concept as well as the absolute loyalty requirement is more than questionable.

Id. (footnotes omitted). See also *Prevratil v. Mohr*, 678 A.2d 243, 250 (N.J. 1996) ("Plainly stated, in any litigation, counsel for an insurer must put the insured's interests ahead of the insurer's."); *Purdy v. Pacific Auto Ins. Co.*, 203 Cal. Rptr. 524, 533-34 (noting that lawyer retained by insurer for policyholder has primary duty to, "further the best interests of the insured"); see *JERRY & RICHMOND*, *supra* note 11, at 892 (noting view that when conflict is such that counsel can equally represent interests of both the policyholder and insurer, counsel, "assumes a duty of undivided loyalty to the [policyholder].").

20. *Purdy v. Pacific Auto Ins. Co.*, 203 Cal. Rptr. 524 (Cal. App. 1984): In the case at bench, however, there were in fact two clients, the insurance carrier and the insured. We recognize that traditionally, where an insurance carrier is called upon to defend its insured, the attorney retained by the carrier for this purpose owes the same fiduciary duty to the insured as he or she would had the insured made the selection of counsel. The attorney's primary duty has been said to be to further the best interests of the insured. *Id.* at 533 (citations omitted).

21. See, e.g., *id.* at 534 (stating that, "[i]t has long been the law in [California] that when a conflict [of interest] develops, the insurer cannot compel the insured to surrender control of the litigation, and must, if necessary, secure independent counsel for the insured") (emphasis in original).

22. The third restatement's drafters debated the point and ultimately decided to note the unique role of the tripartite relationship in American law. RESTATEMENT (THIRD) OF LAW GOVERNING LAWYERS §134 cmt.f (2006) (stating that the triangular relationship is special, and therefore practices permissible in that relationship may not travel well to other practice settings).

Another concern with the “standard position” is a fundamental one. Emphasis on professional codes and the lawyer’s duty of loyalty has caused courts to give undue emphasis to “interests” at the expense of “rights” which are set forth in the insurance contract.²³ A party’s interests may diverge from the rights he retains to vindicate that interest.²⁴ A proper approach to assessing defense counsel’s role within the triangular relationship should emphasize the rights retained and transferred by the parties to the insurance contract. The current emphasis on “interests” is unduly disruptive of the bargain struck.²⁵

In assessing the “standard position” we cannot lose sight of the difficult environment in which the triangular relationship operates. This environment results from both the myriad demands placed on the participants in the triangular relationship by their own diverging interests and the fact that the relationship is subject to influence by persons outside the relationship, particularly claimants.²⁶ These outsiders may deem it to be in their best interests to exploit tensions and exacerbate disruptive, centrifugal tendencies within the triangular relationship. Therefore, not only must the triangular relationship maintain its own equilibrium, it must occasionally do so in the teeth of efforts by outsiders to destabilize the relationship in order to obtain the benefits of a divide and conquer strategy.²⁷ For example, a claimant may plead a claim solely to force the

23. See, e.g., *Lieberman v. Employers Ins. of Wausau*, 84 N.J. 325, 338 (1980), (holding that when there is an actual conflict of interest between insurer and insured, defense counsel should not continue to represent both clients because of the duty of loyalty to the latter).

24. See William T. Barker, *Laying the Foundation for Staff Counsel Representation of Insureds*, 39 TORT & INS. L.J. 897, 904 (2004).

25. Professor Pepper criticizes the idea that the insurance contract should control the professional relationship between the policyholder and the retained defense counsel. Pepper, *supra* note 7, at 38, 62. I am not arguing that the insurance contract controls, but I do not concede that it is irrelevant; rather, I contend that all the relevant legal documents (insurance contract, retainer) and the legal rules they import (insurance law, professional responsibility) must be evaluated in determining defense counsel’s role and responsibilities within the triangular relationship.

26. See Gregor J. Schwinghammer, Jr., *Insurance Litigation in Florida: Declaratory Judgments and the Duty to Defend*, 50 U. MIAMI L. REV. 945, 945-46, 970-75 (1996). The article features a discussion of *Allstate v. Conde*, a case where a shooter’s victim filed a claim for recovery from insurer even though intentional acts were precluded from recovery. *Allstate v. Conde*, 595 So.2d 1005 (Fla. Dist. Ct. App. 1992).

27. I do not want to lay all of the problems presented by the triangular relationship at the foot of third party claimants. Many difficulties, and many of the most significant cases in this area, have involved disagreement between the parties to the insurance contract as to how the claim should be handled. *Betts v. Allstate Ins. Co.*, 201 Cal. Rptr. 528, 546 (Cal.

defendant's insurer to assume the defense claims in the hope that the insurer may prefer to settle a non-covered claim rather than incur the defense costs.²⁸

The path taken here is to examine and identify the nature of the occasionally opposing interests that are parts of the triangular relationship. This descriptive approach will identify the triangular relationship as it is generally understood; critically evaluate the relationship's strengths and weaknesses; and provide instructive suggestions on how lawyers should approach recurrent problem areas if she finds herself in the middle of a policyholder-insurer disagreement. The approach taken here rejects the all-too-easily invoked tendency to characterize the occasional opposing interests of the insurer and the policyholder as "conflicts of interests."²⁹ It

Ct. App. 1984) (finding that insurer and defense counsel acted improperly in placing interests of insurer ahead of policyholder by resisting settlement and advising policyholder to file for bankruptcy if judgment exceeded policy limits); *Parsons v. Continental Nat'l Am. Group*, 550 P.2d 94, 99 (Ariz. 1976) (holding that insurer was precluded from contesting judgment against policyholder when facts underlying coverage defense were disclosed by retained defense counsel to insurer and constituted policyholder-client's confidential information).

28. See Schwinghammer, *supra* note 26. This tactic occasionally works because the insurer's obligation to defend its policyholders is defined more broadly under the law than its duty to indemnify them. *Id.* at 948 Insurers are frequently required to defend claims that pose only a remote possibility the insurer will be obligated to indemnify the policyholder for the liability loss. *Id.* at 949-50. A claimant may also plead a claim solely to create a conflict that will disqualify the insurer from controlling the defense. Such a loss may increase the insurer's short term financial exposure because the insurer will now be required to pay for counsel selected by the policyholder and this cost is frequently greater than the cost incurred when the insurer selects counsel because (1) the policyholder, unlike the insurer, cannot promise volume in exchange for discounted rates, and (2) the policyholder is paying counsel with the insurer's money and thus lacks the incentive to purchase services economically.

29. The professional bar has consistently treated conflicts that arise within the triangular relationship as subject to resolution as if the problem were a traditional, professional conflicts of interest problem, disruptive of a binary relationship. ABA Standing Comm. on Ethics and Prof'l Responsibility, Formal Op. 96-403 (1996) ("Whatever the rights and duties of the insurer and insured under the insurance contract, that contract does not define the ethical responsibilities of the lawyer to his client") (footnote omitted); ABA Comm. on Ethics and Grievances, Formal Op. 282 (1950) (noting that lawyer retained by insurer to defend policyholder shall defend latter as his client with undivided loyalty); ABA Standing Comm. on Ethics and Prof'l Responsibility Informal Op. 1402 (1977) (noting that lawyer who is a salaried employee of insurer may represent the policyholder *but*, "it is important that the lawyer fully disclose to the client the lawyer's relationship to the insurer, and remain sensitive to any divergence of interests between the [two], and at all times act in a fashion that the insured *has no basis to believe his interests are not fully and fairly represented*" (emphasis added)). Under the professional model, the judiciary's concerns over public confidence in the legal system are frequently relied on as a relevant

is important to distinguish between the interests which are subsumed within the insurance contract and bargained out in favor of either the insurer or the policyholder and the conduct by the policyholder or insurer that compromises defense counsel's ability to represent competently and loyally the interests of a client as they are framed by the insurance contract. Not every occasion of policyholder-insurer disagreement should be treated as controlling how retained defense counsel discharges his professional obligations under the retention.

The standard position has not escaped prolonged and probing criticism. Charles Silver and Kent Syverud have criticized the preferred treatment afforded policyholders within the triangular relationship.³⁰ They contend that the triangular relationship should not be deemed unique but should be dealt with in a manner consistent with the legal system's general handling of joint representation questions.³¹ I substantially agree with many of the positions taken by Silver and Syverud. Following their path, I believe that refinement of the standard position is preferable to the current approach of resolving insurer-policyholder conflicts, which *affect* retained defense counsel, solely by reference to professional codes.

One should address questions involving defense counsel's role within the triangular relationship from a perspective that emphasizes practical, functional solutions.³² Viewed from such a perspective, judicial decisions making should be focused so that the benefits both parties sought from the insurance contract are preserved. The courts should not be guided by a desire to force the insurer and policyholder to accept a form of representation that is outside that contemplated by the insurance contract.

factor in deciding whether counsels continued representation of a client should be terminated due to the perception of a conflict of interest. *See Silver Chrysler Plymouth, Inc. v. Chrysler Motor Co.*, 518 F.2d 751, 754 (2d Cir. 1975) (noting that court must decide the issue of counsel's ability to represent a client loyally in a manner that does not violate to the administration of justice and simultaneously maintains in the public mind a high regard for the legal profession).

30. Charles Silver and Kent Syverud, *The Professional Responsibilities of Insurance Defense Lawyers*, 45 DUKE L.J. 255, 335-389 (1995).

31. *Id.*

32. *See Simon by Simon v. Van Steenlandt*, 664, N.E.2d 231, 233-34 (Ill. Ct. App. 1996) (noting the fact that parent-insured was named as defendant in personal injury action did not create conflict of interest because parent and child were only "nominally adverse," and the "lawyer in this case was only retained to defend the parent's interest *under the policy*" (emphasis added); *cf. Buehler v. Sbardellati*, 41 Cal. Rptr.2d 104 (Cal. Ct. App. 1995) (approving jury instruction that lawyer who was asked by clients to represent a partnership to be formed by them did not have a conflict of interest when clients had a common plan and engaged lawyer's services to implement their joint plan).

If there is any inequality between the policyholder and insurer insofar as defense counsel is concerned, it is often addressed by the insurance contract and thus implicitly accepted by the insurer and the policyholder.³³ Consequently, if defense counsel finds that her duty of loyalty is subjected to conflicting pulls from the policyholder and the insurer, she may find, after reflective analysis, that the parties to the insurance contract implicitly accepted that some conflicts may be resolved by defense counsel in favor of either the policyholder or the insurer in order that both the lawyer-client relationship between defense counsel and the policyholder and the continuation of the defense may be preserved. This is a method of interest resolution that courts should respect. Rather than focusing so intently on the individual constituents of the relationship, it would be more helpful to conceive of defense counsel as the lawyer for the “common defense” and evaluate her duties in that context. I appreciate that this is controversial, but as I hope to demonstrate in this paper, this approach avoids the current tendency to see the dilemma as a Hobson choice and to align counsel with the interests of the policyholder as, in effect, the lesser of two evils.

One last point before the main discussion is that it is not unusual for the professional responsibility issue to be encased in another controlling legal rule. For example, in the context of representing a defendant in a civil commitment proceeding, the issue of lawyer-client authority issue may be encased within the question whether the client’s right to due process of law was violated by the lawyer’s assertion of unilateral decision making in an area the rules of professional responsibility assign to the client or jointly to the lawyer and the client.³⁴ In this context, the

33. For example, most liability insurance policies contain deductibles, which effectively transfer to the policyholder the first dollar costs of an indemnification. If a policy has a \$100,000 policy limit with a \$5,000 deductible and the matter settles for \$15,000, the loss will be allocated \$10,000 to the insurer and \$5,000 to the policyholder. The policyholder’s substantial financial interest in settlements due to deductible obligations, does not deprive the insurer its right to control the defense and to settle, even to settle entirely within the deductible. See Jon Epstein, Annotation, *Liability of Insurer to Insured for Settling Third-Party Claim Within Policy Limits Resulting in Detriment to Insured*, 18 A.L.R. 5TH 474, 487-88 (1994) (noting that majority of jurisdictions do not permit policyholder to escape the obligation to reimburse the insurer for deductibles after the insurer has settled a claim against the policyholder).

34. See *People v. Allen*, 50 Cal. Rptr.3d 913, 915 (Cal. Ct. App. 2006) (holding that lawyer’s decision not to honor defendant’s express wish to testify in civil commitment proceeding did not violate defendant’s right to due process because proceedings were civil, defendant did not have a right to testify, and allowing him to testify would interfere with counsel’s ability to control defense and provide best defense possible); cf. *Taylor v. Illinois*, 484 U.S. 400, 415-18 (1988) (holding that defendant’s Sixth Amendment right to effective

professional rule may not be referenced, but if it is referenced it may be criticized as outside the scope of matters properly to be considered.³⁵ It is interesting that the negation of professional obligations in the due process context have generated no consternation among commentators; the integration of professional duties within a larger body of legal rights is accepted.³⁶ I argue that the same approach should be taken here.

This article discusses the role of retained defense counsel from the vantage point of two hypotheticals. The hypotheticals each use an automobile liability insurance problem to frame the issue; however, the problems discussed are generic and would arise and be resolved similarly under other forms of liability coverage, such as Homeowners Liability or Commercial General Liability. The hypotheticals will hopefully provide a context for ideas and solutions to the difficult representation issues that arise out of the triangular relationship.

III. WHO CONTROLS DEFENSE COUNSEL REGARDING LITIGATION TACTICS

Policyholder is involved in a two vehicle collision and is sued by the driver of the other vehicle's driver for personal injuries. Policyholder tenders the claim to the insurer which unconditionally accepts the defense and appoints Lawyer to represent the policyholder.

Lawyer reasonably believes that the best trial strategy is to concede liability and only contest damages and communicates this opinion to Policyholder and Insurer. Policyholder is adamant that he is not responsible for the accident despite the consistency in the evidence that he was negligent, perhaps even grossly negligent.

assistance of counsel was not infringed when defense counsel withheld from defendant counsel's intent to employ the tactic of violating a discovery order to spring a "surprise" witness even though the tactic resulted in an evidence sanction imposed on the defense). *See generally* Rodney J. Uphoff, *Who Should Control the Decision to Call a Witness: Respecting a Criminal Defendant's Tactical Choices*, 68 U. CIN. L. REV. 763 (2000).

35. *Nix v. Whiteside*, 475 U.S. 157, 176-77 (1986) (Brennan, J., concurring) (criticizing majority for extended discussion of Model Rule 3.3 dealing with candor to the court, in Sixth Amendment challenge to lawyer's threat to inform the court if defendant provided false testimony in a criminal trial). ABA Model Rule 3.3 then permitted, but did not require disclosure. MODEL RULES OF PROF'L CONDUCT R. 3.3 cmt. (1983).

36. *See* Susan P. Shapiro, *Bushwhacking the Ethical High Road: Conflict of Interest in the Practice of Law and Real Life*, 28 LAW & SOC. INQUIRY 87, 125-26, 128, 151 (2003).

Insurer informs Lawyer that it agrees with Lawyer's assessment.
May Lawyer concede liability and try only the issue of damages?
May Lawyer present no defense to the liability proof and contest
only damages?

Control of the defense by the insurer is the hallmark of the triangular relationship,³⁷ but what is specifically included in this notion of "control" receives little attention.³⁸ It is expected that defense counsel is normally given substantial discretion simply because counsel is knowledgeable and

37. See Ronald E. Mallen, *Looking to the Millennium: Will the Tripartite Relationship Survive?*, 66 DEF. COUNS. J. 481, 481 (1999).

38. Some attention has been given, however, to the related problem of devoting too little resources by the insurer to the defense of the claim. See *Bevevino v. Saydjari*, 76 F.R.D. 88, 93-94 (S.D.N.Y. 1977) (refusing to set aside verdict due to defense counsel's ineptitude when counsel's conduct was result of insurer's deliberate underfunding of the defense), *aff'd* 574 F.2d 676, 685 (2d Cir. 1978). See Thomas Cooney, *The Perils of Defense Counsel's Relinquishment of Control Over Preparation of the Defense to the Insurer*, 52 INS. COUNS. J. 259 (1985) (discussing problems raised by insurer litigation related cost containment efforts). Insurer-imposed litigation guidelines have received significant judicial and academic attention as to whether the guidelines themselves improperly interfere with retained defense counsel's independent professional judgment. ABA Comm. on Ethics and Prof's Responsibility, Formal Op. 01-421 (2001) ("[A] lawyer must not permit compliance with 'guidelines' and other directives of an insurer relating to the lawyer's services to impair materially the lawyer's independent professional judgment in representing an insured.") But the larger issue is cost containment and payment, not independent judgment: who decides how much the contracted defense will cost the defense counsel or the insurer? A lawyer may be professionally obligated to do more than the insurer wishes to pay. See *Evans v. Jeff D.*, 475 U.S. 717, 728-29 n.14 (1986) ("Generally speaking, a lawyer is under an ethical obligation to exercise independent professional judgment on behalf of his client; he must not allow his own interests, financial or otherwise, to influence his professional advice.") Should the lawyer's professional obligations, as defined by the lawyer and the professional bar, determine the insurer's contractual obligation to provide a defense? Compare Michael D. Morrison and James R. Old, Jr., *Economic, Exigencies and Ethics: Whose Choice? Emerging Trends and Issues in Texas Insurance Defense Practice*, 53 BAYLOR L. REV. 349 (2001) (lawyers and professional bar determine); with Charles Silver, *Flat Fees and Staff Attorneys: Unnecessary Casualties in the Continuing Battle Over the Law Governing Insurance Defense Lawyers*, 4 CONN. INS. L.J. 205 (1997-1998) (arguing that insurer imposed litigation guidelines and cost-containment strategies do not *per se* improperly interfere with retained defense counsel's professional obligations to the client-policyholder). See generally Claire Hamner Maturro, *Ethical and Legal Snares Waiting for Attorneys Subject to Legal Fee Audits and Billing Guidelines*, 24 J. LEGAL PROF. 111 (2000) (discussing legal audits and billing audits throughout article); Susan Randall, *Managed Litigation and the Professional Obligations of Insurance Defense Lawyers*, 51 SYRACUSE L. REV. 1 (2001) (collecting and discussing case and commentary on the topic).

experienced in the matter. In most cases the matter is resolved through default; the insurer instructs retained defense counsel and the policyholder, if she is even informed *ex ante* about the decision, either (1) acquiesces, (2) agrees after a half-hearted opposition, or, (3) in the most common of cases, acts simply as a passive spectator. Much of this soft underbelly of the law defies exposure because of the lawyer's ability to "control" the client. A lawyer persuades and, to a larger extent, the client accepts that the lawyer's analysis and legal recommendations should be followed. It would, after all, be somewhat surprising if the client consistently disregarded the lawyer's advice and recommendations as to matters germane to the representation. A client desires to be represented by a lawyer because lawyers possess the knowledge, experience, and expertise that clients lack. Occasionally however, the lawyer's recommendations and advice will conflict with the client's personal agenda and the client will resist following the lawyer's recommendations. That is the situation assumed in this hypothetical. Thus, the question is poised as to how counsel should resolve the dilemma of conflicting instructions received from the policyholder and the insurer.

Before we address the issue who, policyholder or insurer, may instruct counsel, we should first address whether a client has a say in the matter. Are litigation and trial tactics some things that are left to the lawyer's professional competence and the lawyer's unfettered discretion? The professional codes are somewhat opaque on this point. The American Bar Association's Model Rules, Rule 1.2 provides in pertinent part, "a lawyer shall *abide* by a client's decisions concerning objectives of representation . . . and shall *consult* with the client as to the means by which they are to be pursued."³⁹ The distinction between the objectives or ends of the litigation and the means by which they are to be achieved is frequently stated in the law and just as frequently conceded to be relatively imprecise. "[A] clear distinction between objectives and means sometimes cannot be drawn, and in many cases the client-lawyer relationship partakes of a joint undertaking."⁴⁰ Nonetheless, the black letter rule suggests that the client controls the identification and defining of representation "objectives", i.e., the lawyer must "abide" by the client's decision on those points;⁴¹ but the term "consults" suggests more lawyer discretion for the means to achieve the client's objectives. This distinction is also supported by the comment to Rule 1.2, that states, "[c]lients normally defer to the special knowledge

39. MODEL RULES OF PROF'L CONDUCT R. 1.2 (2007) (emphasis added).

40. MODEL RULES OF PROF'L CONDUCT R. 1.2 cmt. (1992).

41. See MODEL RULES OF PROF'L CONDUCT R. 1.2 (2007).

and skill of their lawyer with respect to the means to be used to accomplish their objectives, particularly with respect to technical, legal and tactical matters.”⁴² Rule 1.2 seems to support, within the context of the hypothetical, that it is counsel’s initial decision to litigate only the damages issues on the theory that evaluating evidence and case presentation are technical and legal tactical issues, and tactical decisions will not result in any direct expense to the policyholder. Direct expense here refers to immediate “out of pocket” outlays such as expert witness fees, deposition costs, etc. There is always the prospect that the lawyer’s tactical choices will fail and the client will end up paying more because of it, but this type of cost is inherent in any representational relationship.

The problem is that almost any issue in a litigated matter can be defined as an end or as a means to achieve an end. In the above hypothetical, is the "end" minimization of economic exposure, or vindication of self and one's sense of self-worth? It is difficult to treat the decision to litigate only damages as a "means" decision under the vindication of self-worth “end.” We may expect that the insurer and the policyholder will often define ends differently, and this may be intensified when a claim is presented and the insurer assumes control of the defense. Insurers may be expected to be more oriented towards loss minimization; policyholders may be expected to be more inclined than insurers to see the litigation process as a forum for vindication and self-validation. But even this viewpoint may be inverted. A policyholder may be tremendously risk averse to any prospect of a financial loss arising out of the litigation and may see loss minimization as the primary objective. The insurer, as the prototypical "repeat player,"⁴³ may evaluate a particular lawsuit as one in which the larger objective is the signal a steadfast defense will send to plaintiff's counsel in the particular case and/or the plaintiff trial bar in general. Either the insurer or the policyholder may see a particular claim as a self-contained event or as part of a process. The insurer may be concerned about the case’s precedential value because it is a repeat player and is similarly situated across a number of claims. The policyholder will not share this concern, but may be concerned about the impact that litigation will have when the claimant has a business or family relationship

42. MODEL RULES OF PROF’L CONDUCT R. 1.2 cmt. (2007).

43. See Marc Galanter, *Why the “Haves” Come Out Ahead: Speculations on the Limits of Legal Change*, 9 LAW & SOC’Y REV. 95, 97-101 (1974) (noting that parties that have substantial experience with the legal system may be expected to be better able to use the system to their advantage and will be less risk adverse regarding the uncertainty of litigation than parties who only occasionally encounter the legal system).

with the policyholder. That relationship will color the viewpoints of both policyholder and insurer, but often in different ways. The policyholder will often desire that the claim be resolved in a fashion that preserves the relationship. This suggests action short of litigation and the loss of negotiation leverage. The insurer may be concerned that the relationship has fostered the claim. This attitude is so strong on the insurer's part that they frequently seek to exclude coverage for claims against the policyholder by related family members.⁴⁴

Even when the lawyer has initial discretion, that discretion may be subject to overriding by client instruction, at least to the extent the instruction would not require the lawyer to violate a professional code.⁴⁵ Lawyers are interchangeably characterized as both agents and independent contractors with respect to clients.⁴⁶ The label seems to follow the result

44. See Keeton & Widiss, *supra* note 4, at §4.9(c)(1) (noting prevalence of household and family member exclusion clauses in automobile liability insurance policies).

45. See *Wisconsin v. Divanovic*, 546 N.W.2d 501, 506 (Wis. Ct. App. 1996) (noting that court appointed counsel must abide by the client's instructions concerning the objectives of the representation, but that the lawyer, in so doing, may not engage in action that would "constitute a violation of the Rules of Professional Conduct or other law"). Some decisions, particularly in the context of the criminal justice system, are deemed so fundamental that the court must directly obtain the defendant-client's assent. *Jones v. Barnes*, 463 U.S. 745, 751 (1983) (listing "fundamental" choices). In other cases, a court may assume that counsel speaks for the defendant-client. There is, admittedly, a fine line between a case which holds that counsel must abide by the client's instruction as to objectives, see *id.* at 753-54, and a case which holds that a decision is technically complex and therefore appropriately assigned to counsel to make rather than being deemed personal or fundamental and thus belonging to the client, see *United States v. Boyd*, 86 F.3d 719, 724 (7th Cir. 1996) (holding that decision whether to challenge juror is tactical decision committed to counsel). No objection to counsel's decision was made at trial and the *Boyd* court's decision was influenced by an unwillingness to allow a defendant to "game the system" by feigning acquiescence but thereafter objecting if the strategy failed. *Id.* at 722-23; see also *Gonzalez v. United States*, 128 S. Ct. 1765, 1771 (2008) (holding that decision to conduct voir dire before Article 1 Magistrate Judge could be made by counsel). The Court expressly noted that it did not address the question of the client's objection to counsel's tactical choice. *Id.* at 1772. ABA Model Rule 1.2 takes no position how disagreements over means-based decisions should be resolved, other than to advise consultation and the option of termination of the relationship by either the lawyer or the client if the matter cannot be resolved. MODEL RULES OF PROF'L CONDUCT R. 1.2 cmt. 2 (2007).

46. See *McCarthy v. Recordex Service, Inc.*, 80 F.3d 842, 853 (3d Cir. 1996); see also RESTATEMENT (SECOND) OF AGENCY 1, cmt.(e) (1958) (noting that attorneys are agents of their clients, although as to physical activities, they are independent contractors). In some cases defense counsel is characterized as a co-agent of the policyholder and the insurer. *Marten Transport Ltd. v. Hartford Speciality Co.*, 533 N.W.2d 452, 457 (Wis. 1995) (noting that co-agency was proper identification of relationship when the policyholder selected

rather than assist in determining the result. While courts sometimes characterize lawyers as independent contractors, and therefore outside client control as to the manner of performing their legal work, the fact is that those statements are made in contexts where the client has not specifically instructed the lawyer.⁴⁷ The more accurate view is that client instruction trumps lawyer professional discretion as long as the instruction does not require the lawyer to act illegally or unprofessionally.⁴⁸ Thus, while we may expect that the client will defer to the lawyer's expertise, the client is not legally obligated to do so; rather, it is the lawyer who must defer to the client's call. Even on the issue of trial tactics, while the lawyer proposes, the client disposes.⁴⁹ Consequently, we must confront the issue of from whom retained defense counsel must take instruction, the

counsel and distinguishing such a case from the "relationship between an insurer and a defense counsel fostered by a classic tripartite insurance scheme).

47. The Restatement of the Law Governing Lawyers adopts this view, noting that while the lawyer may usually exercise any lawful means to advance a client's objectives, that discretion is limited by client instruction. RESTATEMENT (THIRD) OF LAW GOVERNING LAWYERS 21(3) (2000). The client's authority to instruct the lawyers is, on the other hand, only limited by the lawyer's obligation not to engage in unlawful conduct or disobedience of an order of a tribunal. *Id.* at 23; see *Foothills Dev. Co. v. Clark County Bd. Of County Comm'rs*, 730 P.2d 1369, 1373 (Wash. Ct. App. 1986) (holding that lawyer was obliged to follow client's specific instructions).

48. As noted earlier, instances do occasionally arise when courts approve of lawyers refusing or failing to follow a client's direct instructions, but these appear limited to representation in criminal or quasi-criminal matters when the issue is raised in the context of the defendant's right to a fair trial. See *supra* note 30. See *Sistrunk v. Vaughn*, 96 F.3d 666, 668, 671 (3d Cir. 1996) (holding that as to non-fundamental issues appointed appellate defense counsel may, after consultation, override client's wishes as to which issues to raise in the Brief); *People v. Penrod*, 169 Cal. Rptr. 533, 537-540 (Cal. Ct. App. 1980) (stating that ordinarily decision as to which witnesses to call is tactical decision within attorney's control). In *Penrod*, the client objections were framed in terms of a mid trial effort to substitute new counsel for court-appointed counsel and a complaint that he was not personally permitted to interview witnesses so as to play a larger role in witness designation for trial. *Id.* at 540; see generally GEOFFREY C. HAZARD, JR. ET AL, THE LAW AND ETHICS OF LAWYERING, 826-28 (4th ed. 2005) (collecting cases).

49. RESTATEMENT (THIRD) OF LAW GOVERNING LAWYERS 22, cmt. d (2000). For an interesting application of this principle, see *Johnson v. Amethyst Corp.*, 463 S.E.2d 397, 400 (N.C. Ct. App. 1995) (finding error when the trial court permitted defense counsel, retained by the insurer to represent the policyholder without the policyholder's consent, to set aside a default judgment against the policy-holder); but cf. *Reliance Ins. Co. v. Superior Court*, 100 Cal. Rptr.2d 807, 810-11 (Cal. Ct. App. 2000) (concluding that insurer could intervene in litigation commenced against its policyholder when the policyholder, a corporation, was unable to appear because its corporate status was suspended due to non-payment of taxes; the insurer had a direct interest in preventing the entry of a default judgment that it might be required to satisfy).

policyholder or the insurer?⁵⁰ Is the matter controlled by the professional rules or does the tripartite relationship warrant a different approach?

Pursuant to the insurance contract the policyholder has ceded control over the litigation to the insurer. Does that fact control counsel's relationship with the policyholder-client? In the context of this hypothetical, the central issue is control over litigation tactics. The policyholder wishes to contest liability, perhaps to avoid the stigma of responsibility or the economic consequences of a finding of fault.⁵¹ A defense limited to the issue of damages may be perceived by the policyholder as an acknowledgment of legal responsibility. For some individuals such an admission may be difficult to make even in the face of clear evidence of fault. Some individuals can live with the vagaries of life. They will accept the decision to focus the litigation on minimizing the loss even though it means admitting, or being understood as admitting, responsibility for conduct they do not actually believe was legally wrongful. Other individuals will find such conduct morally and emotionally repugnant. These individuals have, of course, an option. They can defend at their own expense or they can bargain for "consent to settle" provisions.⁵² Should policyholders be allowed to tender the defense of the

50. While regulation of the legal profession has found support and criticism in a number of models, see John Leubsdorf, *Three Models of Professional Reform*, 67 CORNELL L. REV. 1021 (1982) (noting and comparing market, regulatory, and personal responsibility approaches), courts have consistently emphasize the overarching duties of the lawyer against a backdrop of client vulnerability; see WOLFRAM, LEGAL ETHICS, *supra* note 2, at 146-47 (noting that courts consistently treat lawyer-client relationship as involving highest trust and confidence). These judicial sentiments are also expressed, albeit with somewhat lessened vigor, to the preliminary conduct leading to the formation of the relationship. See *Id.* at 495-504, 553-556 (noting that courts retain broad power to regulate fee disputes even though the traditional view is that a lawyer does not act in a fiduciary capacity when negotiating the initial retainer agreement with the client).

51. The policyholder's interest in avoiding reputation stigma is consistently subordinated to the insurer's financial interest. See *Caplan v. Fellheimer, Eichen, Braverman & Kaskey*, 68 F.3d 828, 837-38 (3d Cir. 1995) (noting that policyholder's concern over harm to reputation would not support "bad faith" action against insurer for settlement within policy limits of claim against policyholder); *Charter Oak Fire Ins. Co. v. Color Converting Indus. Co.*, 45 F.3d 1170, 1172 (7th Cir. 1995) (stating that majority view is that the insurer does not have duty to handle the claim in a manner that would protect the policyholder from losing its best customer); *W. Polymer Tech., Inc. v. Reliance Ins. Co.*, 38 Cal. Rptr. 2d 78, 84-85 (Cal. Ct. App. 1995) (holding that insurer could settle claim without consent of policyholder even though settlement allegedly injured policyholder's reputation).

52. *Caplan v. Fellheimer, Eichen, Braverman & Kaskey*, 68 F.3d 828, 837-38 (3d Cir. 1995) (noting that a "consent-to-settle provision protects the professional . . . who is

claim to their liability insurers, by which they surrender control of the defense to the insurer, yet still insist upon and expect the same ability to control defense counsel retained by the insurer as if the policyholder had retained counsel directly and independently for its own account?

The difficulty with a solution to the above questions lies in the legal system's adherence to a professional imperative that binds the lawyer by ties of loyalty to the client.⁵³ The professional codes are largely silent as to whether, and if so to what extent, the client can delegate control to another, such as an answer. The Restatement recognizes that the client may broadly delegate authority to the lawyer,⁵⁴ however, that delegation is revocable.⁵⁵ The problem is the Restatement addresses the problem as a binary relationship between lawyer and client in which the parties allocate and distribute authority between themselves. The Restatement does not address the problem from a multilateral perspective when the parties enter into separate, but integrated relationships that require some accommodation from strict insistence on rights expressed at one part of the relationship in order for the entire relationship to be successful.

The notion of loyalty is fundamentally expressed by the ideal that the lawyer must not permit her independent professional judgment -- which is to be devoted to the achievement of the client's lawful objectives -- to be corrupted by the lawyer's devotion to the interests of others. In the context of the triangular relationship this ideal has been captured by the idea that the lawyer may not permit the interests of the insurer to deflect the lawyer from her duty of loyalty to the policyholder-client. Yet, it is somewhat surprising that an ideal that is supposedly based on client interest cannot be subordinated to the wishes of the client. If the client authorizes another to exercise all or some of the prerogatives of a "client", why should a lawyer be precluded from functioning as a lawyer under such an arrangement? And if a lawyer is retained as a result of an arrangement whereby one person authorizes another person to control and direct the lawyer, should the first person be permitted to abrogate that agreement yet retain the benefits derived from the arrangement -- the services of the lawyer?

concerned about his or her reputation"); CAL. BUS. & PROF. CODE 801(d) (requiring the consent of health care professionals for settlement of health care malpractice claims).

53. Loyalty to the client is an integral aspect of the lawyer-client relationship. Rule 1.7 cmt.1: "Loyalty and independent judgment are essential elements in the lawyer's relationship to a client"; *see, supra*, note 2.

54. RESTATEMENT, LAWYERS, *supra* note 1, § 22(1).

55. *Id.* at § 22(3).

The allocation of the right to control the lawyer, as between joint clients, can be compared to the allocation between constituents of a represented entity of the right to control the lawyer for the entity.⁵⁶ Owners of an entity may contract amongst themselves with respect to how a lawyer for that entity will be instructed and delegate the power to instruct and control the lawyer to specific constituents of an entity client.⁵⁷ Transfer of

56. Rule 1.13(a) (adopting rule that lawyer represents entity as client); *cf.* American Mut. Liab. Co. v. Superior Court, 113 Cal. Rptr. 561, 571 (Cal. Ct. App. 1974):

In the insured-insurer relationship, the attorney characteristically is engaged and paid by the insurer to defend the insured. The insured and the insurer have certain obligations each to the other, as previously noted, arising from the insurance contract. Both the insured and the insurer have a common interest in defeating or settling the third party's claim. If the matter reaches litigation, the attorney appears of record for the insured and at all times represents him in terms measured by the extent of his employment.

In such a situation, the attorney has two clients whose primary, overlapping and common interest is the speedy and successful resolution of the claim and litigation. Conceptually, each member of the trio, attorney, client-insured, and client-insurer has corresponding rights and obligations founded largely on contract, and as to the attorney, by the Rules of Professional Conduct as well. The three parties may be viewed as a loose partnership, coalition or alliance directed toward a common goal, sharing a common purpose which lasts during the pendency of the claim or litigation against the insured. Communications are routinely exchanged between them relating to the joint and common purpose – the successful defense and resolution of the claim. Insured, insurer, and attorney, together form an entity – the defense team – arising from the obligations to defend and to co-operate, imposed by contract and professional duty. This entity may be conceived as comprising a unitary whole with intramural relationships and reciprocal obligations and duties each to the other quite separate and apart from the extramural relations with third parties or with the world at large. Together, the team occupies one side of the litigating arena.

Id.

57. See RESTATEMENT, LAWYERS, *supra* note 1, 14, cmt. f: When the client is a corporation or other organization, the organization's organic law determines whether a particular agent has authority to retain and direct the lawyer. In Formal Opinion 1994-137

the power to control counsel by consent of the owners of an entity does not appear to be objectionable.⁵⁸ The lawyer retained by the entity would rightfully look for instruction to the constituents with the delegated power to control the lawyer.⁵⁹ Professional codes have historically prevented the owners of the entity from having any direct control over the lawyer for the entity to the extent that the lawyer could not report entity misfeasance to the owners. In this context, the legal profession exhibited no unease with the view that the owners of the entity (shareholders) could irrevocably delegate to their agent (Board of Directors) the power to control the entity's lawyer. Until recently, professional codes expressly ordered the lawyer for the entity to report no further than the Board. Here delegation of authority is enshrined as necessary to permit the proper functioning and advising of the entity. Although the current version of Model Rule 1.13 relaxes the strict requirement of no outside disclosure absent consent, the relaxation is

the California State Bar Committee on Professional Responsibility and Competence emphasized the desirability of a partnership agreement defining how and by whom the lawyer for the partnership would be instructed. Although the Committee did not expressly address how the agreement would control counsel, its comments carry the inference that the agreement could control counsel. Similarly, in *Griva v. Davison*, 637 A.2d 830, 840 (D.C. App. 1994), the court held that a unanimous consent provision in partnership agreement made individual partners functional clients of the partnership's lawyers. The inference again from the opinion is that the partnership agreement may control not only who is counsel's client but who instructs counsel. For example, if the agreement specified that partner A should instruct counsel, this would indicate that partners B and C were not functional clients and that as between A, B, and C, the three have delegated authority to A to speak for the partnership when dealing with counsel. See generally WOLFRAM, LEGAL ETHICS, *supra* note 2, at 8.3, pp.426-27 (noting that issue has been ducked by most courts because of judicial disinclination to become involved in client selection while at the same time the court is hesitant to vest one faction with the sole right to select and control counsel for the entity).

58. The professional codes expressly address decision-making between corporate client and lawyer (see ABA Rules, Rule 1.13(b) and comment) but do not expressly address the issue as to non-corporate entities. See CENTER FOR PROFESSIONAL RESPONSIBILITY ANNOTATED RULES OF PROFESSIONAL CONDUCT 206-207 (6th ed. 2007) (noting split among authorities whether non-corporate entities should be treated as entities or as aggregation of individual constituents of non-corporate entity). The position taken in the Restatement of the Law Governing Lawyers that the entity's organic law determines which entity constituents directs and instructs counsel, *see, supra*, note 57, was not accompanied with any authorities in the Reporter's Note to comment f.

59. This is the accepted model in the corporate context. WOLFRAM, LEGAL ETHICS, *supra* note 2, at §13.7.2, p.734 (noting that lawyer should accept direction from person(s) within corporation who is lawfully entitled to give direction to counsel and that person is defined by the internal structure of the corporation).

slight and reserves discretion to the lawyer on whether to disclose outside the entity.⁶⁰

The entity model adapts nicely to the triangular relationship. The insurer and policyholder have, in function and effect, created a defacto joint venture to defeat or resolve the claim brought against the policyholder that affects their shared, mutual interests. Admittedly, there are some differences between the traditional entity representation and the defacto joint venture that is the triangular relationship. In the triangular relationship, a lawyer-client relationship exists between the lawyer and the person (policyholder) who has surrendered the right to control the lawyer to another (insurer).⁶¹ In the entity representation case, no lawyer-client relationship necessarily exists between the lawyer and the constituent who has been assigned the right to instruct and control the lawyer.⁶² Concededly, in the entity context, the lawyer formally represents the entity, whereas in the triangular relationship, the lawyer formally represents the individual policyholder.⁶³ But, the formal presence of a lawyer-client

60. See MODEL RULES OF PROF'L CONDUCT R. 1.13 (2007); see also HAZARD, *supra* note 48, at 367 (discussing revision of Model Rule 1.13(c) to permit attorney disclosure of entity wrongdoing when entity's highest authorities refuse to address and rectify the problem and the wrongdoing will likely result in substantial injury to the entity). The ABA initially rejected a draft of the Model Rules that would have permitted the lawyer in limited circumstances to disclose corporate wrongdoing to shareholders or others as necessary in the best interests of the organization in favor of the previous version of Rule 1.13 that did not allow for disclosure except as authorized by the entity client's highest authority. See Evan A. Davis, *The Meaning of Professional Independence*, 103 COLUM. L. REV. 1281, 1284, 1287-88 (2003). The current rule version permits disclosure outside the entity in limited circumstances. See HAZARD, *supra* note 48, at 367.

61. Susan P. Shapiro, *Bushwhacking the Ethical High Road: Conflict of Interest on the Practice of Law and Real Life*, 28 LAW & SOC. INQUIRY 87, 120 (2003).

62. James M. Fischer, *Representing Partnerships: Who is/Are the Client(s)?*, 26 PAC. L.J. 961, 963 (1995).

63. Compare Shapiro, *supra* note 61, at 120 with Fischer, *supra* note 62, at 963. However, the concession is broader than the law requires:

There are two competing theories that apply to the issue of client identification when the lawyer represents an artificial legal contract, such as a corporation or partnership. The "group" or "aggregate" theory holds that the lawyer represents both the legal entity and leading individuals who control or manage the entity. The "entity theory" holds that the lawyer represents the entity alone.

relationship on this point should not be determinative; functionally, the situations are similar.⁶⁴ In both situations, the retention of the lawyer is designed to achieve a common goal. The insurer and the policyholder have contractually identified a common goal, defense of the claim, just as the constituents of the entity have identified a common goal, the success of the entity. In both situations, the interested parties have decided, as between themselves, that control over the lawyer should not be shared but should be delegated to one of the parties. In both situations, the decision to delegate control can be assumed to be generally beneficial to the interested parties.

Neither the decisional law nor the professional codes prohibit joint representation, except in limited situations.⁶⁵ The ways in which conflicts of interest issues are raised—for example, lawyer discipline, motion to disqualify, legal malpractice, etc.—tend to emphasize the negative aspects of joint representation.⁶⁶ Yet, the very persistence of joint representation is evidence of its value to clients.⁶⁷ If insurer control of the defense was an

Fischer, *supra* note 62, at 963 (footnotes omitted). The “entity” theory dominates in the context of corporate representation, but is less entrenched in other areas, such as the representation of partnerships, associations, ventures, etc. *Id.* at 965-68.

64. *But see* Pepper, *supra* note 7, at 29-31 (arguing that in forming a partnership or venture the lawyer is often confronted with conflicts among the promoters of the venture). That is correct, but besides the point here. The issue here is not forming a relationship among potentially or actually conflicted persons, but addressing how decision making authority has been allocated within relationships formed independently of one another, but with an awareness of and dependence on the other relationships. The legs of the triangular relationships do not act in isolation; they act together. In assigning rights and duties within the triangular relationship that fact should not be ignored.

65. *See* WOLFRAM, *supra* note 2, at 349-50.

66. *Id.* at 349.

67. *Id.* Wolfram notes that:

[T]here are good reasons for clients to wish a lawyer to undertake a joint representation. The net fee charged to the clients can be less than for separate representations. Two or more clients may so trust or otherwise value the same lawyer that they are willing to overlook relatively minor differences in their positions. The clients might find it better for tactical reasons to band together behind a common champion rather than to hang separately. Among other things, clients may deliberately choose joint representation in order to minimize mutual recrimination.

Id. (footnote omitted). *See generally* Jonathan R. Macey & Geoffrey P. Miller, *An Economic Analysis of Conflict of Interest Regulation*, 82 IOWA L. REV. 965 (1997) (arguing that the conflicts of interest rules found in modern professional codes are efficient rules,

ineffective and inefficient allocation of resources, it would not command the usage that it does. Indeed, there is little question but that the economies of scale, litigation experience, and risk neutrality that insurers bring to claim adjustment and litigation reduce both the aggregate costs of defense and the amount expended to satisfy claims against policyholders.⁶⁸

Both course of practice and intuition support the cost effectiveness of insurer control.⁶⁹ If policyholder control were more efficient, one assumes that one or more insurers would have stumbled upon it by now and it would have come to dominate the market. The fact that the market does support insurer control is evidence of the superior efficiency of insurer control. In Galanter's study of litigation involving repeat and episodic players, he observed that the repeat players' ability to control their lawyers was central to their success.⁷⁰ Galanter's observations were anecdotal; they are, nonetheless, consistent with informed intuition regarding litigation.

The limits to my model need to be recognized. Defense counsel is permitted to look to a person for instruction who is authorized to control the defense in the policyholder's place consistent with the insurance contract. But the model does not permit counsel to engage in conduct inconsistent with the policyholder's legitimate expectations regarding representation. Defense counsel may not make tactical decisions for the purpose of benefiting the insurer but prejudicing the policyholder.⁷¹ The model does hold that the policyholder-client, having surrendered control of the defense of the claim to the insurer, does not have a reasonable

consistent with economic theory, and operate in the public interest); *but cf.* Benjamin Hoon Barton, *Why Do We Regulate Lawyers?: An Economic Analysis of the Justifications for Entry and Conduct Regulation*, 33 ARIZ. ST. L.J. 429, 467 (2001) (arguing that professional conflict of interest rules often operate to the primary benefit of the professional bar rather than clients).

68. *See* Galanter, *supra* note 43, at 97, 114, 119.

69. *See id.* at 114-15.

70. *See id.* at 114-119.

71. *See* *Ladner v. Am. Home Assur. Co.*, 607 N.Y.S.2d 296, 298 (App. Div. 1994) (noting that counsel's tactical decision to place emphasis on allegations for which insurer had lowest policy limits exposure was improper). Sometimes this point can be confused by overly broad language. *Cf.* *State Farm Mut. Auto. Ins. Co. v. Traver*, 980 S.W.2d 625, 628 (Tex. 1998) (stating that retained defense counsel may not permit insurer's right to control the defense to prejudice the "interests" of the policyholder). Interests should, however, be understood to refer to rights retained under the insurance contract. *See id.* at 627 (noting that insurer's right to control defense allows the insurer, "to accept or reject settlement offers and, where no conflict of interest exists, to make other decisions that would normally be vested in the client, here the insured.").

expectation that it may control the defense. There may be, in some cases, a fine line between conduct impermissibly designed to further the insurer's interests vis à vis the policyholder and conduct designed to further the insurer's legitimate goal of controlling the defense for the purpose of minimizing the parties' joint exposure to the claimant. Nevertheless, the line does exist. In those situations when the insurer's ability to control the defense will serve to minimize the economic exposure of both policyholder and insurer to the claimant, the case for exclusive insurer control is most strongly made.

We can make the policyholder's interest in controlling the defense more substantial, but this does not change the result. Assume the policyholder publishes a paper in the Gay & Lesbian community. One of the policyholder's staffers sues for same-sex sexual harassment and discrimination. The policyholder tenders the claim to its insurer, which accepts unconditionally. As part of the defense, insurer instructs defense counsel to raise the defense that sexual harassment and discrimination claims are not actionable between members of the same sex, a position that has significant but not absolute legal support.⁷² This litigation position is personally and publicly embarrassing to the policyholder who instructs counsel not to plead the defense.

If counsel were retained directly by the policyholder for its own account, counsel would be obligated to abide by the policyholder-client's instruction.⁷³ But within the context of the triangular relationship, however, the policyholder-client does not have the right to instruct counsel not to plead the defense. The fact that the defense injures the policyholder's reputation is not controlling once the policyholder tenders the claim and surrenders control of the defense to the insurer.⁷⁴ The simple fact is that

72. The Supreme Court has held that same-sex sexual harassment is actionable under Title VII. *Oncale v. Sundowner Offshore Services*, 523 U.S. 75, 79-82 (1998). Not all employers are subject to Title VII and the status of same-sex sexual harassment under state or common law is mixed. See Norma Rotunno, Annotation, *Same Sex Sexual Harassment Under State Anti-Discrimination Laws*, 73 A.L.R.5TH 1 (1999).

73. See *supra* text and notes 45-48 and accompanying text for discussion noting that the decisional law and the professional codes are quite clear that a lawyer may not disregard a client's instructions, save in the most extreme circumstances, e.g., client instructs lawyer to commit an illegal act or compliance with client's instructions would require lawyer to violate professional codes.

74. See *supra* note 51. See *infra* note 108 and accompanying text. Most importantly, the reticence expressed in Rule 1.2 in taking a position when lawyer and client disagree on the means by which the representation will be conducted expressly reference the "interests of ... other persons" as a significant reason for the reticence. MODEL RULES OF PROF'L

the policyholder can not have it both ways. The policyholder can defend on his or her own account or the policyholder can surrender the control of the defense for the liability insurance contract's economic benefits. But once the policyholder surrenders control, the policyholder's rights as a litigant and client are subject to the allocation of rights established by the insurance contract. The insurer is entitled to limit its economic exposure by raising viable defenses that would defeat or reduce the claim. That right may be contrary to the policyholder's current interests, but to the extent the policyholder's interests do not rise to the level of a right protected by the insurance contract, the insurer's right to control the defense is not impaired. The insurer's actions in controlling retained defense counsel are fully consistent with the identified joint interests of the parties under the insurance contract, which is the defeat or minimization of the economic consequences of the claim.

It may be argued that the right to control the defense cannot be contracted away to another as that would impermissibly compromise the lawyer's inviolate duty to maintain professional independence on the client's behalf.⁷⁵ That position was taken in *Hayes v. Eagle-Picher Industries, Inc.*⁷⁶ The decision dealt with a specific conflicts rule that directly addresses the issue, the "aggregate settlement" rule,⁷⁷ but the decision does articulate the view that professional code provisions may be immutable and not subject to waiver even by willing, fully informed

CONDUCT R. 1.2 cmt. 2 (2007). Although the comment does not specifically refer to the triangular relationship, that relationship does reflect the types of concerns that Rule 1.2 recognizes as not warranting the usual deference to client decision making and instruction.

75. *Cf.* *Kracht v. Perrin, Gartland & Doyle*, 268 Cal. Rptr. 637, 639-41 (Cal. Ct. App. 1990) (noting that an attorney's duty of undivided loyalty may not be delegated away and is owed solely to the client).

76. 513 F.2d 892, 893-94 (10th Cir. 1975).

77. A lawyer who represents two or more clients shall not participate in making an aggregate settlement of the claims of or against the clients, or in a criminal case an aggregated agreement as to guilty or nolo contendere pleas, unless each client gives informed consent, in a writing signed by the client. The lawyer's disclosure shall include the existence and nature of all the claims or pleas involved and of the participation of each person in the settlement. MODEL RULES OF PROF'L CONDUCT R. 1.8(g) (2007). *See generally* ANNOTATED RULES *supra* note 58, at 148-149; Howard M. Erichson, *A Typology of Aggregate Settlements*, 80 NOTRE DAME L. REV. 1769, 1769-70 (2005) (arguing for a more precise understanding of the term "aggregate settlement" and providing suggested definitions).

clients.⁷⁸ As this paper takes a contrary position, the decision is worth exploring.

The *Hayes v. Eagle-Picher* lawsuit was commenced by a large number of plaintiffs who were all represented by common counsel. The plaintiffs agreed amongst themselves to be bound by a majority vote regarding a proposed settlement and voted thirteen to five to accept the defendant's lump sum offer.⁷⁹ The trial court reduced the settlement to a judgment based on the vote.⁸⁰

The appellate court's holding that the approval process was flawed rested on two grounds.⁸¹ First, the court found the approval agreement to interfere with the attorney-client relationship:

[T]his arrangement is contrary to the plain duties owed by an attorney to a client. An agreement such as the present one which allows a case to be settled contrary to the wishes of the client and without his approving the terms of the settlement is opposed to the basic fundamentals of the attorney-client relationship. Inasmuch as the attorney is merely an agent for the client in negotiation and settlement, the approval of the client is an all important essential to a settlement which is to be binding, and if this approval is not present the court is placed in a most unfavorable position in enforcing it.⁸²

Second, the court found that the clients could not agree to the settlement until they were informed of the terms of the actual settlement:

One other aspect which complicates the problem is the fact that the agreement calling for the majority governing the decision to settle was entered into some time prior to the date of negotiations. It is difficult to see how this could be binding on

78. *Hayes*, 513 F.2d at 892-93. Other provisions of the professional codes also carry this immutability trait. For example, the no ex-parte contact rule that prohibits a lawyer from communicating with a represented person without the consent of that person's attorney, is immutable; the client may not waive the attorney's right to give or withhold consent. MODEL RULES OF PROF'L CONDUCT R. 4.2 (2007). Waivers of conflicts of interest are circumscribed by Rule 1.7(b), that in some contexts bars the waiver of the conflict of interest by the client. MODEL RULES OF PROF'L CONDUCT R. 1.7(b) (2007).

79. *Hayes*, 513 F.2d at 892-93.

80. *Id.*

81. *Id.* at 893-95.

82. *Id.* at 894.

non-consenting plaintiffs as of the time of the proposed settlement and in the light of the terms agreed on. In other words, it would seem that plaintiffs would have the right to agree or refuse to agree once the terms of the settlement were made known to them.⁸³

The ABA Ethics Committee stated that the primary justification for the “aggregate settlement” rule is to protect each client’s right to control the decision to settle and protect that right from outside interference.⁸⁴

Hayes v. Eagle-Picher states a position that is attractive to those who believe that the client oriented (policyholder) obligations expressed in professional code should control the conflicts presented by the triangular relationship.⁸⁵ Moreover, the *Hayes v. Eagle-Picher* position on advance consent to aggregate settlements is well accepted in the case law.⁸⁶ The position denies clients the right to contract around a rule of professional conduct and vest actual authority in their attorneys to negotiate on their

83. *Id.*

84. ABA COMM. ETHICS AND PROF’L RESPONSIBILITY, Formal Op. 06-438 (2006).

85. Pepper, *supra* note 7, at 47. *But cf.* Charles Silver & Lynn A. Baker, *Mass Lawsuits and the Aggregate Settlement Rule*, 32 WAKE FOREST L. REV. 733, 770-773 (1997) (criticizing *Hayes v. Eagle-Picher* and the rigorous application of Model Rule 1.8(g) which has been construed to require consent by all jointly represented clients to an aggregate settlement).

86. *Abbott v. Kidder Peabody & Co., Inc.*, 42 F. Supp. 2d 1046, 1048-51 (D. Colo. 1999) (holding a retainer provision that purported to deprive a client of the right to control the case is void as against public policy). In *Abbott*, 200 plaintiffs filed a non-class action, single complaint against the defendant. *Id.* at 1048. The plaintiffs hired a single law firm to represent their interests. *Id.* The retainer agreement created a steering committee to control the litigation and provided for a formula for allocating the proceeds of the litigation amongst the plaintiffs. *Id.* at 1048-49. The court found a violation of the aggregate settlement rule, citing *Hayes v. Eagle-Picher* and disqualified the law firm. *Id.* at 1050-51. In *Tax Authority v. Jackson Hewitt, Inc.*, 898 A.2d 512 (N.J. 2006), the court reached a similar conclusion when 154 franchisees sued their common franchisor through one lawyer. The retainer provided for a majority vote as binding on all franchisees. *Id.* at 515. The court found that such provisions violated New Jersey’s Rule 1.8(g), which is patterned on Model Rule 1.8(g), but the court gave its decision prospective application only, thus saving the provision from invalidation. *Id.* at 523. The court treated the matter as one of first impression, as New Jersey had recently replaced its Model Code based rules within a Model Rules based regime. *Id.* Given that the court found no significant difference between the Model Code and Model Rule provisions, that position is interesting to say the least. Perhaps the court was troubled by the difficulties rigid enforcement of Rule 1.8(g) would engender. The court did refer the matter to the Commission on Ethics Reform to examine the matter. *Id.*

behalf and commit the clients to a settlement.⁸⁷ Such a conferral of actual authority would be contrary to the “approval” language of the first part of the opinion and the “knowledge of terms” language in the second part of the opinion.

Decisions, such as *Hayes v. Eagle-Picher*, proceed from the flawed premises that clients are either less competent and less capable than principals in general or that a client cannot delegate authority *ex ante* unless the client is as fully informed of the benefits and costs of the decision as the client would be *ex post*.⁸⁸ The first premise has no basis in fact; there is no reason to suppose that clients, as principals, are less informed as to their own interests and how those interests may be achieved than principals in general. The second premise is also flawed; uncertainty is a necessary element of most decision making. Decision makers have to balance the cost of acquiring more information against the benefit of having that information. Sometimes the information is not now available; yet, the benefits of action based on a present commitment may be compelling. In such a situation, the decision to proceed, based on a commitment in the face of uncertainty, is reasonable.

Using professional codes to disable clients from entering into agreements delegating authority to control counsel begs the question why a requirement ostensibly for the client's benefit, cannot be waived or modified by the client. The professional codes take an inconsistent approach on this point – some provisions limiting client options are

87. *Hayes v. Eagle-Picher Indus., Inc.*, 513 F.2d 892, 894-895 (10th Cir. 1975).

88. The professional codes do not prevent the client from conferring actual authority on the lawyer to settle the case on terms the lawyer deems advisable. MODEL RULES OF PROF'L CONDUCT R. 1.2 cmt. 3 (2007) (noting that “[a]t the outset of a representation, the client may authorize the lawyer to take specific action on the client's behalf without further consultation.”). See Eunice A. Eichelberger, Annotation, *Authority of Attorney to Compromise Action – Modern Cases*, 90 A.L.R. 4TH 326, § 8 (1991) (collecting cases holding that an attorney may be delegated actual authority *ex ante* to enter into agreement on the client's behalf to settle the matter for the client). This approach is countermanded by Rule 1.8(g) apparently out of concern that the lawyer may sacrifice the interests of some clients to advance the interests of others, although why a client could not provide *ex ante* an advance waiver of that right is not addressed in Rule 1.8(g). By its terms, Rule 1.8(g) requires disclosures that are not amenable to advance waiver, but it is an open question whether the protection provided by Rule 1.8(g) could be waived by appropriate general disclosures as to what protections Rule 1.8(g) provides to individual clients. The Restatement briefly addresses the issue. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 122 cmt. d (2000) (stating that advance waivers are subject to “special scrutiny”). See *infra* note 89 (discussing advance waivers). See *infra* Part IV.

waiveable, others are not.⁸⁹ The professional codes have not developed a rationale that explains this inconsistency.⁹⁰

Is the right to instruct and control counsel so sacrosanct and so essential to the professional relationship that any effort by a non-entity client to divest himself of the right and delegate it to an *interested* party would be deemed socially and legally unacceptable *per se*?⁹¹ When an indemnitor (insurer) is sued directly, the indemnitee (policyholder) does not control the defense.⁹² Under a no reservation, policy limits defense,

89. A client can generally waive most protections provided to clients against lawyer breaches of the professional codes. *Zador Corp. v. Kwan*, Cal. Rptr. 2d 754, 763 (Cal. Ct. App. 1995) (approving the use of advance waivers of otherwise disqualifying conflicts so as to permit the lawyer to represent continuing client adverse to now former co-client). See generally RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 122 (2000) (noting general ability of clients to waive disqualifying conflicts of interests otherwise preventing joint representation). Consent may also be given to “future conflicts” although such consent is subject to “special scrutiny.” *Id.* § 122 cmt. d. Although the consent may not be open-ended, but should be specific and tied to the matter in which the lawyer is representing the client providing the consent. This requirement tracks existing law: some opinions permit open-ended waivers when the parties are “experienced users of legal services.” *E.g.*, ABA Comm. on Ethics and Prof'l Responsibility, Formal Op. 436 (2005). Some protections may not be waived. See ABA MODEL RULES OF PROF'L CONDUCT R. 1.8(h) (2007) (barring lawyer from making *ex ante* agreement with client limiting liability of lawyer for malpractice, unless the client is independently represented in making such a decision). No American jurisdiction so permits, but such limitations are recognized in a few foreign jurisdictions. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 54 (2000) (stating that “[a]n agreement prospectively limiting a lawyer’s liability to a client for malpractice is unenforceable”). Many American jurisdictions now permit lawyers to avoid vicarious liability for the malpractice of other members of a law firm by forming the firm as a professional corporation or limited liability partnership. Annotation, *Liability of Professional Corporation of Lawyers, or Individual Members Thereof, for Malpractice or Other Tort of Another Member*, 39 A.L.R. 4TH 556 (1985).

90. Richard W. Painter, *Advance Waiver of Conflicts*, 13 GEO. J. LEGAL ETHICS 289 (2000) (discussing default and immutable rules of professional conduct). Silver & Syverud, *Insurance Defense Lawyers*, *supra* note 30 (discussing mutable and immutable rules of professional conduct). Professor Painter develops the theme that rules of professional conduct should be more contractual in structure and function. Richard W. Painter, *Rules Lawyers Play By*, 76 N.Y.U. L. REV. 665 (2001).

91. WOLFRAM, LEGAL ETHICS, *supra* note 2, at 148 (noting that the traditional bilateral model of the lawyer-client relationship is antiquated and unduly limiting); Leubsdorf, *supra* note 6 (noting disharmony between the traditional concept of the lawyer-client relationship as between individuals and the modern reality that legal relationships exist between and among groups of individuals).

92. See *Sherwood Brands v. Hartford Accident & Indem. Co.*, 698 A.2d 1078, 1083 (Md. 1997); *cf. Canton Poultry & Deli Inc. v. Stockwell, Harris, Widom & Woolverton*, 135 Cal. Rptr.2d 695, 703 (Cal. Ct. App. 2003) (holding that in workers compensation litigation once employer is dismissed from the litigation, employer has no reasonable basis for

the claim is effectively only against the insurer, as if the claim were brought as a direct action.⁹³ Function should control form. A general prohibition against a lawyer accepting instructions from the insurer because of an abstract ideal of professional independence arising out of the fact that the indemnitee rather than indemnitor is the named defendant would inflict injury on the very persons that the ideal is supposed to protect because this course of action would prevent policyholders from reaching bargains that protect their economic interests at their least cost.⁹⁴ It would also interfere with the policyholder's ability to exercise control over his affairs by depriving him of options that are preserved when insurer control is respected.⁹⁵ Under the insurer-control model the policyholder has the choice of withholding tender and controlling the defense or making the tender in exchange for the benefits of insurance.⁹⁶

While the alternative (tender the claim yet retain control) appears superficially superior for the policyholder, that alternative raises problems that may diminish the value of the insurance contract to the policyholder. For example, if the policyholder controls the defense, the traditional basis for binding the insurer to the adjudication of the underlying claim and barring the insurer from raising coverage defenses is lost.⁹⁷ Moreover, insurer control is economically efficient.⁹⁸ Depriving the insurer of control

believing that it is a client of retained defense counsel; counsel owes sole duty to insurer absent developments in the case that require counsel to defend or protect the interests of the employer).

93. See *Robertson v. Chen*, 52 Cal. Rptr. 2d 264, 267-68 (Cal. Ct. App. 1996). See generally Douglas R. Richmond, *Liability Insurers' Right to Defend their Insureds*, 35 CREIGHTON L. REV. 115 (2001-2002).

94. See generally William T. Barker, *Insurance Defense Ethics and the Liability Insurance Bargain*, 4 CONN. INS. L.J. 75 (1997-1998) (discussing the bargaining aspects of the insurer/insured relationship).

95. *Id.*

96. *Cf. Delmonte v. State Farm Fire & Cas. Co.*, 975 P.2d 1159, 1173 (Haw. 1999) (noting that if the policyholder elects to reject a defense offered by the insurer, the policyholder would thereafter be financially responsible for the costs of the defense). In the spirit of full disclosure, it should be noted that the Delmonte court takes positions contrary to those proposed in this paper in stating, "a contractual provision that conflicts with an attorney's representation in accord with the Hawaii's Rules of Professional Conduct . . . must yield to the requirement of professional ethics. *Id.* (internal citation omitted).

97. See James M. Fischer, *Insurer or Policyholder Control of the Defense and the Duty to Fund Settlements*, 2 NEV. L.J. 1, 12 (2002).

98. See 7C JOHN APPLEMAN, *INSURANCE LAW AND PRACTICE* 4687 (rev. ed. 1979). In situations where the claim is within policy limits, courts frequently state that only the insurer has a financial stake in the litigation. See, e.g., *Davenport v. St. Paul Fire & Marine Ins. Co.*, 978 F.2d 927, 931 (5th Cir. 1992) ("Adequate coverage for the potential liability

will likely raise the cost of policies or require the insurer to take counter action elsewhere, such as by limiting coverage or including the costs of defense in the policy limits.

A blanket rule prohibiting delegation is also inconsistent with the rule permitting the lawyer and the client(s) to define the scope of the representation.⁹⁹ Permitting the insurer to exercise exclusive control over the defense of the claim is a reasonable accommodation of the interests of both insurer and policyholder. These interests include the duties and obligations that both assume under the standard liability insurance policy, the express tender by the policyholder of the defense of the claim to the insurer, and the fact that the claim will be resolved within policy limits. In this respect the Restatement is enlightening in its discussion of some reasons why a client might legitimately wish to limit his representation, “[a] client might reasonably choose to forgo some of the protection against conflicts of interest, for example, in order to get the help of an especially able or inexpensive lawyer or a lawyer already familiar to the client.”¹⁰⁰

So how does counsel respond to the conflicting instructions from the insurer and the policyholder regarding litigation tactics? Counsel should inform the policyholder that pursuant to the arrangement by which counsel was retained, counsel receives and follows reasonable instructions from the insurer regarding the defense of the claim. Counsel can no more follow the policyholder-client’s instructions in this regard than counsel could obey a client’s instruction to disburse funds in the lawyer’s possession impressed with a litigation lien, which is to say that counsel cannot.¹⁰¹

being conceded, control by the carrier is virtually absolute, since the insured has no exposure whatever.”). This issue is discussed in connection with Hypothetical 2. *See infra* Part IV.

99. “Subject to other requirements stated in this restatement, a client and lawyer may agree to limit a duty that a lawyer would otherwise owe to the client if: (a) the client is adequately informed and consents; and (b) the terms of the limitation are reasonable in the circumstances.” RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 19 (2000). *See also* MODEL CODE OF PROF’L CONDUCT R. 1.2(c) (2007).

100. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 19 cmt. (b) (2000).

101. *See In the Matter of Respondent F*, 2 Cal. State Bar Ct. Rptr. 17, 28 (1992) (“[A]n attorney must retain funds in trust when the attorney’s right to the funds is disputed by the client. The funds are required to be kept in trust until the resolution of the dispute. The rule also applies to obligations to third parties.”); *State v. Angelo*, 667 A.2d 81, 83 (Conn. Ct. App. 1995) (a defense attorney who disbursed funds to a client in disregard of a state-imposed lien was liable to the state for damages); *Achrem v. Expressway Plaza Ltd. P’ship*, 917 P.2d 447, 450 (Nev. 1996) (holding that when a client assigns rights to the proceeds of litigation to a creditor the client’s attorney is not obligated to pay the proceeds to his client); *Selective Ins. Co. of Am. v. Ronzo*, 605 A.2d 705, 707 (N.J. Super.Ct. App.

That does not mean that the policyholder is an inconvenient but necessary appendage to the litigation, a “potted plant” to borrow a phrase.¹⁰² Counsel must, however, resolve the issue of control consistent with the client's reasonable expectations of the scope of the representation, and, on that point, the policyholder-client cannot reasonably expect that he may control a defense that he has tendered away to the insurer.¹⁰³

What happens, however, if the issue involves a matter that has traditionally been deemed an “end” of the representation rather than a “means,” for example, the right to settle? Does this factor tip the balance in favor of ceding to the policyholder/client the right to control the defense? In addition, the discussion of control over litigation strategy elides the issue of whether the insurer and the policyholder are both clients of retained defense counsel, or whether the policyholder was the sole client. Is that distinction meaningful in this context? These questions are addressed in the next hypothetical.

IV WHO CONTROLS DEFENSE COUNSEL REGARDING SETTLEMENTS

Policyholder is sued for covered personal injuries. Insurer has unconditionally accepted the tender of the claim and has appointed Lawyer as retained defense counsel. Insurer is willing to settle the matter for \$25,000, a sum within policy limits.

Div. 1992) (holding that lienholder could recover against attorney who disbursed funds in derogation of lien securing workers' compensation benefits paid to attorney's client); *Leon v. Martinez*, 638 N.E.2d 511, 514 (N.Y. 1994) (holding that when attorneys have notice of an assignment of a portion of their client's recovery, the attorney may be liable to the assignee if he disburses funds in derogation of the assignment).

102. The now famous comment was made by Mr. Brendan Sullivan, Jr., counsel for Lt. Col. Oliver North during the Iran-Contra investigation. *Iran-Contra Investigation: Joint Hearings Before the S. Select Comm. on Secret Military Assistance to Iran and the Nicaraguan Opposition and the H. Select Comm. to Investigate Covert Arms Transactions with Iran*, 100TH CONG. 263, (1988) (testimony of Lt. Col. Oliver North). The term has found its way into the popular language and now refers to an individual's refusal to be seen or perceived as an uninvolved spectator. *See, e.g., United States v. Batka*, 724 F. Supp. 350, 352 (E.D. Pa. 1989) (“[A] federal judge is not required merely to grace the proceedings with his presence as would the proverbial potted palm tree).

103. *See Hurvitz v. St. Paul Fire & Marine Ins. Co.*, 135 Cal. Rptr. 2d 703, 713 (Cal. Ct. App. 2003) (plaintiff physician did not have a cause of action against the defendant insurance company for settling against his wishes because he had tendered his defense; had he wished to retain the right of consent he could have paid for a policy that allowed for insured consent).

Policyholder opposes the settlement. The insurance policy contains standard conditions requiring the policyholder to assist and cooperate in the defense of the claim. Insurer instructs Lawyer to settle the case. What should Lawyer do?

The insurer, having assumed the defense of its policyholder, has a duty to settle the claim¹⁰⁴ and a concomitant right to settle even over the policyholder's objections,¹⁰⁵ although there is some authority that the insurer's right to settle over the policyholder's objections must be exercised in good faith,¹⁰⁶ and not prejudice the policyholder's rights.¹⁰⁷ Let us

104. *Bailey v. Allstate Ins. Co.*, 844 P.2d 1336, 1339 (Colo. Ct. App. 1992) (reasoning that due to the contractual nature of the insurer/insured relationship, the insurer owes the insured a duty of good faith in the performance of the contract); *Short v. Dairyland Ins. Co.*, 334 N.W.2d 384, 388 (Minn. 1983) ("The insurer's duty of good faith is breached in situations in which the insured is clearly liable and the insurer refuses to settle within the policy limits...").

105. *Mitchum v. Hudgens*, 533 So.2d 194, 201-02 (Ala. 1988) (holding that retained defense counsel had authority to settle medical malpractice claim for sum within policy limits notwithstanding physician-policyholder's objections); *Harbor Ins. Co. v. City of Ontario*, 282 Cal. Rptr. 701 (Cal. Ct. App. 1991) (reaching the same result regarding a self-insured retention); *Shuster v. S. Broward Hosp. Dist. Physicians' Prof'l Liab. Ins. Trust*, 591 So.2d 174, 178 (Fla. 1992) (holding that, absent exigent circumstances, when the insurance contract provides that the insurer may settle the claim as it deems expedient, no bad faith action may be maintained against the insurer for a within policy limits settlement); *Am. Home Assurance Co., Inc., v. Hermann's Warehouse Corp.*, 563 A.2d 444, 446, 448 (N.J. 1989) (holding that an insurer which settled a third party claim against the policyholder for an amount within policy limits could recover the deductible from the policyholder even though the policyholder did not approve the settlement). A few courts have limited the insurer's right to settle over the objections of the policyholder, but these are a distinct minority. *Rogers v. Robson*, 392 N.E.2d 1365, 1372 (Ill. Ct. App. 1979) (holding that retained defense counsel breached duty to policyholder by continuing with representation without informing policyholder of imminent settlement knowing that policyholder objected to settlement), *aff'd*, 407 N.E.2d 47 (Ill. 1980); *Saucedo v. Winger*, 915 P.2d 129, 132-36 (Kan. Ct. App. 1996) (holding that unless the policy expressly gives the insurer the right to settle without the policyholder's consent, the insurer must secure the policyholder's consent to a within limits settlement). *Saucedo* involved a medical malpractice liability policy and the court noted that the policy did prohibit the policyholder from settling without the insurer's consent unless the policyholder assumed all responsibility for the settlement. *Id.* at 132-33. *Cf. Miller v. Byrne*, 916 P.2d 566, 574 (Colo. Ct. App. 1995) (noting that the policyholder must be notified of any pending settlement so that the policyholder can take appropriate action to protect her interests).

106. *See Gardner v. Aetna Cas. & Sur. Co.*, 841 F.2d 82, 86 (4th Cir. 1988) (holding that the insurer did not act in bad faith in settling case). *See generally* BARRY R. OSTRAGER & THOMAS R. NEWMAN, *HANDBOOK ON INSURANCE COVERAGE DISPUTES* § 12.05(a) (8th ed. 1996) (noting that jurisdictions have split as to whether language in standard liability

assume that the insurer's settlement decision is based on a reasonable assessment of the merits of the claim. Let us also assume that the insurance policy does not give the policyholder the right to preclude a settlement by withholding consent.¹⁰⁸

On these facts and with the accompanying assumptions, the insurer can lawfully go through with the settlement; however, the fact that the insurer has the legal right to close the claim by a settlement over the policyholder's objections does not necessarily mean that retained defense counsel may assist and facilitate the settlement.¹⁰⁹ Notwithstanding this absence of a

insurance policies, which authorizes the insurer to effect settlement as it "deems expedient," insulates the insurer from bad faith actions whenever the insurer settles the claim ultimately within policy limits).

107. For example, an insurer that settles a claim and causes its policyholder lose a valid counterclaim may have acted in bad faith. *Barney v. Aetna Cas. & Sur. Co.*, 230 Cal. Rptr. 215, 221 (Cal. Ct. App. 1986). Similarly, an insurer's broad discretion over settlement may be circumscribed when the policy contains a retrospective premium feature, which allows the insurer to adjust the premium retroactively based on claim experience. *Sec. Officers Serv., Inc. v. State Comp. Ins. Fund*, 21 Cal. Rptr. 2d 653, 658 (Cal. Ct. App. 1993). There is a fine line between the retrospective premium cases and the deductible reimbursement cases; in both situations the insurer is settling with the policyholder's money. Nonetheless, the decisions reach opposite conclusions. Perhaps the broadest constraint on the insurer's ability to consummate a within limits settlement was adopted by the district court in *Caplan v. Fellheimer*, 886 F. Supp. 498 (E.D. Pa. 1995), *rev'd*, 68 F.3d 828 (3d Cir. 1995). In that case the district court held that a settlement that would legally prevent a subsequent claim by the policyholder for malicious prosecution, apparently because the "successful termination" element of the cause of action would be missing, could be enjoined by the objecting policyholder. *Id.* at 501-02. The court did not address how meritorious, if at all, the malicious prosecution action would need to be, although some likelihood of success would be required to the extent the success of the claim for injunctive relief was dependent on a showing of "probability of success on the merits," a standard part of the equitable remedy in most jurisdictions. *Id.* at 501-02. The Third Circuit Court of Appeals reversed on the grounds that federal courts should not involve themselves directly in reviewing settlement of private litigation and the "deems expedient" language of the insurance contract gave the insurer the ability to conclude a within policy limits settlement without obtaining the approval of the policyholder. 68 F.3d at 836-37.

108. Such provisions are usually limited to professional malpractice insurance contexts where policyholders have demonstrated a concern that settlement will damage the policyholder's professional reputation or trigger licensure action by a disciplinary board. Some of the decisions that have subjected insurers to bad faith actions for within policy limits settlements have involved professionals. *See Schuster v. S. Broward Hosp. Dist. Physicians' Prof'l Liab. Ins. Trust*, 591 So.2d 174, 177-78 (Fla. 1992); *cf. Saucedo v. Winger, M.D.*, 915 P.2d 129, 133 (Kan. Ct. App. 1996). *See supra* note 105 for more discussion of *Saucedo*.

109. *See Rogers*, 392 N.E.2d at 1372 (holding that retained counsel defense counsel breached duty to policyholder by continuing with representation without informing policyholder of imminent settlement knowing that policyholder objected to settlement). That

policyholder right to complain under the insurance contract, the professional bar contends that retained defense counsel is precluded from implementing a settlement within policy limits if the policyholder objects.¹¹⁰

That poses the control question here: in implementing a within policy limits settlement who controls retained defense counsel – the insurer or the policyholder? We should not lose sight of the basic problem. If the insurer can instruct defense counsel to implement settlement, even over the policyholder's objections, the insurer's ability to settle is eased. The situation is otherwise if the policyholder may prevent defense counsel from

viewpoint has been generally rejected. See Silver & Syverud, *Insurance Defense Lawyers*, *supra* note 30, at 296-301.

110. See ABA COMM. ON ETHICS AND PROF'L RESPONSIBILITY, FORMAL OP 403 (holding that policyholder retains the right to renege on the tender of the defense provided by the insurer; therefore if a dispute arises as to the desirability of a settlement, the policyholder may terminate the triangular relationship, thus precluding counsel from participating in the settlement on the insurer's behalf); *but cf.* Villa v. Cole, 6 Cal. Rptr.2d 644, 649-50 (Cal. Ct. App. 1992) (holding that in situation where a party was provided a defense by another party, the represented party could not disavow a settlement partially to the extent he perceived it to be in his interest to do so):

Here, Villa accepted all the benefits of the City's representation of him, and of the settlement that terminated the lawsuit against him. He did not express any objection to the fact that the City had assumed all the costs of his defense; he did not offer to reimburse the City for his pro rata share of litigation expenses; and he never offered to hold the City harmless for the costs he would incur in continuing to defend the lawsuit on his own. In short, while accepting the benefits of his dismissal, Villa did nothing to set aside or repudiate the settlement of which that dismissal was a part. On this basis, the City clearly could not assume that Villa would forego later claiming the right to reimbursement and indemnification from the City for any attorney fees, litigation costs, or damage he incurred in further defense of Seeterlin's action. In order to protect itself against further litigation, the City was entitled to provide for Villa's representation and also to require his dismissal as part of the overall settlement. Villa may not now disavow that settlement, having effectively ratified it by accepting its benefits.

Id. Having accepted the benefits of a defense, is it reasonable to permit the policyholder to now disavow the defense because it is in his interest (but not his right) to do so?

assisting the insurer. The insurer will have to independently deal with the plaintiff/client and her lawyer. This will increase costs and present opportunities for confusion.

An aspect of the duty of loyalty is the obligation to follow the client's lawful instructions and help the client achieve the ends of the representation as defined by the client.¹¹¹ Counsel should advise the client of the consequences of implementing the client's choices,¹¹² but, as discussed previously, in connection with Hypothetical 1, under the professional codes the choice of ends belongs to the client.¹¹³ Indeed, the failure to follow a client's lawful instructions can be grounds for professional discipline and malpractice even though the lawyer's decision to disregard the client's instructions was not unreasonable.¹¹⁴

To the extent that the choice of ends belongs to the policyholder-client, it would not be proper for counsel to take the policyholder out of the loop by failing to inform the policyholder of the insurer's decision to settle and thereby avoid receiving an instruction not to settle from the policyholder. It is the duty of counsel to keep the client reasonably informed about significant developments affecting the representation.¹¹⁵ Settlement falls within this category,¹¹⁶ and this would be particularly true if a client has

111. *See supra* note 2.

112. *Doe v. Hughes*, Thorsness, Gantz, Powell & Brundin, 838 P.2d 804, 807 (Alaska 1992); *Nichols v. Keller*, 19 Cal. Rptr.2d 601, 608 (Cal. Ct. App. 1993):

One of any attorney's basic function is to advise ... Not only should an attorney furnish advice when requested, but he or she should also volunteer opinions when necessary to further the client's objectives ... [E]ven when a retention is expressly limited, the attorney may still have a duty to alert the client to legal problems which are reasonably apparent, even though they fall outside the scope of the retention.

113. *See supra* notes 45-48 and accompanying text.

114. *See Olfe v. Gordon*, 286 N.W.2d 573, 577 (Wis. 1980) (stating that a lawyer may be liable for losses resulting from the lawyer's failure to follow "with reasonable promptness and care" the explicit instructions of the client; the fact that the lawyer honestly believes deviation from the client's instruction is in the client's best interests is no defense). *See generally* RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 21 cmt. D (2000).

115. MODEL RULES OF PROF'L CONDUCT R. 1.3 (2007) ("A lawyer shall act with reasonable diligence and promptness in representing a client"); *see* RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 20 (2000); ANNOTATED RULES, *supra* note 58, at 49-52.

116. *See Miller v. Sloan*, 978 P.2d 922, 931 (Kan. 1999) (holding that defense counsel breached their fiduciary duty owed to the policyholder-client when they failed to

made known his position on a matter and the development is directly contrary to the client's position.¹¹⁷ Efforts by counsel to burden a client's free decision making in this area have been consistently struck down.¹¹⁸ A corollary of this rule holds that counsel must seasonably inform the client of all settlement offers in order that the client may exercise his authority over the matter.¹¹⁹ Thus, under the professional codes deliberately bypassing the policyholder in order to facilitate the insurer's instructions to settle, even though the insurer's instructions are lawful, appears, on the surface, to put counsel in the untenable position of disregarding the policyholder's rights *as a client* regarding settlement.

When defense counsel informs the policyholder/client of the settlement or prospect of settlement, how should counsel respond to an instruction from the policyholder/client (such as: don't settle) that is inconsistent with instructions received by the insurer (settle)? The focus in the decided cases has been on the rights and duties of defense counsel vis à vis her

inform the client of a settlement hearing); MODEL RULES OF PROF'L CONDUCT R. 1.2 (2007) ("A lawyer shall abide by a client's decision whether to accept an offer of settlement of a matter); ANNOTATED MODEL RULES OF PROF'L CONDUCT 34 (2007) (noting that lawyers have no inherent authority to settle a client's claim.").

117. *Hobart v. Decker (In re Estate of Falco)*, 233 Cal. Rptr. 807, 815 (Cal. Ct. App. 1987) (stating that the client's right to reject a settlement is absolute and unqualified); *see generally* RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS 22, cmt. c (2000) (stating that authority to settle belongs to client, client may delegate authority to lawyer but delegation is revocable). *But cf.* *Ramirez v. Sturdevant*, 26 Cal. Rptr.2d 554, 561 (Cal. Ct. App. 1994) (holding that it was not unfair or unconscionable for a lawyer to condition his willingness to represent a client on the client's agreement to accept a "minimum settlement amount"). In *Ramirez* the court found that the minimum amount was a reasonable if not generous valuation of the client's claim. *Id.* at 561. More importantly, the dispute centered not over the enforceability of the settlement, because the client did agree to the settlement, but was centered on counsel's right to fees and the related issue whether counsel's conduct disqualified him from receiving a fee or operated to reduce the fee he would take under the retainer agreement. *Id.*

118. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS 22 cmt. c (2000) (noting that an irrevocable delegation of settlement authority to the lawyer is illegal as is an agreement that both the client *and the lawyer* must approve any settlement); *but cf.* *Ramirez*, 26 Cal. Rptr. 2d at 561; *Robertson v. Chen*, 52 Cal. Rptr.2d 264, 267 (Cal. Ct. App. 1996) (holding that written consent of policyholder was not required by "open court" statute when defense counsel, with authority from insurer, agreed to within limits settlement). An "open court" statute requires that settlements be signed by the party or made before the court if the settlement is to be summarily enforced. *See* CAL. CIV. PROC. CODE 664.6 (West 1996 Supp.); *see generally* James M. Fischer, *Enforcement of Settlements: A Survey*, 27 TORT & INS. L.J. 82, 88-89 (1991) (discussing "open court" requirements).

119. RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS §20(3) (2000) (stating that "lawyer must notify a client of decisions to be made by the client...").

relationship with the policyholder and the insurer. The assumption appears to be that counsel should handle that situation the same as any situation when a lawyer, having entered into a concurrent or simultaneous joint “client” representation, receives conflicting instructions from each principal.¹²⁰ The “client” may be an actual client or a “client equivalent,” which is a non client who is owed some or all of the duties that a lawyer would owe an actual client.¹²¹

There is a tendency here to attempt to resolve the issue by focusing on whether counsel has one client or two clients, and, if the latter, whether, as between the two clients, one client should be preferred over the other as a matter of law. To determine counsel’s professional obligations we must look at the entire relationship between the parties and not just focus exclusively on the lawyer-client relationship. Trying to resolve the problem solely from the “who is the client” perspective introduces tremendous artificiality into the triangular relationship. Do policyholders really know or care whether retained defense counsel’s relationship with the insurer is that of “client” or “third party payer?” The reality of the relationship turns on who selects and instructs counsel, a point repeatedly driven home in the conflict of interest cases. Under either a “client” or “third party payer” approach the insurer selects and instructs counsel and will continue to select and instruct counsel absent a fundamental reworking of the triangular relationship.¹²² Having this power, having an immediate

120. In most cases courts take the position that the presence of conflicting instructions from co-clients or client equivalents reflects an actual conflict which counsel must address under the professional codes. See Susan Randall, *Managed Litigation and the Professional Obligations of Insurance Defense Lawyers*, 51 SYRACUSE L. REV. 1, 3-4 (2001). In some cases the potential for conflicting obligations induces courts to find no lawyer-client relationship with one of the parties. Cf. *Goodman v. Kennedy*, 556 P.2d 737, 743 (Cal. 1976) (finding no duty to advise buyer when recognition of such a duty would conflict with Lawyer’s duty to client-seller).

121. ANNOTATED MODEL RULES OF PROF’L CONDUCT R. 1.18 (2007) (discussing “duties” owed to prospective clients who consult an attorney regarding representation, but no retention results).

122. The furthest any court has gone in challenging the basic assumption that, absent a conflict of interest, the insurer may select defense counsel and control the defense, is to impose some limits when the insurer uses in-house staff counsel. Even here, only two jurisdictions have prohibited the insurer from using staff counsel to represent the policyholder. See *Am. Ins. Assoc. v. Ky. Bar Assoc.*, 917 S.W.2d 568 (Ky. 1996). There are a few ethics opinions proscribing the use of in-house staff counsel. Ohio Supreme Court Bd. of Comm’rs on Grievances and Discipline, Op. 94-9 (1994), reported in 10 ABA/BNA LAWYER’S MANUAL ON PROF’L CONDUCT 291 (1994-1995). Several articles have addressed the issue of using staff counsel to represent policyholders in third party actions. See Robert J. Johnson, *In-House Counsel Employed by Insurance Companies: A Difficult Dilemma*

financial stake in the matter, and having a relationship with defense counsel that transcends the individual case, the insurer is a “client-equivalent” if it is not a client. The lawyer will necessarily, and rightly, be concerned with the insurer’s interests, as the lawyer is necessarily and rightly concerned with the policyholder’s interests. The critical question is not “who is the client” but what rights (and duties) attend to the insurer’s right under the insurance contract to select counsel and control the defense through the instruction and direction of counsel.

Silver and Syverud argue that in the context of “within limits” settlements “defense counsel has no duty to advise or act for the [policyholder] on settlement, period.”¹²³ I agree, but for a different reason than offered by Silver and Syverud. They based their position on the claim that retained defense counsel enjoys a scope-limited relationship with the policyholder-client. Settlement responsibility is not part of the representation:

Counsel must inform the insured of developments relating to settlement, including settlement demands received from other parties, because the insured is entitled to that information. Counsel also must tell the insured about the scope restriction and explain that the insured may need to hire separate counsel to handle settlement issues. But, in our judgment, counsel need not and should not otherwise advise the insured. When responsibility for settlement is excluded from the scope of the relationship with the insured, it is not defense counsel’s job to tell the insured how the insured may be affected by settlement developments or by settlement on particular terms.¹²⁴

This approach likely complies with scope-limited representation recognized by the ABA Model Rules as long as it is explained to the client and the client gives informed consent.¹²⁵ Counsel must also not forget that

Confronting the Model Code of Professional Responsibility, 57 OHIO ST. L.J. 945 (1996); Leo J. Jordan & Hilde E. Kahn, *Ethical Issues Relating to Staff Counsel Representation of Insureds*, 30 TORT & INS. L.J. 25 (1994); Ronald E. Mallen, *Defense by Salaried Counsel: A Bane or a Blessing?*, 61 DEF. COUNS. J. 518 (1994); Douglas R. Richmond, *Lost in the Eternal Triangle of Insurance Defense Ethics*, 9 GEO. J. LEGAL ETHICS 475 (1996).

123. Silver & Syverud, *Insurance Defence Lawyers*, *supra* note 30, at 299.

124. *Id.* (citations omitted).

125. MODEL RULES OF PROF’L CONDUCT R. 1.2(c) (2007) (permitting “reasonable” limitation).

the scope-limited representation may still require him to advise the client of the ramifications of retention-related activities even if those activities are outside the scope of the retention.¹²⁶

I prefer to base the role of the retained defense counsel regarding settlement on the policyholder's economic indifference to the within limits settlement. Only the insurer has money on the table, so only the insurer should be playing.¹²⁷ Implicit in Silver and Syverud's position is the idea that the policyholder's residual interests in the matter (such as reputation, preexisting relationships with the claimant effect of settlement on future insurability and premiums, etc.) are too attenuated to warrant legal protection.¹²⁸ If the policyholder believed otherwise, he could bargain for a "consent-to-settle" clause or self insure.¹²⁹ "Consent-to-settle" provisions are not commonplace in liability policies; they either increase the cost of insurance or decrease the value of the policy purchased. Consent-to-settle provisions commonly contain risk shifting language so that the cost of an erroneous decision not to settle is borne by the policyholder who withheld consent.¹³⁰ Such a risk allocation strategy is not a viable alternative for consumer-oriented, insurance purchase decisions. When a policyholder decides to purchase traditional insurance without a consent-to-settle provision and decides to tender a claim to the insurer for a defense, the essence of the Silver-Syverud position is that, as to within limits

126. *Nichols v. Keller*, 19 Cal. Rptr. 2d 601, 608 (Cal. Ct. App. 1993) (holding that the basic responsibility of an attorney is to advise their client, the attorney may limit the scope of representation, but not the scope of the duty to advise).

127. *See supra* note 92, discussing *Canton Poultry & Deli, Inc.*, 135 Cal. Rptr.2d at 703 (holding that retained defense counsel could negotiate global settlement of claims for which only worker's compensation insurer would be responsible; in doing so counsel breached no duties owed to policyholder-employer).

128. *See Fiege v. Cooke*, 23 Cal. Rptr. 3d 496, 499 (Cal. Ct. App. 2004) (holding that settlement was binding even though the defendant (policyholder) did not give assent; it was sufficient that the retained defense counsel and the insurance adjuster consented to the settlement); *Orion Ins. Co. v. General Electric Co.*, 493 N.Y.S.2d 397, 401, 403 (N.Y. Sup. Ct. 1985), *aff'd* 509 N.Y.S.2d 778 (N.Y. App. Div. 1986) (holding that the insurer retained the right to settle the action in which its policyholders were represented by independent counsel selected and controlled by the policyholders pursuant to the terms of the insurance contract). *See supra* notes 33-34, 52, 81 and accompanying text.

129. *See supra* note 52, 108.

130. *See Kent D. Syverud, The Duty to Settle*, 76 VA. L. REV. 1113, 1172-78 (1990) (discussing the use of "consent-to-settle" clauses to protect professional reputation).

settlements, the policyholder has ceded all its legally recognizable rights to the insurer.¹³¹

Silver and Syverud capture the economic realities of the insurance contract in their approach to within limits settlements. They also capture the realities of the lawyer-client relationship and the lawyer's professional duties attendant to that relationship because that professional relationship is created as a result of and flows from the insurance contract; it does not exist independent of the insurance contract. The analysis here is therefore similar to that taken with respect to the first hypothetical and, as was the case earlier, the proper construction of the client-lawyer relationship is influenced by the underlying insurance contract from which the client-lawyer relationship evolves.¹³² This conclusion should apply under either the two-client or one-client model that is recognized in the context of the triangular relationship.¹³³

A. INSURER AS CO-CLIENT

For a joint client representation, the standard position is that counsel must give each client the quality and kind of representation each would

131. Silver & Syverud, *Insurance Defense Lawyers*, *supra* note 30 (does not specifically address the issue of insurer authority to settle when to do so would cause the policyholder to lose a valid counterclaim or when the insurer could recover settlement costs through retrospective premium rating).

132. This point has received some judicial acceptance. The Alabama Supreme Court has stated:

[W]e believe that the insurance contract does affect the attorney-client relationship with respect to settlement of an action brought against an insured. If the insured has contracted away the right to require his consent prior to a settlement of a claim against him, no real conflict of interest exists between the insured and the insurer, at least where the claim or settlement is within policy limits and there has been no reservation of rights by the insurer.

Mitchum v. Hudgens, 533 So.2d 194, 201 (Ala. 1988) (rejecting contrary position taken in Rogers v. Robson, 392 N.E.2d 1365 (1979)). However, a subsequent Alabama decision held, however, that if the policyholder has a direct stake in the settlement because of a deductible reimbursement requirement, the policyholder's consent must be obtained. St. Paul Fire & Marine Ins. Co. v. Edge Memorial Hosp., 584 So.2d 1316, 1326-27 (Ala. 1991).

133. See 4 Ronald Mallen & Jeffrey Smith, *Legal Malpractice* §29:7, at 176 (2006) (discussing application of Rule 1.8(f) and one-client/two-client models).

receive if that person was counsel's sole client.¹³⁴ This is, however, on reflection too simplistic; the very essence of a situation presenting a conflict of positions is the presence of conflicting interests as to specific matters. No lawyer in the context of the joint representation can provide the exact same representation that would be provided in the single client representation. Joint representation necessarily implies that to some extent the lawyer may (re)solve client differences in a fashion that help one client yet disadvantage the other client as to that particular application. The reason for this is the clients' belief that the overall benefits derived from the joint representation will outweigh localized disadvantages resulting from the lawyer's effort to maximize joint gains for the jointly represented clients. The question is whether, and to what extent, the clients may agree to enter into a relationship that envisions that their shared attorney may, for their joint aggregate benefit, act pursuant to the instruction of one of the clients alone even though, on occasion, that specific action that is not in the immediate, short term interests of one of the clients, as the client now defines his interests. Again, in keeping with the specifications of the discussion, we assume that the instruction given is consistent with the rights established by the underlying document that controls the relationship between the clients, the insurance contract. That condition is met here since the insurance contract vests settlement authority in the insurer exclusively and bars the policyholder from undermining the insurer's right to settle if the insurer deems a within limits settlement appropriate.

In the joint client context the clients should be permitted to agree between themselves as to how counsel shall be instructed. The proposal offered by Silver and Syverud implicitly adopts this approach by treating the insurance contract and the retainer agreements as authority allocating documents. Under the approach suggested in response to hypothetical number 1, in the normal case the allocation of authority to the insurer would legitimate the insurer's instruction to counsel to settle the claim within policy limits. The standard objection to this approach is as follows: even if the parties make provisions in their agreements allocating authority, between themselves, the provisions in the retainer may not be irrevocable as between attorney and client.¹³⁵ In other words the insurance contract

134. *Ishmael v. Millington*, 50 Cal. Rptr. 592, 596 (Cal. Dist. Ct. App. 1966) (stating that the loyalty owed one client cannot consume that owed another); MODEL RULES OF PROF'L CONDUCT R. 1.7 cmt. 31 (2007) (stating that "the lawyer has an equal duty of loyalty to each client...").

135. Courts frequently state that the lawyer-client relationship does not create a general implied authority for the lawyer to settle the client's claim, and that there is no

cannot control the retainer. If counsel must respect a client's decision to revoke a prior consent, we are back to our starting position; the insurer may act, but counsel must sit on the sidelines.¹³⁶

prohibition against a competent client vesting the lawyer with actual authority to settle. *Michaud v. Michaud*, 932 F.2d 77, 80 (1st Cir. 1991); *Garabedian v. Allstates Eng'g Co.*, 811 F.2d 802, 803 (3d Cir. 1987); *McEnany v. West De. County Com. Sch. Dist.*, 844 F. Supp. 523, 529 (N.D. Iowa 1994). Similarly, the policyholder may authorize the insurer to settle on its behalf. The Restatement addresses the issue:

A client may authorize a lawyer to negotiate a settlement that is subject to the client's approval or to settle a matter on terms indicated by the client. In class actions, special rules apply; a court, after notice and hearing, may approve a settlement negotiated by the lawyer for the class without the approval of named representatives or members of the class. The Section allows a client to confer settlement authority on a lawyer, provided that the authorization is revocable before a settlement is reached. A client authorization must be expressed by the client or fairly implied from the dealings of the lawyer and client. Thus, a client may authorize a lawyer to enter a settlement within a given range. A client is bound by a settlement reached by such a lawyer before revocation.

RESTATEMENT (THIRD) OF THE LAW GOVERNING LAWYERS § 22 cmt. c (2000). Similarly, the policyholder may authorize the insurer to settle on its behalf. The policyholder authorizes settlement by the terms of the standard liability insurance contract and the tender. *Cf. Ramirez v. Sturdevant*, 26 Cal. Rptr. 2d 554, 561-62 (Cal. Ct. App. 1994) (holding that client's agreement in retaining authorizing lawyer to accept specified "minimum" settlement amount was neither unfair nor unconscionable when amount reflected reasonable assessment of the value of the claim). A "within limits" settlement as contemplated by the parties to the insurance contract is functionally equivalent to the "minimum settlement amount" discussed in *Ramirez*. In both situations the client/policyholder has agreed to a specific position.

136. Outside the "conflict of interest" context, the general approach of courts is to permit the insurer unilateral authority to execute "within limits" settlements, *see supra* note 105 and accompanying text, and even recover the cost of the settlement if it turns out no indemnity was owed under the insurance contract if the policyholder has been given appropriate notice and has objected to the settlement. *See Md. Cas. Co. v. Imperial Contracting Co., Inc.*, 260 Cal. Rptr. 797, 803 (Cal. Ct. App. 1989) (stating that an insurer who defended under reservation of rights could recover amount of settlement from policyholder when it was subsequently determined that claim was not covered). Given the insurer's preemptive authority in the matter of concluding settlements, it is difficult to reconcile any suggestions that retained defense counsel should adopt a "hands off" approach towards settlements because of policyholder objections communicated to defense counsel.

The usual judicial approach to the dilemma is to accept the “standard position”, and find that counsel’s professional duties trump the clients’ duties and obligations under the insurance contract, insofar as counsel’s representation is concerned. Faced with conflicting instructions from the policyholder and the insurer, the fair inference from the decided “conflict of interest” cases is that counsel should inform the insurer that its instructions cannot be carried out by counsel. Because disclosure of the reasons for counsel’s non-assistance would possibly prejudice the policyholder by disclosing a possible breach of the policyholder’s duty to cooperate and assist, counsel may not be able to disclose the reasons for non-assistance to the insurer,¹³⁷ absent policyholder authorization.¹³⁸

Although the case law and ethics opinions state that when defense counsel receives conflicting instructions she should withdraw, there is little case law actually applying that thinking to the problem presented by Hypothetical 2. That is not really surprising because requiring defense counsel to withdraw and permitting the policyholder to complicate reasonable settlements is a singularly bad idea when the policyholder has previously surrendered his right to control the defense to the insurer. Courts quite reasonably resist taking the withdrawal principle to its natural and logical conclusion because the end product is socially wasteful and inconsistent with the expectations of the parties to the insurance contract. This reluctance should encourage us to reexamine the validity of the arguments that underlie the withdrawal requirement when defense counsel receives conflicting instructions. Rather than emphasizing the status of the parties to the insurance contract as clients or non-clients, as the traditional approach does, I propose that we emphasize the parties’ reasonable expectations of defense counsel’s role as developed from the insurance contract, as common sense and good judgment would direct us. This approach will, I believe, lead to views of the triangular relationship that further, rather than frustrate, the goals of the insurance contract.

137. *Cf.* *Parsons v. Cont’l Nat’l Am. Group*, 550 P.2d 94, 99 (Ariz. 1976) (defense counsel should not have disclosed policyholder-client confidential information to the insurer; insurer was estopped from basing coverage denial on information counsel improperly conveyed); *Employers Cas. Co. v. Tilley*, 496 S.W.2d 552, 560-61 (Tex. 1973) (same).

138. *Cf.* ABA Standing Committee on Ethics and Professional Responsibility, Formal Op. 08-450 (2008) (opining that retained defense counsel may not disclose client confidential information of policyholder to insurer absent policyholder consent; if failure to disclose would involve counsel in the commission of a fraud against the insurer, counsel must withdraw from the representation).

The critical issue is whether providing a policyholder with a lawyer who owes certain responsibilities to a co-client, the insurer, would be, in the context of the hypothetical, injurious to the policyholder, the public, or the profession. If retained defense counsel were permitted to ignore the policyholder's instruction not to settle, and implement the insurer-client's instruction to effect the within policy limits settlement, would the interests of either the policyholder or the legal profession be damaged such that we should reject empowering counsel to so act? In resolving this question we must remember that the insurer still retains, in most jurisdictions, the power to settle the claim over the policyholder's objections.¹³⁹ The inability to control the defense by instructing counsel to effect the settlement may, however, complicate the implementation of the settlement since it will be necessary to file the dismissals and take other action in the litigation related to the claim, which will conclude the litigation and the insurer cannot do this unilaterally.¹⁴⁰ Nonetheless, unless the policyholder takes control of the defense away from the insurer, the policyholder's recalcitrance regarding settlement will, in all likelihood, simply prolong the settlement process, rather than prevent settlement realization and conclusion of the litigation.

Moreover, as discussed in connection with Hypothetical 1, there is no overriding reason why the policyholder's delegation of control of the defense to the insurer pursuant to the tender should not influence the allocation of power as between the policyholder and the insurer insofar as the lawyer is concerned. Pursuant to the tender, the policyholder has requested a defense of the claim by the insurer. It hardly now lies for the policyholder to contend that he should be permitted to assume a position that he earlier relinquished, particularly given the insurer's reliance on the

139. See *New Plumbing Contractors, Inc. v. Edwards, Sooy & Byron*, 121 Cal. Rptr. 2d 472, 474 (Cal. Ct. App. 2002) (barring claim of malpractice against retained defense counsel for failing to notify the policyholder-client of settlement negotiations and failing to interpose defenses to claim; insurer properly exercised its right under the policy to settle the claim; therefore, policyholder-client sustained no damages); cf. *Purdy v. Pac. Auto. Ins. Co.*, 203 Cal. Rptr. 524, 535 (Cal. Ct. App. 1984) (holding that legal malpractice claim for excess policy limits judgment could not be stated because the cause of the loss was the insurer's independent decision not to settle).

140. If the policyholder wishes to assert control of the defense, it must be for the policyholder's account, not the insurer's. See *Rogers v. Robson*, 392 N.E.2d 1365, 1372 (Ill. Ct. App. 1979) (noting that if the policyholder objects to a settlement negotiated by the insurer, the policyholder may "release the insurance company from its objection under the policy, select different counsel, defend the action at his own expense and bear the risk of an adverse decision."), *aff'd on other grounds*, 407 N.E.2d 47 (Ill. 1980).

tender in assuming the cost of the defense. The policyholder should not be allowed to manipulate the situation to her advantage any more than the insurer should be allowed to manipulate its right to control the defense to its sole advantage in a manner not expressly allowed by the contract.¹⁴¹

A number of courts have recognized that powers normally possessed by the client may be limited when the client has induced reliance on the belief that the power will not be exercised. In *Unified Sewerage Agency v. Jelco, Inc.* the court refused to disqualify a law firm when the former client attempted to revoke a prior consent that the current client and the law firm had relied on in establishing the lawyer-client relationship.¹⁴² In Ethics Opinion 317 the District of Columbia Bar Association directly addressed the issue of continued representation when the lawyer and the current client relied on a consent that the consenting party now wishes to revoke. The Opinion noted that permitting the revocation to force the termination of the lawyer-client relationship would be improper and not reflect the interests of the other affected parties who in reliance on the consent had invested time, money, and effort in the representation.¹⁴³ The triangular relationship likewise involves an investment of time, money, trust, and effort that both parties (policyholder and insurer) will adhere to their prior commitments, here, the ceding of control of the defense and the right to settle to the insurer. That ceding and accompanying reasonable reliance by the insurer warrants permitting retained defense counsel to implement an instruction by the insurer to settle within policy limits even over the objections of the policyholder.

The better view of the policyholder-insurer arrangement under the standard liability insurance policy permits the insurer to control the defense, including having the sole right to instruct counsel. In other words,

141. *Cf.* *Hannebaum v. Drenzo & Bomier*, 469 N.W.2d 900, 904 (Wis. Ct. App. 1991) (holding that any problem associated with a verdict form was created by the defendants' decision to use single counsel and defendants should not be permitted to use a self-created situation to obtain a reversal).

142. 646 F.2d 1339, 1346 (9th Cir. 1981); *cf.* *Armenta v. Superior Court*, 124 Cal. Rptr. 2d 273, 279 (Cal. Ct. App. 2002) ("Where such work product is the result of collaboration by counsel, all holders of the work product privilege must consent to waiver of the privilege.").

143. DC BAR LEGAL ETHICS COMM., OP. 317, available at http://www.dcbar.org/for_lawyers/ethics/legal_ethics/opinion/opin317.cfm. The same result was recently reached by the North Carolina State Bar Ethics Committee. N.C. BAR ETHICS COMM., IN FORMAL OP. 11 (2007), available at <http://www.ncbar.com/ethics> (in the "select by number" drop down menu choose "2007 Formal Opinion 11").

control of counsel should follow the right to select counsel. Whoever has control possesses the sole right to exercise direction and instruction of counsel to the exclusion of the other party to the arrangement.

B. INSURER AS THIRD PARTY PAYER

The same arguments that apply in the joint client context also compel a similar result in the single client/third party payer context. The absence of a lawyer-client relationship between defense counsel and the insurer does not diminish the role of the insurance contract, its language vesting control of the defense in the insurer, and the tender of the defense to the insurer by the policyholder as facts imbuing the insurer with the contractual authority to control the defense by directing and instructing counsel.¹⁴⁴ Detailed disclosures by counsel in order to obtain the type of informed consent envisioned by the professional codes to obtain a waiver of a potential conflict of interest have not been the norm in the triangular relationship context.¹⁴⁵ Courts have consistently held, or implied, that the provisions of

144. *See supra* note 16.

145. Under certain circumstances a person may by contract clothe another with power to retain a lawyer to conduct a defense. . . . ‘Consent and approval’ to represent the insured are clearly implied when the insured complies with his reciprocal duty under the insurance contract by forwarding the court process to the insurance company. If the insured does not desire to avail himself of the company’s obligation to defend the suit including counsel, together with payment of any judgment and costs, he is at complete liberty to renounce his rights under the insurance contract and employ independent counsel at his own expense.

ABA COMM. ON PROF’L ETHICS AND GRIEVANCES, FORMAL OP. 282 (1950) International Association of Defense Counsel, 7:4 PRACTICAL GUIDE FOR INS. DEFENSE LAWYERS 17, (Supp. 2003) (“A defense lawyer who is engaged by a claims professional need not separately obtain an insured’s consent to or ratification of the appointment. By demanding a defense under a standard liability insurance policy, an insured authorizes a carrier to retain a lawyer for the insured.”); *but see* Johnson v. Amethyst Corp., 463 S.E.2d 397 (N.C. Ct. App. 1995), in which the court held that counsel retained by the insurer to represent a policyholder could not move to strike a default entered against the policyholder when the policyholder had never consented to the representation. Some courts have permitted the insurer to intervene and present a defense in the face of a policyholder’s default. *Reliance Ins. Co. v. Superior Court*, 100 Cal. Rptr.2d 807, 809 (Cal. Ct. App. 2000); *Nasongkhla v. Gonzalez*, 34 Cal. Rptr.2d 379 (Cal. App. Dep’t., Super. Ct. 1994) (holding that insurer should be permitted to intervene to set aside a default entered against the policyholder for failure to respond to discovery requests otherwise the insurer possibly would have no other opportunity to litigate fault or damages issues and would carry an unfair burden of proving lack of coverage). Intervention is, however, limited to protecting the insurer’s interest, not the policyholder’s.

the insurance contract, coupled with the tender of claim to the insurer, adequately manifest the policyholder's knowing intent that the insurer assume the defense of the claim.¹⁴⁶ No court has required further disclosures by counsel as a precondition to counsel undertaking the representation of the policyholder. The tendency has been just to the contrary. Some courts have required the insurer to assume the defense, and appoint counsel, simply upon being notified by the policyholder of the claim, a tender being implied by the courts from the notice.¹⁴⁷

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Under the terms of most liability insurance policies, the insured agrees to permit the insurer to choose counsel to defend the insured against claims by third parties. As we stated in *Fid. & Cas. Co. v. McConnaughy*, this "customary clause in insurance policies . . . is consent in advance by the insured to such dual representation and obviates an improper relationship." However, if an actual conflict develops during the course of the representation, the attorney may not continue to represent both parties.

Atlanta Ins. Co. v. Campbell, 639 A.2d 652, 658 (Md. 1994) (citation omitted); *see Crist v. Insurance Co. of N. Am.*, 529 F. Supp. 601, 603 (D. Utah 1992) (noting that "the insurer's duty to defend corresponds to the insured's duty to relinquish control of the defense and one cannot arise without the other"); *but see* Tenn. Super. Ct. Board of Prof. Resp., Formal Opn. 99-F-143 (1999) *available at* <http://www.tbpr.org/Attorneys/Ethics> Opinions/Pdfs/99-F-143.pdf, holding that defense counsel must refrain from accepting directives from the insurer about the conduct of the defense and must refuse to share client confidential information with an outside audit service without the policyholder-client's consent. More importantly, the committee also concluded that the policyholder's rights could not be waived in advance by the insurance contract, but required contemporaneous disclosure by the lawyer and consent by the client upon full disclosure; *Dunkley v. Shoemate*, 497 S.E.2d 713, 715 (N.C. App. 1998) (holding that insurance defense counsel selected by the insurer may not enter an appearance without the consent of the client-policyholder); *but see supra* note 135.

147. *See White Mountain Cable Constr. Co., Inc. v. Transamerica Ins. Co.*, 631 A.2d 907, 910 (N.H. 1993) (holding that notice by policyholder to insurer was sufficient to trigger insurer's duty to defend when notice was coupled with policyholder's statement that insurer had duty to defend); *Employers Cas. Co. v. Mireles*, 520 S.W.2d 516, 521-522 (Tex. Civ. App. 1975). The "notice only" test appears to be a minority view. *SCSC Corp. v. Allied Mut. Ins. Co.*, 536 N.W.2d 305, 316 (Minn. 1995) (formal tender of defense of the claim to the insurer is condition precedent to triggering insurer's duty to defend); *see LaFarge Corp. v. Hartford Cas. Ins. Co.*, 61 F.3d 389, 399-400 (5th Cir. 1995); *Eastman v. United States*, 257 F. Supp. 315, 319 (S.D. Ind. 1966); *Celina Mut. Ins. Co. v. Citizens Ins. Co.*, 349 N.W.2d 547, 551 (Mich. Ct. App. 1984).

V. CONCLUSION

The appropriate approach to allocation of power between policyholder and insurer in the context of the triangular relationship is to recognize that the delegation of control accomplished by the insurance contract and by the tender affects the relationship between the policyholder and defense counsel. The policyholder is provided a defense and counsel necessarily looks for instruction to the party who has the lawful authority to control the defense. That person is the insurer. And that authority extends both to tactical questions, such as presented in hypothetical 1, or ends related questions, such as presented in hypothetical 2, as long as those questions are within the boundaries of the insurance contract. A workable, albeit rough, rule of thumb here is that counsel should accept and follow instructions from the insurer, and disregard contrary instructions from the policyholder, to the extent (1) the insurer's instructions are consistent with the insurer's right to control the defense; (2) the implementation of the insurer's instructions do not require counsel to commit an illegal act or violate the professional codes, as illuminated by the lawful delegation of control over the attorney to the insurer by the policyholder; and (3) the implementation of the insurer's instructions would not cause counsel knowingly to assist the insurer in breaching a duty owed by the insurer to the policyholder.¹⁴⁸ The issues raised by hypotheticals 1 and 2 falls squarely within the above guidelines. In controlling the defense and settling within limits, the insurer, whether or not a client or third party payor, is acting within its lawful rights and consistent with the reasonable expectations of the policyholder. In both cases, retained defense counsel should follow the insurer's instructions.

There appears to be no compelling reason why it should be presumed that a lawyer representing joint clients or joint interests cannot exercise independent professional judgment and render competent advice or engage in proper conduct consistent with the intended scope of the representation. If and when a lawyer fails to do this, remedies exist which may be

148. I use the term "knowingly" deliberately as I am attempting to define the lawyer's professional obligations in the context of the triangular relationship. Rule 1.0(f): " 'Knowingly,' 'known,' or 'knows' denotes actual knowledge of the fact in question. A person's knowledge may be inferred from circumstances." ANNOTATED MODEL RULES OF PROF'L CONDUCT R. 1.0(f) (2007). Whether the lawyer should be liable for recklessly or negligently assisting the insurer in breaching a duty owed to the policyholder raises issues more closely connected with malpractice liability than professional responsibility, issues that I do not address here.

employed by the injured parties. Yet the fact that rules have been broken does not lead one to conclude that they will necessarily be broken. Nor has it been demonstrated that the frequency of violations or their severity is so great that a preemptive rule is required that would restructure the relationship so as to preclude the lawyer from giving advice that advances the parties' stated objectives and which caused the lawyer to be retained in the first place.

THREE INSIGHTS FROM THE CANADIAN D&O INSURANCE MARKET: INERTIA, INFORMATION AND INSIDERS¹

M. Martin Boyer²

ABSTRACT

This paper contributes to our understanding of the role of Director's and Officer's insurance by answering three very specific questions: Do directors and corporations actively optimize their decision to purchase D&O insurance? Can we devise a profitable investment strategy based on the D&O insurance information? And does D&O insurance motivate managers to increase profitability? To answer the first question, I will argue that the most important determinant of D&O purchase in any year is whether the firm purchased it in the previous year so that managers do not appear to reassess actively their need for such coverage very often. For the second question, I find that there are profitable investment strategies that entail the purchasing of the stock of corporations that have relatively high directors' and officers' insurance unit price (premium divided by coverage) and sell the stock of corporations that have relatively low directors' and officers' unit price. I attribute the profitability of the strategy to the fact that directors' and officers' insurance represents an aggregate measure of board efficiency and corporate governance health. Finally, using a cross section of Canadian unit trust companies, I show that D&O insurance seems to demotivate managers to extract cash flows from assets, although this demotivation does not seem to reach the stock market. Two important caveats are in order: I am using a very short time period and I am using only Canadian corporations. Sadly, information regarding directors' and officers' insurance has not been available for very long, and is still not available publicly in the United States.

1. I would like to thank Mathieu Delvaux-Derome and Pascal Drouin for able research assistance, as well as Stéphane Rousseau and Claude Francoeur for animated discussions. Part of this research was sponsored by the Social Sciences and Humanities Research Council of Canada. The continuing financial support of CIRANO is also gratefully acknowledged.

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INTRODUCTION

A. CORPORATE DIRECTOR LIABILITY AND PROTECTION

As representatives of the corporation, directors and officers are liable for the corporation's actions.³ More importantly, the directors and officers are personally responsible for those actions, and accordingly their personal assets are at risk in the event of a lawsuit against the corporation and its management.⁴ Following the recent loss of confidence in corporate governance resulting from the debacle of corporate giants like Enron, Worldcom, Adelphia and Anderson, corporate managers are facing greater risk of lawsuits originating from angry shareholders who feel they were kept in the dark regarding the company's operations. According to a 2002 survey, 19% of firms had at least one lawsuit brought against their directors in the previous ten years.⁵ One way for a corporate director to protect his personal wealth is to have the corporation buy insurance on his behalf.⁶ This insurance is known as Directors' and Officers' (D&O) insurance.

A D&O insurance policy becomes applicable when a manager is sued in his capacity as a representative of the corporation.⁷ The insurance company indemnifies the corporation and/or the manager only if the manager acted in good faith on behalf of the company; i.e., managers are not covered in case of gross negligence or criminal behavior.⁸ Depending on the type of D&O contract, the manager could be indemnified directly, or the corporation could be compensated for the expenses incurred in the manager's defense.⁹ As with traditional insurance contracts, D&O insurance contracts stipulate a premium to be paid, a policy limit, and a deductible.¹⁰

3. M. Martin Boyer, *Directors' and Officers' Insurance and Shareholders' Protection 1* (Ctr. for Interuniversity Research and Analysis on Orgs., Working Paper No. 2003s-64, 2003), available at <http://www.cirano.qc.ca/pdf/publication/2003s-64.pdf>.

4. *Id.*

5. Tillinghast-Towers Perrin, *2002 Directors and Officers Liability Survey: US and Canadian Results*, Apr. 23, 2003, available at www.towersperrin.com/tp/getwebcachedoc?webc=TILL/USA/2003/200304/DO_summary2002a.pdf.

6. Boyer, *supra* note 3, at 1.

7. *Id.*

8. Sanjai Bhagat, James A. Brickley & Jeffrey L. Coles, *Managerial Indemnification and Liability Insurance: The Effect on Shareholder Wealth*, 54 J. RISK & INS. 721, 724 (1987); John M. R. Chalmers, Larry Y. Dann & Jarrad Harford, *Managerial Opportunism? Evidence from Directors' and Officers' Insurance Purchases*, 57 J. FIN. 609, 613 (2002).

9. Bhagat et al., *supra* note 8, at 724; Chalmers et al., *supra* note 8, at 613.

10. Bhagat et al., *supra* note 8, at 724.

It is important to note that D&O insurance is not the only way to protect managers against lawsuits. A corporation can also amend its charter so that the director liability is limited.¹¹ These limited liability provisions “all but eliminate the directors’ personal financial responsibility toward the firm and its shareholders.”¹² By 1996, more than 70% of American corporations adopted limited liability provisions.¹³ A third way that a corporation can protect its directors is through corporate indemnification plans. These plans give directors protection against third-party lawsuits because under these plans the corporations are responsible for indemnifying the directors for court expenses.¹⁴ Corporate indemnification plans protect directors who acted in the best interest of the corporation, even if they are found guilty, so long as the harm was caused while acting in the best interests of the corporation and the director did not reap any personal benefit from their conduct.¹⁵ The public data collected for this study makes no mention of corporate indemnification plans and because Canadian corporate law does not allow limited liability provisions,¹⁶ this study relies exclusively on D&O insurance to study the financial protection offered to corporate directors.

B. PAST RESEARCH

Because of the limited access to public information prior to 1990,¹⁷ only a few studies have been conducted on the demand for D&O insurance. Public information became available following the Cadbury Report in the United Kingdom and the Dey Report in Canada.¹⁸ Both reports recommended to their respective securities commission that more information be made available on the compensation of officers and directors.¹⁹ As a result, more information regarding managerial

11. Maria Gutierrez, *A Contractual Approach to the Regulation of Corporate Directors’ Fiduciary Duties* 17 (Universidad Carlos III de Madrid, Working Paper No. 0013, 2000).

12. Boyer, *supra* note 3, at 1.

13. Gutierrez, *supra* note 11, at 17.

14. *Id.*

15. *Id.*

16. R. Crête et S. Rousseau, *Droit des sociétés par actions*, 2e éd., Montréal, Éditions Thémis, 2008, 881 p.

17. Prior to 1990, the only information related to D&O insurance was collected via surveys by Wyatt, now part of Tillinghast-Towers Perrin. Boyer, *supra* note 3, at 8.

18. *Id.*

19. COMM. ON THE FIN. ASPECTS OF CORPORATE GOVERNANCE, REPORT OF THE COMMITTEE ON THE FINANCIAL ASPECTS OF CORPORATE GOVERNANCE § 3.2 (1992), available at <http://www.ecgi.org/codes/documents/cadbury.pdf>; TORONTO STOCK EXCH.

compensation is available in both countries, including the purchase of D&O insurance.

The first studies that used the newly available public data in Canada and the United Kingdom were conducted by J.E. Core and N. O'Sullivan.²⁰ Using a sample of 222 firms whose fiscal year ended between May 31, 1994 and December 31, 1994, Core found that the most important determinants of whether D&O insurance was purchased were the risk of a lawsuit and the cost of financial distress.²¹ In a follow-up article, Core found that the factors explaining premiums were about the same as the factors explaining the demand for D&O insurance.²² Core's results are supported by O'Sullivan who concluded that in the United Kingdom, D&O insurance coverage and managerial share ownership are corporate governance instrument substitutes.²³ Moreover, Core and O'Sullivan suggested that D&O insurance acts as a monitoring device.²⁴

If D&O insurance reduces the expected cost of bankruptcy and acts as a corporate governance instrument or monitoring device, one should expect that stock returns should be positively correlated with D&O insurance purchases. Surprisingly, however, D&O insurance does not seem to have any impact on stock returns.²⁵

More recently, a study conducted by J. Chalmers, L. Dann, and J. Hartford examined the interaction between D&O insurance coverage and initial public offering (IPO) under-pricing.²⁶ This study looked at an original sample of firms that went public between 1992 and 1996.²⁷ The Chalmers study found that corporations with substantial D&O insurance coverage were, on average, more likely to be sued in the future for

COMM. ON CORPORATE GOVERNANCE IN CAN., WHERE WERE THE DIRECTORS? GUIDELINES FOR IMPROVED CORPORATE GOVERNANCE IN CANADA § 5.50 (1994).

20. John E. Core, *On the Corporate Demand for Directors' and Officers' Insurance*, 64 J. RISK & INS. 63, 64, 70 (1997); Noel O'Sullivan, *Insuring the Agents: The Role of Directors' and Officers' Insurance in Corporate Governance*, 64 J. RISK & INS. 545, 546 (1997).

21. Core, *supra* note 20, at 70, 81.

22. See John E. Core, *The Directors' and Officers' Insurance Premium: An Outside Assessment of the Quality of Corporate Governance*, 16 J.L. Econ. & Org. 449 (2000); Core, *supra* note 20.

23. O'Sullivan, *supra* note 20, at 554.

24. O'Sullivan, *supra* note 23, at 554. See generally Core, *supra* note 22 (suggesting that D&O premiums contain useful information about the quality of corporate governance).

25. Bhagat et al., *supra* note 8, at 722.

26. Chalmers et al., *supra* note 8, at 609-10.

27. *Id.* at 610-611.

mispricing.²⁸ More specifically, the study found that the three-year performance is negatively related to the amount of D&O insurance purchased at the IPO.²⁹ Put another way, the greater the D&O insurance coverage, the less underpriced the stock was at the time of the initial public offering.

The liability crisis of the late 1970s and early 1980s was a period of intense uncertainty for insurance companies, especially D&O insurance providers. This crisis affected all types of liability insurance including personal automobile liability insurance, medical malpractice, product liability and general liability.³⁰ This uncertainty is attributable to changes in the legal environment.³¹ As changes in the legal environment were an undiversifiable risk for insurers, the law of large numbers no longer applied to these insurance products.³² As a result, diversification was necessary to cover for legal environment risks.³³ The increased economic importance of mutual insurance companies resulted directly from this liability crisis.³⁴ This organizational response from the insurance industry was also accompanied by a contractual response: The introduction of “claims made and reported” (CMR) insurance policies.³⁵

Most D&O insurance contracts are written on a CMR basis.³⁶ CMR contracts differ from regular occurrence based contracts in that they cover losses that are made and reported during the policy year, even though such claims may have been incurred in previous years.³⁷ Regular occurrence based contracts cover losses that are incurred during the policy year no matter when the claim is reported in the future.³⁸

28. Chalmers et al., *supra* note 8.

29. *Id.* at 633.

30. See generally George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521 (1986). For a discussion on the insurance crisis and D&O insurance see, Roberta Romano, *The Shareholder Suit: Litigation Without Foundation?*, 1 J.LAW, ECON & ORG. 55, 68-9 (1991).

31. Neil A. Doherty, *The Design of Insurance Contracts When Liability Rules are Unstable*, 58 J. RISK & INS. 227, 227 (1991).

32. *Id.*

33. *Id.* at 227-28.

34. *Id.*

35. *Id.*

36. Boyer, *supra* note 3, at 7.

37. *Id.* “For example, suppose that an incident occurs in 1995 but is not reported until 2000 when a claim is filed. Under a CMR contract, all the financial responsibility for the loss falls upon the 2000 insurer. Under an occurrence based insurance contract, it is the 1995 insurer who is responsible.” *Id.*

38. *Id.*

Past behavior has a double importance in designing the current year's insurance contract. Firstly, past behavior could be an indication of current behavior so that any information related to the insured's risk gathered in the past will be used as a signal regarding the insured's current risk.³⁹ This is true both for occurrence based and CMR contracts.⁴⁰ Secondly, past behavior is an indication of current losses paid in the case of CMR contracts.⁴¹ Thus past behavior becomes doubly important when the insurance contract is written on a CMR basis.

C. FINDINGS

The findings of this study are based on an original data set of publicly traded Canadian corporations that filed their annual reports between January, 1 1993 and December 31, 1998. Canadian data is used because basic D&O insurance information (policy limit, deductible and premium) is made public in the corporations' management proxies and information circulars (information that is absent from standard reporting documents in the United States).⁴²

The first point this paper makes is that there is a lot of inertia embedded in the decision to purchase D&O insurance, as much as to the amount of coverage chosen. This result is not completely new, but it is important to mention when trying to explain why firms purchase insurance and in what amount. It appears that when asked whether to purchase D&O insurance and in what amount, firms answer by a question: What did we do last year? The only noticeable variation from year to year is the premium paid.

The second result relates to the informational value to investors of making public the D&O insurance coverage. In a world where insurers are examining thoroughly the risk level of their clients, one would expect that an investment strategy based on the perceived risk levels of Canadian corporations should be profitable. How should one infer from the management proxy and information circular an insurer's assessment on one firm's riskiness? I will argue that the unit price of insurance (that is the premium-to-limit ratio) is a good indicator. This indicator should also have more explanatory power for large firms because an insurer should be

39. *Id.*

40. *Id.*

41. *Id.*

42. Sean J. Griffith, *Uncovering a Gatekeeper: Why the SEC Should Mandate Disclosure of Details Concerning Directors' and Officers' Liability Insurance Policies*, 154 U. PA. L. REV. 1147, 1200 (2005-2006).

spending more time auditing the internal procedures and financial health of a larger corporation because it has more to lose by not doing so. Using a limited number of yearly data points, I found that large firms who face a higher unit price of insurance are more likely to experience a low market return than large firms who face a lower unit price. The evidence for this is not as robust for smaller firms unless the first year of data, 1994, is not considered. An investment strategy that would be long in low unit price firms and short in high unit price firms would, on average, earn a five-year return of 25% from 1994 through 1998. This result supports the position that D&O insurance information is valuable to investors and should therefore be made public in the public firms' management proxies.

Finally, the third result of the paper is based on a particularity of the Canadian securities market: the existence of income trust companies. Income trusts in Canada, which are similar to the now defunct limited master partnerships in the United States, are characterized by a dual-class structure, which presumably, reduces investor protection. If that is the case, then the moral hazard problem for managers of having D&O insurance (that is, not investing as much effort in generating wealth for the shareholders) should be more evident for income trust than for stock corporations. I found that a measure of accounting performance (growth of the earnings before interest, taxes, depreciation and amortization) is lower when coverage is larger, but that does not translate into lower stock market performance (measured as the total yield).

Data Collection and Data Source

The financial data used in this study was obtained from three different sources: Compustat, Stock Guide and CanCorp Financial. The use of three different sources allowed for a larger data set compared to Compustat alone. Unfortunately information was not always the same for corporations whose financial information appeared in more than one source. If that occurred, a lexicographic approach to the problem was utilized, trusting the Compustat entry over the other two, and the Stock Guide entry over CanCorp's. Stock prices and total returns were drawn from the TSE-Western tapes. All values are in Canadian dollars; any U.S. dollar figure has been converted to Canadian dollar using the exchange rate at the fiscal year-end of each company. Precise information was collected regarding executive compensation of publicly traded Canadian companies listed on the Toronto Stock Exchange. Companies traded on the TSE are required to

make public much more information concerning their D&O policies than was previously required, including coverage limits and premiums.⁴³

Information regarding D&O insurance purchases and executive compensation of publicly traded Canadian companies listed on the Toronto Stock Exchange was collected from the annual management proxies and information circulars. These management proxies also gave information related to the firm's block holders, board member compensation and ownership, as well as the type and number of shares held by each officer (regular or multi-voting).⁴⁴ These proxies also report the basic information regarding D&O coverage, such as whether the corporation had D&O insurance, the D&O insurance policy limit, and occasionally the deductible and the premium paid.⁴⁵

The original sample included 354 Canadian corporations drawn from 7 economic sectors: bio-pharmaceutical, forest and paper, industrial products, technological, consumer products, merchandising, and communication and media. These sectors were chosen based on the Toronto Stock Exchange (TSE) sector list drawn from the TSE Fact Book. Two important sectors of the Canadian economy, financial institutions, and mining and natural resources, were deliberately omitted to keep the sample more homogenous. Because of holes in the data 27 firms, mainly smaller firms were deleted from the start. There is no survivor bias because we collected data on new companies, as well as companies that disappeared during the sampled years. Because of this incomplete panel, the study was left with 1594 observations, which gave an average of 4.9 years per company (out of a maximum of 7). Of the 327 firms used in the final sample, close to 60% had information for 5 years or more, including 22% for all the years. Of the sample in this study, 73.4% of the firms (241 firms) purchased D&O insurance at least once during those seven years. Of the 327 firms, over 17% did not exist anymore at the start of 2000. Table 1.1 presents a

43. Griffith, *supra* note 42, at 1200. Since 1996 all this information is available on the Ontario Securities Commission's internet site (<http://www.sedar.com>). *Id.* Prior to 1996, the information was collected directly from companies or purchased from Micromedia. Martin Boyer, *Is the Demand for Corporate Insurance a Habit? Evidence of Organizational Inertia from Directors' and Officers' Insurance* 12 (Ctr. for Interuniversity Research and Analysis on Orgs., Working Paper No. 2004s-33, 2004), available at <http://www.cirano.qc.ca/pdf/publication/2004s-33.pdf>.

44. M. Martin Boyer, *Is the Demand for Corporate Insurance a Habit? Evidence from Directors' and Officers' Insurance* 12-13 (Ctr. for Interuniversity Research and Analysis on Orgs., Working Paper No. 2003s-42, 2003), available at <http://www.cirano.qc.ca/pdf/publication/2003s-42.pdf>.

45. *Id.* at 13.

detailed table of the number of firms, divided by sector, per year included in the sample.

Table 1.1. Number of firms per year by economic sector								
Year	1993	1994	1995	1996	1997	1998	1999	
Sector								% of total
Bio-pharmaceutical	4	9	10	13	19	19	16	5.83
Forest and Paper	19	27	31	32	29	29	25	12.11
Industrial Products	30	63	79	82	83	80	64	30.18
Technological	5	15	21	28	37	36	33	11.04
Consumer Products	21	38	44	47	48	48	37	11.75
C&I Products	4	5	9	8	8	8	7	3.07
Merchandizing	15	27	33	36	35	29	23	12.42
Media	<u>9</u>	<u>18</u>	<u>21</u>	<u>22</u>	<u>17</u>	<u>17</u>	<u>17</u>	<u>7.56</u>
Total	107	202	248	268	276	266	222	1594

For each economic sector, all corporations listed in the TSE publication and traded on the exchange were included in the data set for each year of the sample. This exercise yielded a total of 1519 observations. Because of incongruities in the financial and management proxies (for example board or CEO ownership of more than 100% of the company's stock or no trading in the stock during the year) a high number of observations were deleted from the original data set, so that the final data set included 1407 observations for 318 firms. Table 1.2 presents the statistics related to D&O insurance penetration by industry.

Insurance penetration was calculated as the proportion of corporations that purchased D&O insurance. On average, 70% of the firms purchased D&O insurance, although penetration seemed to increase over the years (67% in 1993, 73% in 1998). D&O insurance penetration in the data set

was slightly below that reported by Tillinghast-Towers Perrin (1999), for the year 1998, but higher than Core (1997) for the years 1993 to 1994.⁴⁶ In the case of Tillinghast-Towers Perrin, 84% of Canadian corporations were reported to purchase D&O insurance in 1998.⁴⁷ That is a full ten percentage points higher than in the sample used for this study. My understanding is that these differences are explained by four important factors. First, Tillinghast-Towers Perrin relied on a corporation survey that biased their results because of the type of respondent. Second, the number of corporations polled was smaller than the entire sample of possible companies. Third, the same companies were not polled every year, so that it was difficult to keep a tab on the actual trend in the industry. Finally, the data set constructed for this study does not include financial firms, mining firms, public utilities and not-for-profit firms.

46. See Tillinghast-Towers Perrin, *1999 Directors and Officers Liability Survey: Executive Summary of U.S. and Canadian Results* (1999) (on file with the Connecticut Insurance Law Journal); Core, *supra* note 20.

47. Tillinghast-Towers Perrin, *supra* note 46. By comparison, D&O insurance penetration in the United States was 84% in 1993 and 92% in 1998.

Table 1.2. D&O insurance penetration by economic sector and fiscal year						
Fiscal Year	1993	1994	1995	1996	1997	1998
Sector						
Bio-pharmaceutical	88%	92%	92%	90%	90%	89%
Forest and Paper	59%	58%	63%	64%	67%	70%
Industrial Products	68%	69%	71%	76%	74%	64%
Technological	90%	90%	84%	70%	68%	74%
Consumer Products	68%	65%	70%	67%	63%	67%
Merchandizing	52%	57%	58%	56%	55%	55%
Media	77%	78%	78%	73%	79%	85%
Weighted Average	67%	69%	71%	70%	71%	73%
Percentage of corporations by economic sector and by year that carry D&O insurance. The weighted average is calculated by taking into account the number of firms by industry.						

In the case of Core (1997), 63% of corporations whose fiscal year ended between June 1, 1993 and May 31, 1994 were reported to have D&O insurance.⁴⁸ Although Core relied on the same public information source as this study, his sample of companies was different because he included public utility, financial and mining corporations.⁴⁹ This explains why Core's sample consisted of 222 companies, compared to the 181 companies (1993) and 238 companies (1994) used in this study.

48. See Core, *supra* note 20, at 70.

49. Boyer, *supra* note 44, at 1, 10.

I. RESULTS

A. INERTIA

The first argument presented in this paper is that risk management in corporations in general, and D&O purchases in particular, are subject to inertia. An organization plagued with inertia is one that is unwilling to change ex post what it did ex ante.⁵⁰ Applied to the particular case of insurance purchases, inertia means that the current insurance contract specifications are better explained by the managers' previous contract choice than by the current economic condition of the firm. To show that inertia plays a role, my contention is that the traditional financial and governance measures that have been used to explain risk management decisions do not work as effectively as a measure of organizational inertia.

To support the existence of inertia in D&O insurance purchased, it is interesting to note that firms that purchase D&O insurance do so for all the years, and firms that do not, never do. This does tell a lot about the presence of inertia in that the best predictor of a corporation buying D&O insurance this year is whether it purchased insurance last year. One can imagine that managers that were never covered under a D&O insurance policy do not request it because they do not see its use; and managers that have had it cannot think why they would get rid of it.

Why are financial and governance considerations not relevant? One possible explanation relies on the *CMR* structure of D&O insurance contracts. *CMR* contracts act as a lobster trap: corporations who purchase it one year can never realistically get rid of it in the future.⁵¹ Purchasing a *CMR* contract is tantamount to choosing to be consistently insured since firms find it difficult to drop coverage once it is purchased.⁵² Indeed, if a firm cancels its *CMR* insurance policy at a given time, it implicitly decides to drop the coverage in the future for any and every past loss that might have been incurred, but not yet reported.⁵³ And even if the firm decides to reinstate its coverage in later years, it usually will not be covered for past occurrences that have not yet been reported.⁵⁴ Dropping a contract written on a *CMR* basis, such as a D&O insurance contract, is therefore very risky.

50. *Id.* at 14.

51. *Id.*

52. Boyer, *supra* note 3, at 7.

53. James Povlich, *Risk financing solutions to employment practices liability*, RISK MANAGEMENT, May 1994, at 57, 58.

54. Boyer, *supra* note 44, at 14.

The structure of a CMR contract explains why firms never drop coverage, but it does not explain why some firms never purchase the insurance. This latter fact is better explained by considering that some firms view D&O insurance as destructive since it arguably reduces the directors' incentives to work hard.⁵⁵ Either way, both managerial habit (including the CEO's beliefs) and the stated inertia associated with CMR contracts explain the decision to purchase D&O insurance.

The choice of a deductible and policy limit is also very stable over the years. After controlling for the six traditional reasons that explain why corporations purchase insurance (managerial risk aversion, asset substitution, under investment, real services, bankruptcy, and convexity of the tax schedule), the Boyer study finds that nothing explains D&O policy limits and deductibles in a given year as much as the previous year's limit and deductible.⁵⁶ A possible explanation comes from the method used to sell D&O insurance policies. D&O insurance is mainly sold by insurance brokers who negotiate with insurance companies on behalf of the insured.⁵⁷ In Canada, the top two insurance brokers hold a 66% market share in terms of the number of accounts (it is the top four brokers in the U.S. that hold that much market power).⁵⁸ In premium terms, the top two insurers hold a 50% market share in the United States, and the top three D&O insurers (AIG, Chubb and Lloyd's) collect about 65% of the premiums.⁵⁹ In Canada, a majority of corporations receive their D&O insurance coverage from one unique insurer.⁶⁰

Another interesting feature of D&O insurance is the existence of so-called policy limit sticky points. Indeed, coverage limits are sold by layers of \$1,000,000, although the most important steps appear to be \$5,000,000, so that we see a clustering of D&O limits around a few sticky points.⁶¹ For instance, out of the 173 Canadian listed firms that purchased D&O insurance in 1998, two-thirds chose one of six policy limits: \$5,000,000 (18 times), \$10,000,000 (43 times), \$15,000,000 (12 times), \$20,000,000 (18 times), \$25,000,000 (10 times) and \$50,000,000 (13 times).⁶² Other years have similar sticky points.

55. See *ECONOMIST*, June, 2003 at 14.

56. Boyer, *supra* note 44, at 18.

57. *Id.* at 5.

58. Boyer, *supra* note 3, at 7.

59. Boyer, *supra* note 44, at 5; Boyer *supra* note 3, at 7.

60. Tillinghast-Towers Perrin, *supra* note 5, at 6.

61. Boyer, *supra* note 3, at 7

62. *Id.*

B. INFORMATION

Insurance companies that write D&O insurance will, presumably, use all available information as to a company's financial condition and the efficiency of its governance procedures. Because of the amount of money involved in the event of a lawsuit, or only because of their extensive expertise in handling D&O claims, insurers have access to information that is not available to other agents in the economy.⁶³ Insurers could, for example, conduct background checks on some of the firm's board members to better assess their competency and ultimately the real risk of a lawsuit.⁶⁴ Gathering this information may not be possible for investors. Due to the fact that the insurer's assessment of the firm's risk enters a ratemaking matrix that yields only a premium given the amount of coverage demanded,⁶⁵ we may wonder whether there is any information embedded in the premium per dollar of coverage. Put in another way that has more appeal to a financial economist, one could ask whether a profitable investment strategy based on the D&O information contained in the management proxies and information circular could be designed.

Before presenting these results, let us examine how D&O insurance prices evolved during the years under study (1993-1998). Table 2.1 shows the evolution of the premium-to-limit ratio over the six years of my sample, for different cut-off points.

63. See Core, *supra* note 22, at 453.

64. *Id.*

65. *Id.* at 454.

Table 2.1 Premium in Canadian dollars for each thousand dollars of D&O insurance coverage (1993-1998)							
Year	1993	1994	1995	1996	1997	1998	Δ94 – 98
Number of observations	88	150	169	179	186	163	
95%	11.91	13.75	15.00	15.00	13.33	9.40	- 31.6%
75%	5.23	5.85	4.80	4.50	4.40	4.35	- 25.6%
50% (median)	3.12	3.02	3.08	2.79	2.60	2.60	- 13.9%
25%	2.23	2.06	1.99	1.89	1.67	1.75	- 15.0%
5%	1.22	0.70	0.86	0.82	0.80	0.52	- 25.7%

We see in the table that, from 1994 to 1998, the average premium went down for every tranche by an average of 20% and by an average of 25% from 1993 to 1998. As the price of each unit of coverage fell from 1993 through 1998, not all corporations answered according to well known principles of microeconomics by purchasing more coverage. We can observe in Table 2.2 that firms that were small demanders of D&O insurance responded to a reduction in price by decreasing their D&O insurance coverage.⁶⁶

66. This raises an interesting possible area of economic inquiry in that we may have, in this particular instance, an example of a Giffen good.

Table 2.2 D&O insurance policy limit in thousands of Canadian dollars (1993-1998)							
Year	1993	1994	1995	1996	1997	1998	Δ 94 – 98
Number of observations	95	158	177	189	193	170	
95%	390,054	436,363	493,866	486,940	648,078	755,244	73.1%
75%	148,452	153,239	138,737	148,483	175,324	199,505	30.2%
50% (median)	84,521	75,510	71,480	72,267	75,659	64,841	-14.1%
25%	34,630	31,339	31,912	32,814	33,764	29,321	-6.44%
5%	9,686	9,819	9,348	9,600	10,292	8,048	-18.0%

At the same time as the unit price was falling, the average firm size was not increasing much either in terms of assets or market value of equity as we can see in Table 2.3.

Table 2.3 Evolution of firm size as measured by the log of assets and the log of the market value of equity (1993-1998)						
Panel A. Assets						
Year	1993	1994	1995	1996	1997	1998
Number of observations	95	158	177	189	193	170
95%	7.92	8.16	8.22	8.24	8.15	8.68
75%	6.49	6.44	6.48	6.29	6.49	6.75
50% (median)	5.03	4.95	5.19	5.17	5.33	5.59
25%	3.85	3.93	4.00	4.13	4.11	4.18
5%	2.59	2.88	3.16	3.36	3.04	2.71
Panel B. Market value of equity						
Year	1993	1994	1995	1996	1997	1998
Number of observations	90	156	173	187	191	169
95%	7.65	7.66	7.89	7.74	8.06	8.16
75%	6.54	6.22	6.16	6.26	6.48	6.48
50% (median)	4.79	4.70	4.88	5.16	5.22	4.99
25%	3.92	3.80	3.76	4.01	4.08	3.78
5%	1.92	2.27	2.40	2.75	3.05	2.03

The next analysis is by no means robust to many attacks from econometricians and statisticians; but the D&O insurance information is available only once a year, which makes portfolio investment decisions possible only once a year. As a result, only five years' data are available to assess the profitability of the investment strategy, based on the aggregate

information revealed in a firm's management proxy and information circular. The goal is to see whether the unit price of D&O insurance is a profitable decision criterion for portfolio allocation. To do so requires splitting the data set into different investment baskets. The investment strategy would be to sell short the least profitable basket and use the proceeds to invest in the most profitable basket. The hypothesis is that unit price is a measure of the firm's riskiness that is not otherwise observable by investors. As a result, firms that purchase insurance with a low unit price should be more profitable than firms that purchase insurance with a high unit price. The unit price will thus determine, for each year, two baskets of firms with approximately the same number of firms in each basket.

Hypothesis 2.1 Firms faced with a higher unit price of D&O insurance should be less profitable.

An important component of D&O insurance is the sheer size of the corporation,⁶⁷ if only because there are more possible damages that one needs to cover in the event of a lawsuit when the corporation is larger.⁶⁸ Moreover, because lawsuits should be more costly for larger corporations, an insurer underwriting a D&O insurance policy should spend more time verifying governance practices and auditing the financial statements of larger corporations. Insurers should spend more time examining a large corporation and their assessment of the risk should be more precise.

To test this hypothesis, the data were split into four baskets: two size baskets and two unit price baskets. To limit the impact of important outliers in the sample,⁶⁹ the data were windsorized⁷⁰ by removing the company with the highest annual return and the company with the lowest; a total of eight observations per year were removed. The distribution of firms in each basket is displayed in Table 2.4.

67. See Griffith, *supra* note 43, at 1201 (discussing firm size as D&O premium factor).

68. Core, *supra* note 20, at 67-68, 73, 82 (discussing large firm size as a litigation factor). Firm size should be controlled for in portfolio allocation in accordance with the Fama and French model. Eugene F. Fama & Kenneth R. French, *Differences in the Risks and Returns of NYSE and NASD Stocks*, 49 FIN. ANALYSTS J., 37, 38-39 (1993) (explaining firm size as a factor of the three-factor model).

69. The outliers in the sample included an obvious data error, as one firm's return was 4800%.

70. See Karen Kafadar, *John Tukey and Robustness*, 18 STAT. SCI. 319, 322-23 (2003).

Table 2.4 Number of firms in each size and unit price basket										
<u>Year</u>	<u>1994</u>		<u>1995</u>		<u>1996</u>		<u>1997</u>		<u>1998</u>	
Number of firms	32	21	37	30	42	29	44	37	39	33
	21	30	32	40	32	43	35	43	35	39
The basket of firms in the table are					High unit price Large firm	Low unit price Large firm	High unit price Small firm	Low unit price Small firm		

The second hypothesis is that the D&O insurance information related to the unit price of insurance should be more informative for larger corporations than for smaller corporations. The difference in performance between firms that face a low unit price of D&O insurance and firms that face a high unit price of insurance should be more visible for larger firms.

Hypothesis 2.2 The predictive power of the unit price of D&O insurance should be greater for larger firms.

The average basket returns per year are displayed in the Table 2.5.

Table 2.5 Average annual return of firms in each size and unit price basket										
<u>Year</u>	<u>1994</u>		<u>1995</u>		<u>1996</u>		<u>1997</u>		<u>1998</u>	
Annual return (%)	10.3	-4.76	-3.78	2.00	22.6	24.3	17.6	42.0	-11.4	-6.41
	24.4	-1.55	6.99	27.7	34.4	23.7	9.88	8.46	-25.7	-11.6
All returns are calculated as $\frac{P_{\tau}}{P_{\tau-1}} - 1$ and presented as					High unit price Large firm	Low unit price Large firm	High unit price Small firm	Low unit price Small firm		

The hypothesis for the unit price is that, controlling for size and extreme outliers, firms that purchase D&O insurance at a relatively low

price per unit of coverage⁷¹ are more financially sound and face less corporate governance risk. As a result, on average, they should have higher returns. For small firms, this does not appear to be statistically significant. An investment strategy that would require investing the same amount of money in every small firm with a low unit price would only perform marginally better than the same strategy in every small firm with a high unit price. The five-year total return of investing in small firms faced with a low unit price is 49%, whereas the five-year total return of investing in small firms faced with a high unit price is 46%. Given the standard deviations, these total returns are not statistically significant.

For large corporations⁷² the difference is more pronounced. Except for the first year of the study, the average return for low unit price firms is always higher than for high unit price firms. The total return of investing in large firms faced with a low unit price is 61%, whereas the total return of large firms faced with a high unit price is 35%.

If 1994 is removed from the study for concerns associated with devising an investment strategy that uses only nineteen firms in the large firm with low unit price and small firm with high per unit price categories, the total return over four years is 23% for large firms with high unit price, 17% for small firms with high unit price, 69% for large firms with low unit price and 51% for small firms with low unit price. By "going long" with low unit price companies and "going short" with high unit price companies, an investor would have been able, over the years 1995-1998, to generate a sizeable profit margin⁷³.

The unit price of D&O insurance analysis has an interesting predictive power for the company's future profitability. As the unit price is higher, reflecting, in the insurer's mind a higher risk of litigation, future returns appear to be lower. This is even stronger for larger firms than for smaller firms, and supports this section's two hypotheses.

C. INSIDERS

One final insight from the Canadian market is associated with a particular aspect of Canadian security regulation: Income trusts. Trust

71. See the companies in the right two cells of Table 2.4 *supra* p.93.

72. See the companies in the top two cells of Table 2.4 *supra* p.93.

73. The profit margin would have been 46% for large companies and 34% for small companies.

agreements largely replicate the Canada Business Corporations Act (CBCA) provisions, but not completely as shown in Gillen (2006).

Income trusts operate, however, in the context of trust law that has not generally been developed with a view to the use of the trust as a structure for running a business ... (*and*) has thus not been developed with a view to protecting investors and does not contain the kinds of governance and shareholder remedy provisions that one typically finds in corporate statutes. Also, trust instruments of different income trusts differ from one to another in one or more aspects that create a source of potential confusion for unit holders since their governance knowledge of one IT may not be transferable or applicable to another.⁷⁴

An important aspect of Canadian income trusts is their dual-board structure.⁷⁵ As a result of this structure, income trusts have a board of directors as well as a board of trustees whose duty and privileges are not necessarily the same.⁷⁶ It is thus important to control for this aspect of income trusts in Canada.

This section will analyze D & O insurance's impact on the profitability of unit trusts. Income trusts are presumably riskier than stock companies from a governance point of view.⁷⁷ Additionally, being insured induces moral hazard problems.⁷⁸ Therefore it should be more likely that D&O insurance coverage will have a negative impact on performance for a unit trust. Performance was measured in two ways. First, it was measured by D&O insurance coverage's impact on an accounting measure that reflects the trust's earnings before interest, taxes, depreciation and amortization (EBITDA). This performance measure gives investors an idea of how much cash flow is generated by the income trust's activities.⁷⁹ Therefore, if moral hazard is present, income trusts should have lower EBITDA growth where managers are well protected by a D&O insurance policy. The second

74. Mark Gillen, *A Comparison of Business Income Trust Governance and Corporate Governance: Is There a Need for Legislation or Further Regulation?*, 51 MCGILL L.J. 327, 378 (2006).

75. CERTIFIED GEN. ACCOUNTANTS ASS'N. OF CAN., *DEMISTIFYING INCOME TRUSTS* 21 (2006). See Figure 2 *infra* p. 106 for an illustration of income trust corporate structure.

76. CERTIFIED GEN. ACCOUNTANTS ASS'N. OF CAN., *supra* note 75, at 21.

77. See Mark Gillen, *A Comparison of Business Income Trust Governance and Corporate Governance: Is There a Need for Legislation or Further Regulation?*, 51 MCGILL L.J. 327, 378 (2006) (stating that investors avoided investments in business income trusts due to unlimited liability concerns).

78. Eric D. Beal, *Posner and Moral Hazard*, 7 CONN. INS. L.J. 81, 84-85 (2001).

79. See, e.g., *Steiner Corp. v. Benninghoff*, 5 F. Supp.2d 1117, 1130 (D. Nev. 1998) (describing EBITDA as a cash flow measure).

performance measure is the total yield of the unit trust on the Toronto stock market. This total yield is calculated as the annual cash received during the year plus the unit trust price at the end of year divided by the unit trust price at the beginning of the year (i.e., $R_t = \frac{C_t + P_t}{P_{t-1}}$).

This data set is much different from the data set used in the two previous sections. This sample includes all 144 income observations reported in the Canadian Financial Market Research Center database as of December 31st 2005.⁸⁰

Income trusts in Canada are classified according to four categories: business, energy, utility and real estate (REITs).⁸¹ REITs are common and well known in the United States.⁸² The Canadian income trusts market breakdown is as follows: business trusts, fifty-five percent; utility trusts, ten percent; REITs, fifteen percent; and energy trusts, twenty percent.⁸³

The hypothesis is that the amount of insurance coverage should have a negative impact on a firm's performance. To measure coverage, the log of the D&O insurance policy limit as well as the binary variable determining whether the firm is at all insured were used. For firms that are not insured, the log of the policy limit variable was set to zero. These two variables should have a negative impact on performance.

The other variables used for regression control are: firm size; cash flow volatility; managerial compensation; board independence; and managerial entrenchment. For size, the log of the market value of equity was used, whereas stock price volatility in the year was used as a proxy for cash flow volatility. Stock price volatility is calculated as the annualized daily standard deviation of the stock returns. Both the directors' and the trustees'

80. The final sample includes 144 observations. The initial sample included all the relevant information for 237 income trusts whose fiscal year ended in 2005. Forty-eight were excluded because they were created in 2005 and another eighteen because they were created in 2004; it would have been impossible to calculate their performance. Another twenty-seven were excluded due to incomplete accounting data.

81. Canadian income trusts breakdown into three categories: business trusts; royalty trusts; and REITs. See CERTIFIED GEN. ACCOUNTANTS ASS'N OF CAN., *supra* note 75, at 61-64. Royalty trusts can further be broken down into energy and utility trusts. See Trust Units: Income Trusts, <http://www.investcom.com/incometrust/whatis.htm> (last visited Sep. 24, 2007).

82. See S. Titman & A. Warga, *Risk and the Performance of Real Estate Investment Trusts: A Multiple Index Approach*, 14 REAL ESTATE ECONOMICS 3, (1986).

83. See M. Boyer et al., *Income Trusts Governance and Performance: Time for a Post-mortem*, Mimeograph, HEC Montréal (2009).

compensation are controlled. This compensation is calculated as the log of the annual compensation of directors and trustees respectively. If the labour market is efficient, higher paid directors and trustees should have a positive impact on the income trust's performance. It is also important to control for the independence of the board of director and of the board of trustees, because independent boards are signs of good governance⁸⁴ and presumed to have positive impact on firm performance. This independence is measured as the proportion of independent directors on the board of directors, and as the proportion of independent trustees on the board of trustees. Two variables were included that measure the level of entrenchment of officers, directors and trustees. The first, *contract entrenchment*, is whether managers have access to a golden parachute or other anti-takeover measure that could reduce the managers' willingness to invest time and effort in the firm. The second, *insider power*, is measured as the sum of the voting rights of all investors holding more than 10% of the income trust's shares as a percentage of total voting rights.

Table 3.1 and Table 3.2 present the linear regression results that model the accounting performance and the stock market performance of the income trusts in 2005. Accounting performance is measured as the variation in the income trust's EBITDA from 2004 to 2005, and stock market performance is measured as the total yield of the income trust stock in 2005.

The two tables present five regression models, depending on the variables that are included in the regression. Model 1 is the most basic model; it only controls for D&O insurance coverage, firm size, and stock price volatility. Model 2 adds whether insurance is purchased to the regression. Model 3 has the highest goodness of fit of all five models;⁸⁵ and it adds managerial compensation to the regression. Model 4 adds the independence of the two boards to model 3 while Model 5 adds the managerial entrenchment measures to see if either plays any role in determining the income trust's performance. In all regression models a dummy variable was included⁸⁶ to control for the industry in which the income trust operates.

The log of the policy limit consistently has a negative impact on the accounting performance of the income trust through the five empirical models as illustrated in Table 3.1. In line with this hypothesis, it appears

84. Core, *supra* note 22, at 460.

85. The goodness of fit was measured by the adjusted R².

86. The dummy variables are not represented in the tables.

that the growth of cash flows is impeded by the amount of coverage for directors. This lends strong credence to the moral hazard hypothesis regarding D&O insurance protection since the growth of cash flows is lower when firms purchase more coverage, even after controlling for a multitude of other factors.

Table 3.1 The determinants of the performance of Canadian income trusts in 2005:					
Accounting returns as calculated by the growth of the earnings before interest, taxes depreciation and amortization					
	Dependent variable: $\frac{EBITDA_t}{EBITDA_{t-1}}$				
Independent Variable	Model 1	Model 2	Model 3	Model 4	Model 5
Insured		0.349 (0.445)	0.281 (0.442)	0.277 (0.445)	0.328 (0.434)
Log (Limit)	-0.042** (0.015)	-0.060* (0.027)	-0.055* (0.028)	-0.055* (0.028)	-0.060* (0.029)
Firm Size	0.038 (0.107)	0.043 (0.107)	-0.033 (0.111)	-0.026 (0.113)	-0.003 (0.117)
Stock Price Volatility	-4.180** (1.127)	-4.195** (1.129)	-4.413** (1.118)	-4.218** (1.219)	-4.239** (1.227)
Director Pay			0.066* (0.028)	0.070* (0.029)	0.065* (0.030)
Trustee Pay			-0.019 (0.023)	-0.015 (0.027)	-0.013 (0.27)
Independence of Trustee				0.210 (0.779)	0.259 (0.790)
Independence of Directors				-0.471 (0.673)	-0.424 (0.685)
Insider Power					-0.250 (0.603)
Contract Entrenchment					0.187 (0.260)
R ²	0.156	0.154	0.176	0.167	0.159

The dependent variable is the one-year variation in the firm's earnings before interest, taxes, depreciation and amortization; OLS regression with sector (business, energy, utility and real estate income trusts) fixed effects and 144 observations. The ** (*) represents a coefficient that is significant at the 1% (5%) level. Standard errors are in parentheses.

Stock price volatility and the directors' total compensation are also significant through the different models in explaining performance. Volatility has a negative impact whereas director compensation has a positive impact. This suggests that the level of risk of a firm's operation does have an impact on its ability to generate future cash flows, perhaps because financiers are less likely to invest resources in firms that have riskier operations. In terms of managerial compensation, there is support for the labour market efficiency hypothesis; the more highly paid directors generate high cash flow growth, a signal that quality has its price.

While director compensation has a significant positive impact on EDBITDA growth, the trustees' compensation has no impact, or if any, it is negative. Is trustee compensation less efficient than director compensation? Do trustees not feel as much need to perform as directors? It is not possible to say for sure, but there is an indication that CEOs who are less scrutinized by investors are "really paid like bureaucrats".⁸⁷ This study found no other statistically significant variable in determining the accounting performance of Canadian income trusts.

In terms of stock market performance, D&O insurance protection has no impact on the total yield of income trusts in 2005; this is illustrated in Table 3.2. The only variable that appears to have a significant impact is the volatility of the stock price. Similar to its impact in the accounting performance regressions, stock price volatility, which is used as a proxy for cash flow volatility, has a negative impact on stock market performance. No other variable seems to be able to explain the income trusts' total yield.

87. See Michael C. Jensen & Kevin J. Murphy, *CEO Incentives – It's Not How Much You Pay, but How*, HARV. BUS. REV., May-June 1990, at 138. But see Brian J. Hall & Jeffrey B. Liebman, *Are CEOs Really Paid Like Bureaucrats?*, 113 Q.J.ECON. 653, 654 (1998) (arguing that CEOs are "not paid like Bureaucrats").

**Table 3.2 The determinants of the performance of Canadian income trusts in 2005:
Total stock market yield (cash plus capital gain return)**

Dependent variable: $R_t = \frac{C_t + P_t}{P_{t-1}}$					
Independent Variable	Model 1	Model 2	Model 3	Model 4	Model 5
Insured		0.014 (0.092)	0.023 (0.093)	0.025 (0.093)	0.026 (0.094)
Log (Limit)	-0.001 (0.003)	-0.001 (0.006)	-0.003 (0.006)	-0.003 (0.006)	-0.003 (0.006)
Firm Size	0.003 (0.022)	0.004 (0.022)	-0.008 (0.023)	-0.006 (0.023)	0.016 (0.117)
Stock Price Volatility	-0.935** (0.231)	-0.936** (0.232)	-0.939** (0.234)	-0.958** (0.255)	-0.946** (0.254)
Director Pay			-0.001 (0.006)	-0.003 (0.006)	-0.003 (0.006)
Trustee Pay			0.004 (0.005)	0.004 (0.006)	0.004 (0.006)
Independence of Trustee				0.003 (0.163)	0.042 (0.164)
Independence of Directors				0.112 (0.141)	0.152 (0.142)
Insider Power					0.002 (0.001)
Contract Entrenchment					0.017 (0.054)
R ²	0.176	0.170	0.162	0.155	0.163

The dependent variable is the firm's one-year total stock market yield; OLS regression with sector (business, energy, utility and real estate income trusts) fixed effects and 144 observations. The ** (*) represents a coefficient that is significant at the 1% (5%) level. Standard errors are in parentheses.

An interesting conclusion to draw from this section is that, although D&O insurance coverage has a negative impact on the growth of the income trusts' cash flows, this impact does not appear to translate to a lower stock market return. There are two possible explanations for this. The first one is that there is too much noise in the stock market value. This explanation could be valid if the results were different when using the dividend yield rather than the total yields, but in this case they are not significant.⁸⁸ Even if the impact of D&O insurance coverage had a significant negative impact on the dividend yield, one would be hard pressed to imagine a reason why the impact on the capital gain yield would be positive. Why would investors attribute a positive growth option value to firms that have more D&O insurance coverage?

A second explanation is that using the total yield is too crude a measure to make any inference related to the impact of D&O insurance on firm performance. An alternative would be to use a simple capital asset pricing model (CAPM)⁸⁹ approach for 2004 to find the expected return for 2005, and then look at how much the actual return differed from the expected return. Another alternative would be to look at the total yield Sharpe ratio.⁹⁰ But, it is doubtful that any of these alternatives would change the results significantly.

II. DISCUSSION AND CONCLUSION

The goal of this paper was to: further our understanding of the motivations for a corporation to purchase directors' and officers' liability insurance; explore how investors could use the information; and whether D&O insurance coverage has any impact on firm performance. D&O insurance purchase decisions, based on the dataset of Canadian publicly traded companies from the late 1990's, are largely driven by managerial

88. In this case, the results were not significant and were not included in the data tables.

89. CAPM, "holds that rational investors value stocks according only to their expected return and nondiversifiable risk." Lynn A. Stout, *How Efficient Markets Undervalue Stocks: CAPM and ECMH under Conditions of Uncertainty and Disagreement*, 19 CARDOZO L. REV. 475, 475 (1997).

90. In order to calculate the Sharpe ratio you take the return net of the risk free rate and divide it by the standard deviation of the return. William F. Sharpe, *The Sharpe Ratio*, J. PORTFOLIO MGMT, 49, 50 (Fall 1994). "The Sharpe ratio is designed to measure the expected return per unit for a *zero-investment strategy*. The difference between the returns on two investment assets represents the results of such a strategy." *Id.* at 57.

inertia; one year's decision is tributary to last year's decision.⁹¹ The information contained in the management proxy and information circular related to D&O insurance appears to have value for the market; a profitable trading strategy can be devised by purchasing the common stock of large Canadian corporations that face a low unit price of insurance⁹² and shorting the common stock of large Canadian corporations that face a high unit price. This strategy, over the arguably very short time period under study, yields a profit of 10% on average per year. D&O insurance coverage has a negative impact on the accounting performance of a piece of financial Canadian, Income trust, but that the market return does not seem to be affected. This suggests that managers are faced with moral hazard problems because D&O insurance coverage reduces their ability to increase cash flows in the firm. The fact that market returns do not seem to follow the same pattern is problematic and is left open for further research.

What can be taken away from 'these three insights? The most important conclusion is that studying D&O insurance should be of the utmost importance for anyone interested in corporate governance. There are three reasons for this. First, D&O insurance remains a largely unexplored territory of academic research, not to mention professional research; few papers have been devoted to this aspect of corporate governance.⁹³ Some

91. See *supra* Part I.A.

92. That is to say they have a low premium-to-coverage ratio.

93. While there have been few articles written on D&O insurance, in the past seven years there have been articles written on D&O insurance's role in corporate governance monitoring, as a measure of ex ante litigation risk, and the insurer's role as written reporting results of empirical research on the monitoring role of directors' and officers' liability insurance, and how liability insurer intermediary to s transmit and transform the content of corporate and securities law., as well as articles on how D & O premiums can be used as a measure of ex ante litigation risk, and the connection between corporate governance and D&O insurance. See, e.g., Tom Baker & Sean J. Griffith, *The Missing Monitor in Corporate Governance: The Directors' and Officers' Liability Insurer*, 95 GEO. L.J. 1795 (2007) (discussing how corporate managers buy D&O coverage for self-serving reasons, and that because the coverage itself, "does not control moral hazard, it "reduces the extent to which shareholder litigation aligns managers' and shareholders' incentives."); Tom Baker & Sean J. Griffith, *Predicting Corporate Governance Risk: Evidence from the Directors' and Officers' Liability Insurance Market*, 74 U. CHI. L. REV. 487 (2007) (reporting the empirical study results of an empirical study ofon the underwriting process of D&O insurance which found that insurers seek to price D&O policies according to the risk posed by each prospective insured and in assessing risk, underwriters focus on corporate governance); John E. Core, *The Directors' and Officers' Insurance Prelim: An outside Assessment of the quality of Corporate Governance*, 16 J.L. ECON. & ORG. 449 (2000) (reporting and discussing confirmatory evidence that D&O premiums reflect the quality of the firm's corporate governance); Sean J. Griffith, *Uncovering a Gatekeeper: Why the SEC Should*

governance questions are still left unanswered: Is D&O insurance part of the compensation package? Is it a tool to align the manager's incentives with those of the shareholders? Is it truly designed to protect corporate directors or other stakeholders like the shareholders and the debtholders? Second, there is evidence that D&O insurance conveys information to the market about the future performance of the companies, whether the stock market performance or the accounting performance.⁹⁴ The reason D&O insurance conveys information is that insurers, contrary to most firm stakeholders, have a lot to lose by insuring a company at the wrong price.⁹⁵ As a result we should expect insurers to invest resources in auditing the corporate governance behaviour of the companies that seek protection through a D&O insurance policy. This auditing is even more informative because of the claims made and reported nature of D&O insurance; it reflects as much past behaviour as current risk of litigation.

The most important conclusion is that shareholders should value D&O insurance information. As a result, the information should be made public in the United States."⁹⁶ A company's D&O insurance premium could thus signal important information concerning the firm's governance quality to investors and other capital market participants."⁹⁷ This is supported by hypothesis 2. D&O insurance information is a better signal than the CEO's age, and could be construed as part of the compensation package of the directors and officers of the corporation. Given that so much is revealed regarding the compensation of top executives and the structure of the board, it appears to me paradoxical that information as easy to present as D&O insurance policy limit, deductible and premium, and so informative as to the governance health of a firm does not find its way to the annual reports.

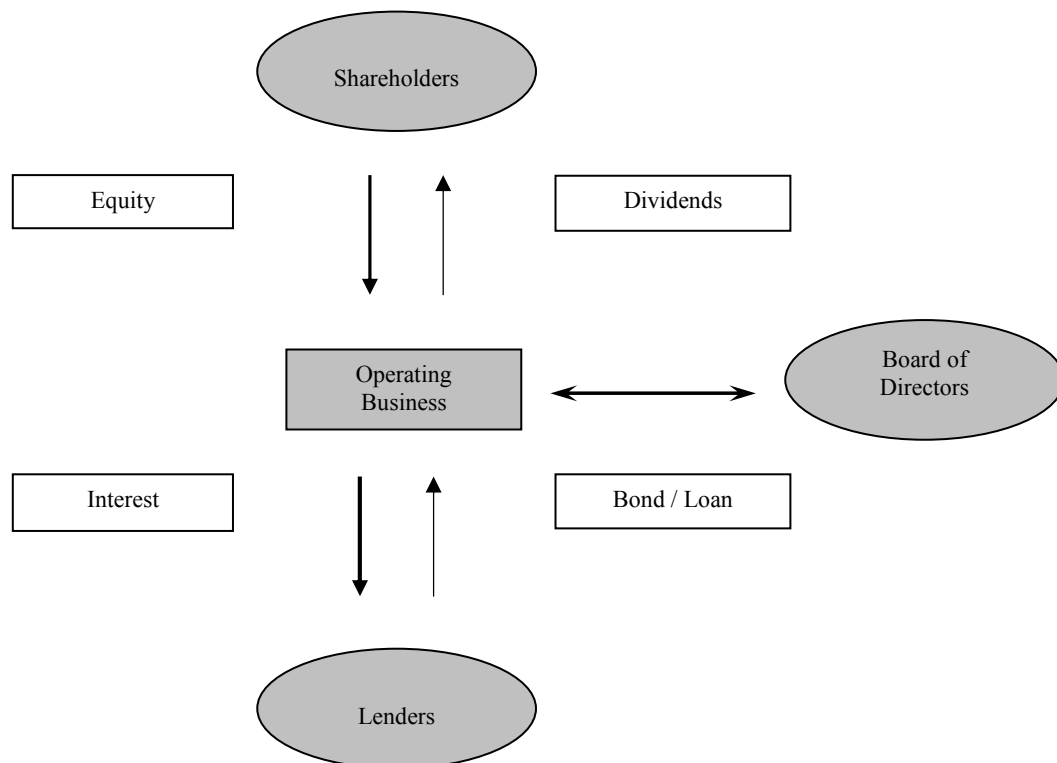
Mandate Disclosure of Details Concerning Directors' and Officers' Liability Insurance Policies, 154 U. PA. L. REV. 1147 (2006) (advocating for a change in U.S. securities regulation to make mandatory disclosure of D&O policy details).

94. See Chalmers et al., *supra* note 8, at 625, 629 (discussing relationship between D&O insurance premiums and future stock value).

95. Ronald E. Mallen & David W. Evans, *Surviving the Directors' and Officers' Liability Crisis: Insurance and the Alternatives*, 12 DEL. J. CORP. L. 439, 442-43 (1987).

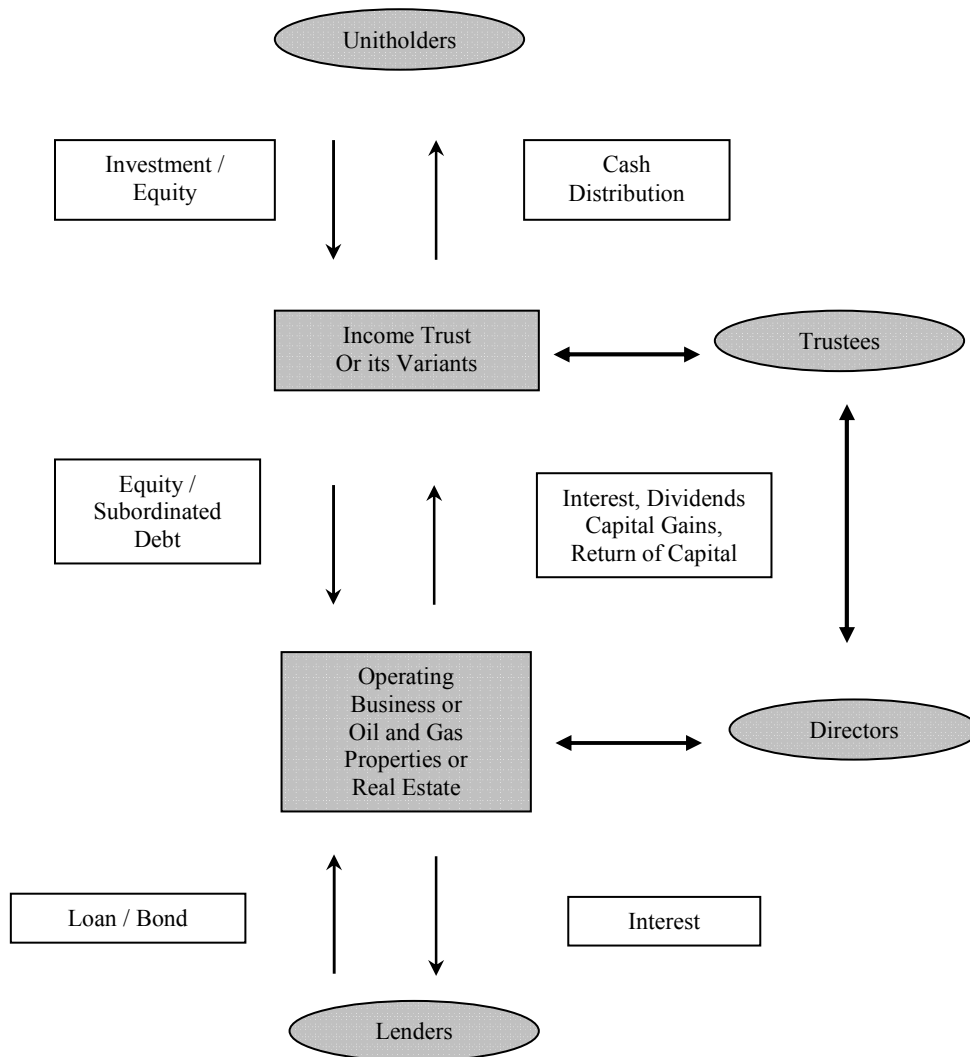
96. See Griffith, *supra* note 43, at 1203-07 (discussing importance of D&O insurance disclosure to investors).

97. *Id.* at 1208.

Appendix: Corporate structures**Figure 1:** Stock company corporate structure

Source: Demystifying Income Trusts – CGA Canada – March, 2006

Figure 2: Income trust corporate structure



Source: Demystifying Income Trusts – CGA Canada – March, 2006

FREEDOM OF CONTRACT IN INSURANCE

Susan Randall

I. INTRODUCTION

Insurance case law is increasingly marked by judicial reliance on the principle of freedom of contract. In recent years, courts have been inclined to enforce insurance policies as written, with the goal of effectuating the intentions of the parties and the result that the insurance company typically prevails. This reflexive invocation of contract principles is not appropriate in insurance disputes, for at least two reasons.

The first is familiar, centering on the adhesive nature of insurance relationships. Insurance policies, like many consumer contracts, are standardized forms, offered on a take-it-or-leave-it basis. Policyholders have no opportunity to negotiate terms, conditions, or price and typically do not even see the policy until after they have completed the purchase. Insurance policies are complex and technical documents that very few policyholders can read or understand. These ideas have been thoroughly explored in the scholarly literature.¹

The second reason to question the increasing judicial adherence to standard contract doctrine is well-known but its relevance in this context has not been explored. Insurance is a highly regulated industry. The laws of every state require regulatory review and approval of insurance policies prior to their use, and all states have some form of rate regulation. States also regulate the format and appearance of insurance policies; impose “readability” standards; prescribe and proscribe numerous policy provisions; and in some contexts require an individual’s purchase of insurance or a company’s provision of it.

This statutory and regulatory control of insurance relationships should displace judicial reliance on contract principles. Just as an insurance consumer’s freedom is limited to the initial choice to purchase insurance (or to engage in an activity for which insurance is required), an insurance

1. See generally Friedrich Kessler, *Contracts of Adhesion—Some Thoughts about Freedom of Contract*, 43 COLUM. L. REV. 629 (1943); Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 HARV. L. REV. 1173 (1983). For a specific discussion of the concept in the context of insurance, see James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context*, 24 ARIZ. ST. L.J. 995 (1992).

company's freedom is limited and constrained in varying degrees, depending on the level of statutory and regulatory control exercised in each of the jurisdictions regulating it. The extensive regulation of insurance policy provisions and pricing, in combination with the adhesive nature of insurance relationships, demonstrates that freedom of contract as a public policy consideration is largely irrelevant in the interpretation of standard insurance policies. No "intent of the parties" undergirds the substantive terms and provisions of the policy. There is no "bargain" to be protected; instead, there is an agreement on terms over which the consumer has no control and the insurance company has incomplete control. To determine the meaning of insurance policies, courts should rely on interpretive constructs that emphasize regulatory goals and strategies: solvency of insurance companies, fairness to consumers, and availability of insurance. These goals, rather than freedom of contract and protection of the parties' intentions, constitute the important public policies at issue in interpretation and construction.

Acknowledging the centrality of regulation and the accordingly diminished relevance of contract doctrine in insurance policy interpretation will make no difference in the outcome of many disputes. Like freedom of contract, the legislative and administrative role in mandating or approving policy language suggests that the language of policies should be enforced. However, different starting points will often yield different results. Where the analytical frame is contract, the judicial focus must be the parties' intentions. The writing documents the parties' intentions, and so the policy comprises the "law of the bargain" and the analytical starting point. In some views, it is also the end of the analysis.² When judges operate in the paradigm of contract, the fictional will of the parties—as expressed in the policy language—prevails.

In contrast, where policies are viewed not as a bargain between parties, but as standard documents governed by statute and requiring regulatory approval, the analysis changes. Considerations external to the policy become relevant, including the statutory framework and the intent of the legislature; the power of the regulator and the nature and aims of the approval process, as well as the role of the judiciary in reviewing administrative actions; and broad public policy concerns, as defined by

2. Some courts refuse to consider evidence beyond the policy where the language is plain, following Professor Williston's approach in the first Restatement of Contracts; others take a broader view, following Professor Corbin and the second Restatement, recognizing that the meaning of words depends on context and permitting resort to extrinsic evidence to assist in ascertaining intention.

statute, regulation, and decisional law. Understanding that insurance policies are highly regulated documents rather than freely-negotiated contracts permits judicial interpretation that recognizes the important public policies which justify insurance regulation. Under this analytical paradigm, courts can protect insurance consumers' substantive rights regarding insurance coverage, rather than an illusory freedom of contract.

II. JUDICIAL APPROACHES TO INSURANCE POLICIES

In the 1970s, contract law scholars chronicled a decline in freedom of contract over the preceding century, notably in Grant Gilmore's *The Death of Contract*³ and P.S. Atiyah's *The Rise and Fall of Freedom of Contract*.⁴ Scholars identified various factors accounting for the decline, including the rise of standard form contracts, the growth of consumer protection law, and the development of the concepts of adhesion and unconscionability. The resurgence of free market principles in 1980s, spurred by the transformation of Eastern Europe and the former Soviet Union and the increasing prevalence of scholarship in law and economics, has caused another shift in the law, with a judicial return to standard contract principles.⁵

Insurance law parallels these larger trends. The dominant approach to policy interpretation and construction following the decline of contract was founded on the view that insurance policies are adhesion contracts and that insurance consumers consequently require judicial protection. In contract law generally, courts revised rules for adhesion contracts to account for the consumer's inability to negotiate terms and the corresponding risks of consumer exploitation. Given the distinctive characteristics of insurance agreements, where policyholders pay premiums in exchange for a promise to indemnify in the event of specified but uncertain future events, courts created specialized modifications of those revised rules for application to insurance policies. The most notable manifestations of this approach have been a strong version of *contra proferentem*, under which an ambiguity automatically yields a decision for the policyholder;⁶ protection of policyholders' reasonable expectations of coverage even in the face of

3. GRANT GILMORE, *THE DEATH OF CONTRACT* (Ronald Collins ed., 1995).

4. P.S. ATIYAH, *THE RISE AND FALL OF FREEDOM OF CONTRACT* (1979).

5. *See, e.g.*, *The Fall and Rise of Freedom of Contract*, (F.H. Buckley, ed., 1999); P.S. ATIYAH, *AN INTRODUCTION TO THE LAW OF CONTRACT* (5th ed. 1995).

6. *See* discussion *infra* at text accompanying notes 35-46.

explicit policy language to the contrary;⁷ and recognition of breach of an insurance policy as the tort of bad faith in order to provide a disincentive to wrongful denial of claims or coercive settlements.⁸

The competing approach is standard contract doctrine, which has regained ground in recent years. Courts are increasingly willing to treat insurance policies as ordinary contracts,⁹ subject to ordinary principles of

7. The doctrine was first described in Robert Keeton's seminal article, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 967 (1970) ("The objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations."). For subsequent discussions of the doctrine, see *Symposium, The Insurance Law Doctrine of Reasonable Expectations after Three Decades*, 5 CONN. INS. L. J. 1 (1998), and Roger C. Henderson, *The Doctrine of Reasonable Expectations in Insurance Law After Two Decades*, 51 OHIO ST. L. J. 823 (1990).

8. See 14 COUCH ON INS. §204:11 (3d ed. 2006) (Absent the bad faith action, a policyholder's only recourse was through contract, with damages limited to amounts due under the policy plus interest. Bad faith permits recovery beyond contract damages, including damages for emotional or economic harm as well as punitive damages).

9. In the last year, numerous courts have articulated the view that insurance policies are ordinary contracts, subject to ordinary principles of contract interpretation. See, e.g., *Kessler v. Shimp*, 2007 WL 506026 (N.C. App. 2007) (insurance policies must be construed as written in order to preserve fundamental right of freedom of contract); *Axis Reinsurance Co. V. Melancon*, 2007 WL 60968 (E.D. La. 2007) (principle of freedom of contract governs risks an insurance company may exclude); *Federated Mut. Ins. Co., Inc. v. Vaughn*, 2007 WL 20066 (Ala. 2007); *ABT Bldg. Prod. Corp. V. Nat'l Union Fire Ins. Co. Of Pittsburgh*, 472 F.3d 99 (4th Cir. 2006); *United Services Auto Ass'n v. Riley*, 2006 WL 1490160 (Md. 2006) ("Insurance contracts are treated as any other contract."); *Moscarillo v. Professional Risk Management*, 2006 WL 1501050 (Md.App. 2006)(insurance policy construed according to contract principles to determine parties' intentions); *Vestin Mortg., Inc. v. First American Title Ins. Co.*, 2006 WL 1513232 (Utah 2006) ("An insurance policy is merely a contract between the insured and the insurer and is construed pursuant to the same rules applied to ordinary contracts."); *Sims v. Allstate Ins. Co.* 2006 WL 1495110 (Ill. App. 2006) (court's primary objective in construing insurance policy is to give effect to the parties' intentions); *McElmeel v. Safeco Ins. Co. of America*, 2006 WL 1228911 (Ill. App. 2006) ("An insurance policy is a contract and the general rules of contract interpretation apply.") *Rory v. Continental Ins. Co.*, 703 N.W.2d 23, 27 (insurance policies are subject to same principles applicable to any other species of contract; unambiguous provisions enforced to uphold individual freedom to contract); *Klemmetsen v. American Family Mut. Ins. Co.*, 2006 WL 1409549 (D. Colo. 2006) (insurance policy interpreted according to ordinary contract principles, with primary goal to effectuate intent of the parties); *Bonin v. Westport Ins. Corp.*, 2006 WL 1343439 (La. 2006) (insurance policy should be construed using the general rules of interpretation of contracts in Civil Code; noting judicial responsibility to determine parties' intent); see *City Fuel Corp. V. National Fire Ins. Co.*, 846 N.E.2d 775 (Mass. 2006) (applying Maryland law and noting that Maryland does not follow the rule that insurance policies are to be construed most strongly against the

contract law, including protecting freedom of contract and effectuating the parties' intentions. According to one recent opinion, "the judiciary is without authority to modify unambiguous contracts or rebalance the contractual equities struck by the contracting parties because fundamental principles of contract law preclude such subjective post hoc judicial determinations of "reasonableness" as a basis upon which courts may refuse to enforce unambiguous contractual provisions."¹⁰ Accordingly, judges have begun to reject the reasonable expectations doctrine and to revise contra proferentem so that there is no longer a distinctive insurance version of the doctrine. The trend towards limitation of bad faith actions is another manifestation of the judicial turn away from specialized rules for insurance policies. The next subsections demonstrate how each of these specialized insurance principles have given way to standard contract doctrine.

A. REASONABLE EXPECTATIONS

The doctrine of reasonable expectations has given way to firm judicial pronouncements about enforcing unambiguous policies as written. Numerous commentators have acknowledged this trend.¹¹ In 1990, twenty

insurer.... instead, Maryland takes the view that insurance policies are to be construed like other contracts in order to determine the parties' intentions." but if ambiguity remains after review of extrinsic evidence, ordinarily resolution against drafter—like Mich. case next paragraph); Chang v. Brethern Mut. Ins. Co. 2006 WL 1130872 (Md. App. 2006); Carter v. Property Owners Ins. Co., 846 N.E.2d 712 (Ind. App. 2006) (insurance contracts subject to same rules of interpretation as other contracts). See also Tech-Built 153, Inc. v. Virginia Sur. Co., Inc., 2006 WL 1042077 (N.H. 2006) ("where the intent of the contracting parties can be conclusively resolved by objective extrinsic evidence..we will not ignore that evidence in favor of dogmatic adherence to insurance maxims.").

10. Rory v. Continental Ins. Co., 703 N.W.2d 23, 26 (Mich. 2005).

11. See, e.g., James M. Fischer, *The Doctrine of Reasonable Expectations Is Indispensable, If We Only Knew What For?*, 5 CONN. INS. L. J. 151 (1998) (noting that most courts use the doctrine only when the policy is ambiguous); Roger C. Henderson, *The Formulation of the Doctrine of Reasonable Expectations*, 5 CONN. INS. L. J. 69 (1998); Robert H. Jerry, II, *Insurance, Contract, and the Doctrine of Reasonable Expectations*, 5 CONN. INS. L. J. 21 (1998) (discussing the relationship between the doctrine of reasonable expectations and contract law); Susan M. Popik and Carol D. Quackenbos, *Reasonable Expectations after Thirty Years: A Failed Doctrine*, 5 CONN. INS. L. J. 425 (1998) (concluding that problems inherent in the doctrine itself account for its failure to develop into a coherent, principled body of law); Mark C. Rahdert, *Reasonable Expectations Revisited*, 5 CONN. INS. L. J. 107 (1998) (noting growing opposition to more aggressive versions of reasonable expectations); Jeffrey Stempel, *Unmet Expectations: Undue Restriction of the Reasonable Expectations Approach and the Misleading Mythology of*

years after its initial explication by Judge Keeton, ten jurisdictions had adopted the doctrine of reasonable expectations.¹² Today only two jurisdictions—Alaska and Hawai’i—accept the doctrine as it was originally formulated, by permitting policyholders’ expectations to trump clear policy language.¹³ Many courts discuss and apply a doctrine which they characterize as “the doctrine of reasonable expectations”; in reality, almost all of these courts are conflating the construction of ambiguities against the insurer with the doctrine of reasonable expectations. For example, the West Virginia Supreme Court recently articulated Judge Keeton’s classic formulation of the doctrine thus, “The doctrine of reasonable expectations provides that the objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of policy provisions would have negated those expectations”¹⁴ but then immediately limited the doctrine to cases of ambiguity:

‘[i]n West Virginia, the doctrine of reasonable expectations is limited to those instances . . . in which the policy language is ambiguous.’ This Court has explained that ‘[t]he doctrine of reasonable expectations is essentially a

Judicial Role, 5 CONN. INS. L. J. 181 (1998) (arguing that the doctrine is underutilized due to the focus on its pure version as opposed to use as a corollary to the ambiguity doctrine); See also Jeffrey E. Thomas, *An Interdisciplinary Critique of the Reasonable Expectations Doctrine*, 5 CONN. INS. L. J. 295 (1998) (noting that research in consumer psychology demonstrates that consumers do not develop expectations about coverage, undercutting the theoretical justification for the doctrine).

12. Roger C. Henderson, *The Doctrine of Reasonable Expectations in Insurance Law After Two Decades*, 51 OHIO ST. L.J. 823, 824 (1990). Jeffrey Stempel, writing in 1998, found “approximately a half-dozen” jurisdictions adopting the “pure” version of the Keeton doctrine. Jeffrey W. Stempel, *Unmet Expectations: Undue Restriction of the Reasonable Expectations Approach and the Misleading Mythology of Judicial Role*, 5 CONN. INS. L. J. 181 (1998). Other commentators have come up with a very different count—38 jurisdictions—but that number includes jurisdictions which use the policyholder’s reasonable expectations to assist in resolving policy ambiguity rather than the original formulation of the doctrine. BARRY R. OSTRAGER & THOMAS R. NEWMAN, *HANDBOOK ON INSURANCE COVERAGE* §103(b) at 21 (9th ed. 1998).

13. See *Nelson v. Progressive Cas. Ins. Co.*, 162 P.3d 1228,1235 (Alaska 2007); *Allstate Ins. Co. v. Herron*, 393 F.Supp.2d 948, 951 (D. Alaska 2005); *Keneke Roofing Inc. v. Island Ins. Co.* 98 P.3d 246(Haw. 2004).

14. See, e.g., *Jenkins v. State Farm Mut. Auto. Ins. Co.*, 632 S.E.2d 346, 352 (W.Va. 2006).

rule of construction, and unambiguous contracts do not require construction by the courts.¹⁵

Similarly, two early adherents of the classic doctrine of reasonable expectations, Iowa and Arizona, have retained it in name, but substituted a very different rule. Both jurisdictions base their version of the doctrine on §211 of the Restatement (Second) of Contracts, Standardized Agreements, which provides in pertinent part:

(3) Where the other party has reason to believe that the party manifesting such assent would not do so if he knew that the writing contained a particular term, that term is not part of the agreement.¹⁶

The focus of the classic insurance doctrine is the policyholder's expectations; the focus of the Restatement is the insurer as drafter of the standardized agreement and the insurer's understanding of the policyholder's assent.¹⁷ Comment (f), as applied to insurance, states that the insurer's reason to believe that the policyholder would not assent "may be inferred from the fact that the term is bizarre or oppressive, . . . eviscerates the non-standard terms explicitly agreed to, . . . or eliminates the dominant purpose of the transaction."¹⁸ The doctrine of reasonable expectations in Iowa and Arizona clearly owes much to the Restatement formulation, specifically drawing from Comment (f). In Iowa, the doctrine may be invoked only where an exclusion (1) is bizarre or oppressive, (2) eviscerates terms explicitly agreed to, or (3) eliminates the dominant purpose of the transaction. . . Moreover, as a precondition to reliance on this doctrine, an insured must establish that an ordinary layperson would misunderstand the policy coverage or that there are circumstances attributable to the insurer that led the insured to expect coverage.¹⁹

15. *Id.* See also *Lawson v. American Gen'l Assur. Co.*, 455 F.Supp.2d 526 (S.D. W. Va. 2006) (doctrine of reasonable expectations applied where policy ambiguous or insurer fails to communicate exclusion to insured or there is a misconception about the insurance purchased).

16. RESTATEMENT (SECOND) OF CONTRACTS §211(3).

17. *But see* *Wallace v. Balint*, 761 N.E.2d 598, 606 (Ohio 2002) (equating the two formulations).

18. RESTATEMENT (SECOND) OF CONTRACTS §211(3), cmt.(f).

19. See *Bituminous Cas. Corp. v. Sand Livestock Sys.*, 728 N.W.2d 216, 220-21 (Iowa 2007); *Iowa Comprehensive Petroleum Underground Storage Tank Fund Bd. v. Federated Mut. Ins. Co.*, 596 N.W.2d 546, 551 (Iowa 1999).

Arizona cases utilize similar language.²⁰ Under this formulation, other contract doctrines—ambiguity, unconscionability, fraud, and estoppel—do the work. The doctrine of reasonable expectations as formulated by Judge Keeton plays no role.

Minnesota utilizes a similar approach, with its courts holding that “[t]he doctrine is generally applied when an insurance policy has been misrepresented or misunderstood, or when a legal technicality would defeat the insured’s objectively reasonable expectations.”²¹ Courts in New Hampshire use the term “reasonable expectations” in cases involving estoppel based on an agent’s representations which are contrary to the policy language,²² while Indiana courts enforce unambiguous clauses in accord with the insured’s reasonable expectations where policies provide “only illusory coverage.”²³ Each of these formulations impose significant restrictions which rob the doctrine of reasonable expectations of its essential character.²⁴

Another measure of the doctrine’s waning importance is its explicit rejection by the great majority of jurisdictions. In these jurisdictions, there is no doctrine of reasonable expectations; the policyholder’s reasonable expectations function only to limit the reach of the principle of resolving ambiguities against the insurer. Twenty-seven jurisdictions fall into this category.²⁵ Some of these jurisdictions continue to refer to the “reasonable

20. *See, e.g.* Morgan v. Am. Family Mut. Ins. Co., No. CV 06-1136-PHX-JAT, slip op. at 2(D. Ariz. 2007). The Arizona Supreme Court specifically adopted the rationale of Comment (f) in Darnier Motor Sales, Inc. v. Universal Underwriters, 682 P.2d 388, 405 (Ariz. 1984).

21. Carlson v. Allstate Ins. Co., 734 N.W.2d 695, 700 (Minn. Ct. App. 2007).

22. *See, e.g.*, Trefethen v. N.H. Ins. Group, 645 A.2d 72, 75 (N.H. 1994)

23. McGuire v. Century Sur. Co., 861 N.E.2d 357, 363 (Ind. Ct. App. 2007).

24. *See, e.g.*, Bituminous Cas. Corp. V. Sand Livestock Sys., 728 N.W.2d 216, 220-21(Iowa 2007); Am. Family Mut. Ins. Co. v. Corrigan, 697 N.W.2d 108, 118 (Iowa 2005); Amco Ins. Co. v. Estate of Wehde, No. 05-0503, 2006 WL 650234, at *5 (Iowa Ct. App. 2006). Arizona imposes similar limitations. *See, e.g.*, Gordiner v. Aetna Cas. & Sur. Co., 742 P.2d 277, 283-84 (Ariz. 1987) (policyholder’s reasonable expectations overcome policy language only where policy is ambiguous; policyholder has inadequate notice of unusual or unexpected terms; or insurer creates an objective or subjective impression of coverage); State Farm Fire & Cas. Ins. Co. v. Grabowski, 150 P.3d 275, 281 (Ariz. Ct. App. 2007).

25. *See* Merino v. Allstate Indem. Co., 231 Fed.Appx. 682, 683 (9th Cir. 2007) (“Under California law, the reasonable expectations doctrine applies only if the policy is ambiguous or if a term is a limitation on coverage not brought to the insured’s attention.”); Terra Nova Ins., Ltd. v. Fort Bridger Historical Rendezvous Site Corp., 151 Fed.Appx. 678, 681 (10th Cir. 2005) (indicating that Wyoming courts would apply doctrine of reasonable expectations to ambiguous policy); Kolb v. Paul Revere Life Ins. Co., 355 F.3d 1132, 1136 (8th Cir. 2004) (applying Arkansas law); Avemo Ins. Co. v. Auburn Flying Serv., Inc., 242

F.3d 819, 822 (8th Cir. 2001) (“Under Nebraska law, we would only consider reasonable expectations if the contract language was first found to be ambiguous.”); *Nationwide Mut. Ins. Co. v. Richardson*, 270 F.3d 948, 954 (D.C. Cir. 2001) (“District of Columbia law forbids application of the reasonable expectations doctrine to alter an otherwise clear policy provision.”); *Park-Ohio Indus., Inc. v. Home Indem. Co.*, 975 F.2d 1215, 1223 (6th Cir. 1992) (Ohio has rejected the reasonable expectation doctrine); *Nelson v. Becton*, 929 F.2d 1287, 1291 (8th Cir. 1991) (Eighth Circuit expressly refused to incorporate doctrine of reasonable expectations as part of federal common law); *Cont’l Cas. Co. v. Gamble*, No. 05-5189, 2007 WL 1657107, at *4 (D. N.J. June 5, 2007); *Dougherty v. Farmers New Century Ins. Co.*, No. 3:CV 06-98, 2007 WL 1074756, at *4 (M.D. Pa. Apr. 9, 2007) (reasonable expectations doctrine does not apply unless policy ambiguous; insurer makes unilateral change to policy without notifying insured; or insured requests one type of coverage and receives another); *S. Land and Golf Co. Ltd. v. Harleysville Mut. Ins. Co.*, No. 2:03-2189-DCN, 2006 WL 2443340, at *3 (D. S.C. Aug. 22, 2006); *Peck v. Pub. Serv. Mut. Ins. Co.*, 363 F.Supp.2d 137, 145 (D. Conn. 2005); *Miller v. Monumental Life Ins. Co.*, 376 F.Supp.2d 1238, 1245 (D. N.M. 2005); *Sigmund v. Progressive N. Ins. Co.*, 374 F.Supp.2d 33, 36 (D. D.C. 2005); *40 Gardenville, L.L.C. v. Travelers*, 387 F.Supp.2d 205, 212 (W.D. N.Y. 2005); *Giddens v. Equitable Life Assurance Soc’y of the U.S.*, 356 F.Supp.2d 1313, 1325 (N.D. Ga. 2004) (reasonable expectations doctrine cannot be used to avoid otherwise unambiguous limitation in policy), *aff’d in part, rev’d in part*, *Giddens v. Equitable Life Assurance Soc’y of the U.S.*, 445 F.3d 1286, 1301 (11th Cir. 2006); *Federated Mut. Ins. Co. v. Abston Petroleum, Inc.*, No. 1051589, 2007 WL 1098564, at *9 (Ala. Apr. 13, 2007); *Safeway Ins. Co. of Ala., Inc. v. Herrera*, 912 So.2d 1140, 1145 (Ala. 2005) (“[T]his Court limited the doctrine of ‘reasonable expectations’ to ambiguous provisions of an insurance policy.”); *TIG Ins. Co. of Mich. v. Homestore, Inc.*, 137 Cal. App. 4th 749, 755-56 (2006) (“Where the policy is clear and unequivocal, the only thing the insured may ‘reasonably expect’ is the coverage afforded by the plain language of the mutually agreed-upon terms.”); *Hodgson v. Banner Life Ins. Co.*, 124 Cal. App. 4th 1358, 1361 n.2 (2004) (“It has never been the rule that a court could ignore the clear and explicit terms of insurance policy under the guise of protecting the reasonable expectations of the insured.”); *Hallowell v. State Farm Mut. Auto. Ins. Co.*, 443 A.2d 925, 928 (Del. 1982) (“[W]e hold that the doctrine of reasonable expectations is applicable in Delaware to a policy of insurance only if the terms thereof are ambiguous or conflicting, or if the policy contains a hidden trap or pitfall, or if the fine print purports to take away what is written in large print.”); *Deni Assoc. of Fla., Inc. v. State Farm Fire & Cas. Ins. Co.*, 711 So.2d 1135, 1140 (Fla. 1998) (“We decline to adopt the doctrine of reasonable expectations. . . . To apply the doctrine to an unambiguous provision would be to rewrite the contract and the basis upon which the premiums are charged.”); *Sapp v. State Farm Fire & Cas. Co.*, 486 S.E.2d 71, 74 (Ga. App. 1997); *Ryals v. State Farm Mut. Auto. Ins. Co.*, 1 P.3d 803, 805 (Idaho 2000) (“We decline the invitation [to adopt the doctrine of reasonable expectations]. We have previously rejected the reasonable expectations doctrine in favor of traditional rules of contract construction.”); *El Rincon Supportive Servs. Org., Inc. v. First Nonprofit Mut. Ins. Co.*, 803 N.E.2d 532, 540 (Ill. App. Ct. 2004) (“The ‘reasonable expectations’ doctrine is not recognized in Illinois.”); *Conseco, Inc. v. Nat’l Union Fire Ins. Co. of Pittsburgh*, No. 49D130202CP000348, 2002 WL 31961447, at *13 (Ind. Cir. Dec. 31, 2002) (reasonable expectations doctrine has no application unless policy ambiguous or illusory); *Rhynerson v. Hardy*, No. 95282, 2006 WL 1976781, at *6 (Kan. App. July 14, 2006) (“In Kansas, the doctrine of reasonable expectations only applies when a contract is ambiguous.”); *A.W. Chesterton Co. v. Mass.*

Insurers Insolvency Fund, 838 N.E.2d 1237, 1250 (Mass. 2005); *Wilkie v. Auto-Owners Ins. Co.*, 664 N.W.2d 776, 782 (Mich. 2003) (“[T]he rule of reasonable expectations . . . is invalid as an approach to contract interpretation.”); *Harvey v. Allstate Ins. Co.*, No. 258695, 2006 WL 707789, at *2 (Mich. App. Mar. 21, 2006) (“[T]he rule of reasonable expectations has no application in Michigan, and those cases that recognized this doctrine’ have been overruled.”); *Reinsurance Ass’n of Minn. v. Johannessen*, 516 N.W.2d 562, 566 (Minn. Ct. App. 1994) (“The doctrine should not be applied where a prominent policy term excludes coverage and the evidence does not indicated the insured was misled.”); *Farmers Ins. Exch. v. Young*, 832 P.2d 376, 379 n.3 (Nev. 1992) (discussing other jurisdictions’ use of reasonable expectations doctrine and stating “We have not gone that far”; using expectations of parties only where the policy is ambiguous); *N.H. Banfield v. Allstate Ins. Co.*, 880 A.2d 373, 379 (N.H. 2005); *Morrison v. Am. Int’l Ins. Co. of Am.*, 887 A.2d 166, 169 (N.J. Super. Ct. App. Div. 2005); *Argent v. Brady*, 901 A.2d 419, 424 (N.J. Super. Ct. App. Div. 2006) (“Only where the language is ambiguous does the doctrine of reasonable expectations come into play, permitting a construction that favors such expectations of an insured.”); *Rehders v. Allstate Ins. Co.*, 135 P.3d 237, 246 (N.M. App. 2006) (“The doctrine of reasonable expectations may be invoked when the language of an insurance policy or representations of the insurance company lead an insured to reasonably expect coverage. . . . The doctrine is also available where policy language is ambiguous.”); *Nationwide Mut. Ins. Co. v. Lagodinski*, 683 N.W.2d 903, 911-12 (N.D. 2004) (“This Court has expressly declined to adopt the doctrine of reasonable expectations.”); *Sterling Merch. Co. v. Hartford Ins. Co.*, 506 N.E.2d 1192, 1197 (Ohio App. 1986) (“[T]he reasonable expectation doctrine requires a court to rewrite an insurance contract which does not meet popular expectations. Such rewriting is done regardless of the bargain entered into by the parties to the contract. Such judicial activism has not been adopted in Ohio by its courts.”); *Max True Plastering Co. v. U.S. Fid. & Guar. Co.*, 912 P.2d 861, 870 (Okla. 1996) (“Oklahoma law mandates that we join the majority of jurisdictions which have considered application of the doctrine and apply it to cases in which policy language is ambiguous and to situations where, although clear, the policy contains exclusions masked by technical or obscure language or hidden exclusions.”); *BP Am., Inc. v. State Auto Prop. & Cas. Ins. Co.*, 148 P.3d 832, 839 (Okla. 2005); *Morgan v. State Farm Life Ins. Co.*, 400 P.2d 223, 225 (Or. 1965); *Donegal Mut. Ins. Co. v. Baumhammers*, 893 A.2d 797, 819 (Pa. Super. Ct. 2006) (insured may not complain that reasonable expectations frustrated where policy limitations are clear and unambiguous); *JEP Mgmt., Inc. v. Fed. Ins. Co.*, No. 4170, 2006 WL 2372961, at *3 (Pa. Super. Ct. Aug. 8, 2006) (“The reasonable expectations doctrine does not apply to unambiguous policy language. The Supreme court has identified only two applications for the doctrine of reasonable expectations: protecting non-commercial insured from policy terms which are not readily apparent; and protecting non-commercial insured from deception by insurance agents.”); *Ex Parte: United States Auto. Ass’n*, 614 S.E.2d 652, 654 (S.C. Ct. App. 2005) (“The doctrine of reasonable expectations, which is essentially that the objectively reasonable expectations of insured as to coverage will be honored even though a careful review of the terms of the policy would have shown otherwise, has been rejected in South Carolina.”); *Culhane v. W. Nat. Mut. Ins. Co.*, 704 N.W.2d 287, 292 (S.D. 2005) (“[T]his Court has repeatedly declined to adopt [the reasonable expectations] doctrine.” “The doctrine of reasonable expectations simply does not apply to policy language [where it is unambiguous].”); *Vandeventer v. All Am. Life & Cas. Co.*, 101 S.W.3d 703, 710 n.8 (Tex. App. 2003) (“Texas law does not recognize the ‘Doctrine of Reasonable Expectations’ of the insured as a basis to disregard unambiguous policy provisions.”); *Smith v. Rio Grand*

expectations doctrine”; but it is clear from the language and facts of the cases that it is not the doctrine explicated by Judge Keeton. Other jurisdictions, while not explicitly rejecting the doctrine, define it such that it is limited to situations where the policy is ambiguous.²⁶ A number of

Nat'l Life Ins. Co., 227 S.W.2d 579, 582 (Tex. App. 1950); *Allen v. Prudential Prop. & Cas. Ins. Co.*, 839 P.2d 798, 805 (Utah 1992) (court rejects doctrine of reasonable expectations; citing cases which “show our unwillingness to alter fundamentally the terms of insurance policies in the absence of legislative direction” and “consequent uneasiness of a majority of this court with the notion of a reasonable expectations doctrine.”); *Findlay v. United Pac. Ins. Co.*, 917 P.2d 116, 121 (Wash. 1996) (“The ‘reasonable expectation’ doctrine has never been adopted in Washington.”); *Rowland v. State Farm Mut. Auto. Ins. Co.*, 512 P.2d 1129, 1131 (Wash. Ct. App. 1973); *O'Donnell v. Blue Cross Blue Shield of Wyo.*, 76 P.3d 308, 315 (Wyo. 2003) (rules of construction such as doctrine of reasonable expectations inapplicable where contract terms are clear and unambiguous); *St. Paul Fire & Marine Ins. Co. v. Albany County Sch. Dist. No. 1*, 763 P.2d 1255, 1263 (Wyo. 1988) (doctrine of reasonable expectations does not apply where policy is unambiguous); *See, e.g., Walter H. Crosky, The Doctrine of Reasonable Expectations in California: A Judge's View*, 5 CONN. INS. L.J. 451, 457 (1998) (use of objectively reasonable expectations of insured to resolve ambiguities).

26. *See Hoang v. Assurance Co. of Am.*, 149 P.3d 798, 802 (Colo. 2007) (invoking the reasonable expectations doctrine but measuring the insured's expectations against those of a careful reader of the policy); *Brown v. Ind. Ins. Co.*, 184 S.W.3d 528, 540 (Ky. 2005) (“Th[e] principle [of reasonable expectations] pertains to alleged ambiguities within the policy. The gist of the doctrine is that the insured is entitled to all the coverage he may reasonably expect to be provided under the policy. Only an unequivocally conspicuous, plain and clear manifestation of the company's intention to exclude coverage will defeat that expectation.”); *In Re St. Louis Encephalitis Outbreak in Ouachita Parish*, 939 So.2d 563, 568 (La. Ct. App. 2006) (“Ambiguity will be resolved by ascertaining how a reasonable insurance policy purchaser would construe the clause at the time the insurance contract was entered. The court should construe the policy ‘to fulfill the reasonable expectations of the parties in the light of the customs and usages of the industry.’ In insurance parlance, this is labeled the reasonable expectations doctrine.”); *Wellcome v. Home Ins. Co.*, 849 P.2d 190, 194 (Mont. 1993) (“Expectations which are contrary to a clear exclusion from coverage are not ‘objectively reasonable.’”). *See also Hamilton v. Trinity Universal Ins. Co.*, 465 F.Supp.2d 1060, 1067 (D. Mont. 2006) (“[T]he reasonable expectations doctrine is inapplicable where . . . the terms of the insurance policy clearly demonstrate an intent to exclude coverage’ because expectations that are contrary to a clear exclusion are not objectively reasonable.”); *Aguigar v. Generali Assicurazioni Ins. Co.*, 715 N.E.2d 1046, 1048-49 (Mass. App. Ct. 1999) (“Massachusetts cases have smiled upon, even if not yet wholly embraced, the process of analyzing a provision of an insurance contract in light of the reasonable expectation of the insurance buyer.” *But note* that “When reasonable expectations analysis comes into play, it is more likely to do so when the task is to interpret an ambiguous provision rather than an unambiguous one.”); *Kertz v. State Farm Mut. Auto. Ins. Co.*, No. ED 88839, 2007 WL 1976787, at *5 (Mo. Ct. App. July 10, 2007) (“The doctrine of reasonable expectations guarantees that the ‘objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those

jurisdictions, have neither explicitly rejected or adopted the doctrine,²⁷ while in others there is no dispositive discussion of the issue.²⁸ In short, the devolution of the doctrine of reasonable expectations exemplifies the increasing judicial reliance on standard contract in insurance cases.

B. BAD FAITH ACTIONS

Another measure of the courts' reversion to standard contract principles in insurance cases is the increasingly common classification of the action for bad faith as a contract action.

While the cause of action, in both third-party and first-party cases, originally sounded in tort,²⁹ many courts now classify the action as contract-based.³⁰ A significant number of recent decisions state that contract rather than tort provides the theoretical basis for bad faith breach in first-party³¹ as well as third-party³² actions.

expectations.' However, the 'doctrine of reasonable expectations is not in strict accordance with traditional principles of contract interpretation.' Therefore, 'application of the objective reasonable expectation doctrine . . . depends on the presence of an ambiguity in the policy language.'"); *Alea London Ltd. v. Bono-Soltysiak Enters.*, 16 S.W.3d 403, 415 (Mo. Ct. App. 2006) ("The 'objective reasonable expectations of adherents and beneficiaries to insurance contracts will be honored even though a thorough study of policy provisions would have negated these expectations.' However, the reasonable expectations rule cannot be used to construe unambiguous policy terms.").

27. See *Todd v. Dow Chem. Co.*, 760 F.2d 192, 196 (8th Cir. 1985) ("[W]e regard the doctrine of reasonable expectations, as applied in this context, with some skepticism. The effect of such a theory is to place a gloss over the doctrine of estoppel, which would allow recovery without showing prejudice or detrimental reliance. We find no clear support for such a theory in the caselaw of Arkansas."), *Chandler v. Am. Cas. Co. of Reading, Pa.*, 833 F.Supp. 735, 738 n. 8 (E.D. Ark. 1993) (questioning whether doctrine of reasonable expectations applied in Arkansas); *Firemen's Ins. Co. of Wash., D.C. v. Kline & Son Cement Repair, Inc.*, 474 F.Supp.2d 779, 798 (E.D. Va. 2007) ("Virginia has never explicitly adopted the 'reasonable expectations' doctrine.").

28. Maine, Maryland, New York, North Carolina, Oregon, Rhode Island, Tennessee, Vermont, and Wisconsin.

29. See, e.g., *Crisci v. Sec. Ins. Co.*, 426 P.2d 173, 179 (Cal. 1967) (permitting an award of damages for mental suffering where insurer breached duty to settle).

30. See ROBERT H. JERRY, II, *UNDERSTANDING INSURANCE LAW* Law §25G, (3rd ed. 2002). The classification may be inconsequential in some instances, since contract remedies, flexibly applied, can afford full compensation in many cases. For example, in the third-party context, contract damages would cover foreseeable consequences of an insurer's unjustified refusal to defend its policyholder, including the entry of a judgment in excess of policy limits. *Id.*

31. See, e.g., *Coleman Dupont Homsey v. Vigilant Ins. Co.*, 496 F. Supp.2d 433, 437 (D. Del. 2007); *HHC Assoc. v. Assur. Co. of America*, 256 F.Supp.2d 505, 508 (E.D. Va.

Consistent with a contract-based approach, a number of courts have limited the first-party action to situations in which there is actually coverage under the policy, even where the claim depends on the insurer's failure to conduct a timely investigation of the claim.³³ This limitation presumably derives from the view of the action as one sounding in contract rather than tort: even if the insurer's conduct is negligent, reckless, intentional, or even malicious, there is no basis for complaint if there is no coverage and correspondingly no breach of contract. The view extends in some cases to third-party actions. The California Supreme Court found

2003); *Pickett v. Lloyd's*, 621 A.2d 445, 452 (N.J. 1993); *Bhattacharyya v. Quincy Mut. Fire Ins. Co.*, 799 N.Y.S.2d 158 (N.Y. Sup. Ct. Dec. 15, 2004); *Zenor v. Standard Ins. Co.*, No. Civ. 01-1226-FR, 2002 WL 31466503, at *1 (D. Or. Apr. 3, 2002). *See also* *Kakule v. Progressive Cas. Ins. Co.*, No. Civ. A.06-4995, 2007 WL 1810667, at *5 (E.D. Pa. 2007) (predicting that Pennsylvania courts would extend rationale of third-party cases, holding action sounded in contract, to first-party cases); *University Medical Assoc. v. Unumprovident Corp.*, 335 F.Supp.2d 702, 711-12 (S.C. 2004) (recognizing that the first party action for bad faith sounds in tort, but limiting damages to contract damages); *Crookston v. Fire Ins. Exchange*, 817 P.2d 789, 798 n.8 (Utah 1991). *Contra* *Gov't Employees Ins. Co. v. Dizol*, 176 F.Supp.2d 1005, 1033 (D. Haw. 2001); *Stephens v. Safeco Ins. Co. of America*, 852 P.2d 565, 567 (Mont. 1993); *Wathor v. Mut. Assurance. Adm'rs, Inc.*, 87 P.3d 559, 564 n.1 (Okla. 2004) (action sounds in tort, notwithstanding that it also constitutes breach of contract).

32. *See, e.g.*, *New England Ins. Co. v. Healthcare Underwriters Mut. Ins. Co.*, 352 F.3d 599, 606 (2d Cir. 2003); *Hartz v. Liberty Mut. Ins. Co.*, 269 F.3d 474, 476 (4th Cir. 2001); *Ross v. American Family Mut. Ins. Co.*, No. 06-0811-CV-W-FJG, 2007 WL 1774443, at *3 (W.D. Mo. June 18, 2007) (bad faith action for breach of duty to defend sounds in contract, while action for breach of duty to settle sounds in tort); *Fireman's Fund Ins. Co. v. CTIA*, 480 F. Supp. 2d 7, 11 (D. D.C. Jan. 5, 2007); *Naumes, Inc. v. Chubb Custom Ins. Co.*, Civil No. 05-1327, 2007 WL 54782, at *6 (D. Or. 2007); *Geo M. Martin Co. v. Royal Ins. Co. of America*, Civil No. 04-2725 (PJS/JJG), 2006 WL 3804379 at *4 (D. Minn. 2006); *Essex Builders Group, Inc. v. Amerisure Ins. Co.*, 485 F. Supp. 2d 1302, 1305 (M.D. Fla. 2006); *Anderson v. Va. Sur. Co., Inc.*, 985 F. Supp. 182, 185 (D. Me. 1998); *Twin City Fire Ins. Co. v. Colonial Life & Acc. Ins. Co.*, 839 So.2d 614, 616 (Ala. 2002); *Collins v. Anthem Health Plans, Inc.*, 880 A.2d 106, 119 (Conn. 2005); *Aves v. Shah*, 906 P.2d 642, 648 (Kan. 1995); *Birth Center v. St. Paul Co. Inc.*, 787 A.2d 376, 391 (Pa. 2001) (Nigro, J., dissenting). *Contra*, *Microsoft Corp. v. Fed. Ins. Co.*, No. C01-1815C, 2003 WL 24330081, at *8 (W.D. Wash. Feb 13, 2003); *Gov't Employees Ins. Co. v. Dizol*, 176 F.Supp.2d 1005, 1033 n.35 (D. Haw. 2001); *Daugherty v. Allstate Ins. Co.*, 55 P.3d 224, 226 (Colo. Ct. App. 2002); *Canal Indemn. Co. v. Greene*, 593 S.E.2d 41, 46 (Ga. Ct. App. 2003); *Schal Bovis, Inc. v. Casualty Ins. Co.*, 732 N.E.2d 1082, 1092 (Ill. App. Ct. 1999).

33 *State Farm Fire & Cas. Co. v. Slade*, 747 So. 2d 293, 317 (Ala. 1999); *Waller v. Truck Ins. Exch., Inc.* 900 P.2d 619, 639 (Cal. 1995); *Robinson v. State Farm Mut. Auto. Ins. Co.*, 45 P.3d 829, 834 (Idaho 2002) (plaintiff in bad faith case must establish coverage even if claim based on unreasonable delay); *Richardson v. Guardian Life Ins. Co.*, 984 P.2d 917, 923 (Or. App. 1999).

that there was no action for bad faith breach of the duty to defend in a third-party case where there was no potential for coverage under the policy: it is clear that if there is no *potential* for coverage, and hence, no duty to defend under the terms of the policy, there can be no action for breach of the implied covenant of good faith and fair dealing because the covenant is based on the contractual relationship between the insured and the insurer.³⁴

C. CONSTRUING AMBIGUITIES AGAINST THE INSURER

Even the hardest of the specialized insurance rules, the ambiguity doctrine, has shifted, with courts moving away from automatic construction in favor of the policyholder to reliance on standard contract rules.³⁵ The normal analytic sequence in contract interpretation requires the court first to assess the clarity of the contract language. If the language is clear, it is enforced;³⁶ if it is ambiguous, the fact-finder determines the parties' intentions³⁷ through the review of extrinsic or parol evidence.³⁸ If the ambiguity remains, the contract is construed against the drafter.³⁹ *Contra proferentem* is thus a rule of last resort, applicable only after other means of determining the parties' intent have failed. The insurance version of the rule differs radically. Once the court finds an ambiguity, the interpretation favoring the policyholder prevails, without reference to the parties' intent and without examination of extrinsic evidence.⁴⁰ Thus, in the context of

34. *Waller v. Truck Ins. Exch., Inc.*, 900 P.2d 619, 639 (Cal. 1995).

35. See Michelle E. Boardman, *Contra Proferentem: The Allure of Ambiguous Boilerplate*, 104 MICH. L. REV. 1105, 1107-1108 (2006); Scott G. Johnson, *Resolving Ambiguities in Insurance Policy Language: The Contra Proferentem Doctrine and Use of Extrinsic Evidence*, 33 WTR. BRIEF 33, 34 (2004); Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531, 537 (1997); David S. Miller, *Insurance as Contract: The Argument for Abandoning the Ambiguity Doctrine*, 88 COLUM. L. REV. 1849, 1850-1859 (1988), for discussions of the doctrine.

36. See generally 11 SAMUEL WILLISTON & RICHARD A. LORD, A TREATISE ON THE LAW OF CONTRACTS §32.3 (4th ed. 1999); RESTATEMENT (SECOND) OF CONTRACTS §201 cmt. (a), §202 (2005).

37. See generally 11 WILLISTON, *supra* note 36, §32:2.

38. See generally RESTATEMENT (SECOND) OF CONTRACTS §§202-03 (2005); UCC §1-205(4) (2000); 11 WILLISTON, *supra* note 36, §49:19; 5-24 CORBIN ON CONTRACTS §§24.9, 24.10 (2007). Such evidence includes circumstances existing at the formation of the contract, the parties' purposes, the parties' course of performance or course of dealing, and trade usages.

39. See generally RESTATEMENT, *supra* note 38, §206; CORBIN, *supra* note 38, §24.27 (2007); WILLISTON, *supra* note 38, §32:12 (4th ed. 2006).

40. See, e.g., *Daburlos v. Commercial Ins. Co. of Am.*, 521 F.2d 18, 26 (3d Cir. 1975) (applying Pennsylvania law, noting that courts may receive extrinsic evidence where

insurance, *contra proferentem* is applied as a primary rule of construction without resort to ordinary interpretive rules.⁴¹ In recent years, commentators have advocated for adherence to usual contract rules,⁴² and courts have increasingly applied those rules.⁴³ A striking example comes

contract ambiguous, but distinguishing insurance contracts. “However, if the contract is an insurance contract, the ambiguity must be resolved against the insurer. There is no need in an insurance case to take that extrinsic evidence.”) *Little v. MGIC Indem. Corp.*, 649 F. Supp. 1460, 1466 (W.D. Pa. 1986) (no reliance on extrinsic evidence in interpreting insurance policy because Pennsylvania law provides clear rule of construction requiring resolution of ambiguities against insurer); *Beale v. Am. Nat’l Lawyers Ins. Reciprocal*, 843 A.2d 78, 87-88 (Md. Ct. App. 2004) (distinguishing majority rule, strict construction against insurance company, with Maryland rule construing against drafter only if no extrinsic or parol evidence available or such evidence does not resolve ambiguity); *Cheney v. Bell Nat. Life Ins. Co.* 556 A.2d 1135, 1138 (Md. Ct. App. 1989) (distinguishing majority strict construction rule against insurance company with Maryland rule construing against drafter only if no extrinsic or parol evidence available or such evidence does not resolve ambiguity); *Andres v. Am. Std. Ins. Co. of Wisconsin*, 134 P.3d 1061, 1063 (Or. App. 2006) (comparing judicial task in contract interpretation, which requires resolution of contract ambiguity through resort to extrinsic evidence to determine parties’ intent, and interpretation of insurance policies, which involves examination of policy for ambiguity and resolution against insurer). Although they appear to apply the strict insurance law version of *contra proferentem*, many courts have not explicitly discussed the differences between standard contract interpretation and insurance law in the interpretation and construction of policies. Many cases acknowledge the distinction between contract and insurance versions of *contra proferentem*. See *SI Mgt. L.P. v. Winger*, 707 A.2d 37,43 (Del. 1998) (where standard form contract ambiguous, rule of construction against drafter is determinative). See also ALLAN WINDT, *INSURANCE CLAIMS AND DISPUTES*, §603 (3d ed. 1995) (under strict rule, “once an ambiguity is discovered, courts may not look first to extrinsic evidence in order to eliminate the ambiguity; they may, instead, automatically resolve the ambiguity against the insurer.”).

41. *Andres*, 134 P.3d. at 1063. The application of either approach will yield the same result in many instances, since there may be minimal or no extrinsic evidence bearing on the resolution of the ambiguity. Because insurance contracts consist of industry-drafted and statutorily-mandated provisions, they are not typically subject to the sort of negotiation which produces useful extrinsic evidence. However, the difference in the approaches may be dispositive in other situations, such as cases involving an agent’s representations.

42. See generally WINDT, *supra* note 40, §603 (noting that automatic resolution of ambiguity against insurer results in the creation of policy coverage contrary to parties’ intent and arguing that rule should be abandoned in favor of ordinary rule); Johnson, *supra* note 35, at 33 (arguing that presumption of coverage arising from ambiguity no longer universally followed); 1 BARRY R. OSTRAGER & THOMAS R. NEWMAN, *HANDBOOK ON INSURANCE COVERAGE DISPUTES* at 9-11 (13th ed. 2006) (doctrine of ambiguities should only be applied “as a last resort,” and should not arise “unless it is first demonstrated that: (a) the policy is ambiguous; and (b) the ambiguity may not be resolved by resort to extrinsic evidence of intent”).

43. See, e.g., *St. Paul Travelers Cos., Inc. v. Corn Island Shipyard, Inc.*, 495 F.3d 376, 383 (7th Cir. 2007) (applying New York law); *Willing v. Cmty. Ass’n Underwriters of Am.*,

from a recent decision by a divided Michigan Supreme Court.⁴⁴ The majority of the Court held that ordinary contract rules governed an insurance dispute, such that *contra proferentem* applies only if the parties' intent cannot be discerned through use of conventional rules of interpretation, including examination of relevant extrinsic evidence. The dissenters disagreed, arguing that *contra proferentem* in the insurance context is a primary rule of construction, not a rule of last resort, and that extrinsic evidence is not admissible to clarify ambiguity in the contract.⁴⁵ The dissenters stated: "[T]his Court has consistently applied the rule of construing against the drafter as its primary, indeed sole, aid to construction."⁴⁶

III. FREEDOM OF CONTRACT

The principle of freedom of contract rests variously on respect for individual rights and autonomy or on the instrumentalist view that individual choice furthers an efficient market, maximizing individual and social utility. Freedom of contract entails at least three related conceptions of freedom.⁴⁷ The first is a positive conception involving the liberty of

Inc., No. C06-1357RSL, 2007 WL 1991038, at *4 (W.D. Wash. July 5, 2007); *Pierce Assoc., Inc. v. St. Paul Mercury*, 437 F. Supp. 2d 16, 20-21 (D. D.C. 2006) (applying New York law and finding summary judgment improper where policy language ambiguous and extrinsic evidence available); *Sloan v. Hartford Life and Acc. Ins. Co.*, 433 F. Supp. 2d 1037, 1048 (D. N.D. 2006) (if ERISA plan deemed ambiguous, extrinsic evidence may be considered; "any ambiguities should be construed against drafter only as a last step."); *McNeilab, Inc. v. North River Ins. Co.*, 645 F. Supp. 525, 544 (D. N.J. 1986) (calling *Daburlos*, *supra* note 40, into question); *Rich Maid Kitchens, Inc. v. Pa. Lumbermens Mut. Ins. Co.*, 641 F. Supp. 297, 306, 308 (E.D. Pa. 1986) (rejecting *Daburlos*, *supra* note 40, where ambiguity arises because no meeting of minds); *State Auto Prop. & Cas. Ins. Co. v. Ark. Dep't of Env'tl. Quality*, No. 06-1480, 2007 WL 1707358 (Ark. June 14, 2007); *Collier v. MD-Individual Practice Ass'n, Inc.*, 607 A.2d 537, 539 (Md. Ct. App 1992); *Bird v. State Farm Mut. Auto. Ins. Co.*, 165 P.3d 343, 347 (N.M. Ct. App. 2007). *See generally* 2 COUCH ON INS. §22:22 (3rd ed. 2006).

44. *Klapp v. United Ins. Group Agency, Inc.*, 663 N.W.2d 447, 456 (Mich. 2003).

45. *Id.* at 460.

46. *Id.* at 485.

47. Several books and articles treat the conceptual underpinnings of freedom of contract; all of these inform the discussion here. P.S. ATIYAH, ET AL, *THE RISE AND FALL OF FREEDOM OF CONTRACT* 1-3 (1979); MICHAEL J. TREBILCOCK, *THE LIMITS OF FREEDOM OF CONTRACT* 78-79 (1993); *THE FALL AND RISE OF FREEDOM OF CONTRACT* (F. H. Buckley, ed., 1999); Mark Pettit, Jr., *Freedom, Freedom of Contract, and the "Rise and Fall"*, 79 B.U. L. Rev. 263, 282-85 (1999); Robert Braucher, *Freedom of Contract and Second Restatement*, 78 Yale L.J. 598, 616 (1969).

individuals to make their own choices. In contract, this is the freedom to identify a possible exchange, to bargain for terms, and to enter an agreement based on mutual assent. The second is a negative conception, consisting of freedom from governmental constraints or interference while engaging in these acts. Finally, freedom of contract entails the ability of individuals to access the power of government to enforce their agreements.

In each of these aspects, freedom of contract has always embodied fictions.⁴⁸ The idea of freedom to assent, for example, is undercut by the use of an objective test relying on conduct rather than actual intent,⁴⁹ by the increasingly common use of standard form contracts (like insurance policies) to which there is often no meaningful agreement,⁵⁰ and by social and economic conditions which may constrain an individual's autonomous choice. Similarly, although freedom from government interference may have been the norm at some point in the 19th century, the steady encroachment of legislative restrictions has circumscribed that freedom as well.⁵¹ And courts have always had the means of avoiding strict enforcement of the terms of a contract through equity.⁵²

In the context of insurance, there is even greater reason to question the notion of freedom of contract as a first principle. An examination of insurance transactions demonstrates that there is limited freedom involved. The next two sections focus on freedom of contract as protection of the ability to make individual choices and as involving the absence of government interference. The first demonstrates that policyholders (with the possible exception of some large commercial policyholders) have little or no bargaining power and exercise no meaningful choice about policy terms; the second demonstrates that insurance companies are subject to extensive regulation of policy terms, conditions, and rates by state legislatures and regulatory bodies.

48. See P.S. ATIYAH, *AN INTRODUCTION TO THE LAW OF CONTRACT*, 9-13 (5th ed. 1995).

49. See REST. 2D CONTRACTS, §2 Comment b, 16 (2d ed 2005) (the phrase "manifestation of intention" adopts an external or objective standard for interpreting conduct; distinguished from undisclosed intention).

50. See REST. 2D CONTRACTS, §211 Standardized Agreements, Comment b (2d ed 2005) (noting that consumers who agree to standard forms do not read or understand the terms, instead trusting in the good faith of the drafter and accepting the tacit representation that like terms are routinely accepted by others similarly situated).

51. See LAWRENCE M. FRIEDMAN, *A HISTORY OF AMERICAN LAW*, 532-63 (2d ed. 1985).

52. See P.S. ATIYAH, *supra* note 47, 404-05 (noting that even in the classical period, English judges utilized equity and other methods to accomplish substantive justice).

Together, these sections demonstrate that the routine judicial invocation of the principle of freedom of contract in insurance cases is a fundamental error.

A. FREEDOM OF CONTRACT FROM THE POLICYHOLDER'S
PERSPECTIVE: STANDARD FORMS AND ADHESION

Insurance policies are typically standard forms. Standardization is critical because the insurance industry pools claims data to predict future losses and price policies accordingly; accuracy in this important endeavor requires that insurance companies offer uniform coverage.⁵³ Property and casualty insurers rely on the Insurance Services Office (ISO), which collects information from property/casualty companies and makes the resulting database available to help companies in pricing insurance. The ISO also offers widely-used standard commercial and personal policies (including automobile insurance, various types of property insurance, workers compensation insurance, and liability policies of various types).⁵⁴ Standardization of insurance policies is crucial to the collection of actuarial data, but it also functions, as do all types of standardized contracts, to reduce costs.

From the consumer's perspective, standardization means that the insurance industry controls the content of the policy and that there is no negotiation over terms. Insurance policies are thus adhesion contracts,⁵⁵ standard forms drafted by the insurer, offered on a take-it-or-leave-it basis, with the prospective policyholder at a complete disadvantage in terms of bargaining power. As one noted author observes, insurance policies are

53. See generally KENNETH S. ABRAHAM, *INSURANCE LAW AND REGULATION* 31-36 (4th ed. 2005).

54. See generally Insurance Serv. Office, <http://www.iso.com> (last visited Nov. 2, 2007). Life and health insurance are not generally written on standard forms, primarily because data regarding the insured events (particularly mortality) is more reliable and available. However, there is a great deal of uniformity in these types of policies as well, partly due to statutory requirements. See *infra* text accompanying notes.

55. In fact, insurance policies were the first type of contract to which the term "adhesion contract" was applied. See E. ALLEN FARNSWORTH, *CONTRACTS* 295, 312 (2d ed. 1990). For general discussions of adhesion contracts, see Friedrich Kessler, *Contracts of Adhesion—Some Thoughts about Freedom of Contract*, 43 *COLUM. L. REV.* 629, 641-45 (1943); Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 *HARV. L. REV.* 1173, 1284 (1983). For a specific discussion of the concept in the context of insurance, see James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text versus Context*, 24 *ARIZ. ST. L.J.* 995, 1001-02 (1992).

actually “super-adhesion” contracts, since, in some lines of insurance, all insurance companies provide identical coverage on the same take-it-or-leave-it basis.⁵⁶ The consumer’s only freely-made choice is the choice to purchase insurance.

Insurance policies also satisfy another basic characteristic associated with adhesion contracts, specifically disparity of information.⁵⁷ Insurance companies have far greater information and expertise than do policyholders; insurance consumers, even sophisticated consumers, find it extraordinarily difficult to penetrate the language of insurance policy forms.⁵⁸ Most policyholders do not attempt to read their policies.⁵⁹

Even the decision to obtain insurance is not a freely-made choice in many instances. State legislatures require the purchase of insurance in some instances, most notably automobile insurance. Forty-seven states and the District of Columbia require automobile liability insurance covering bodily injury and property damage in specified amounts.⁶⁰ Some also require uninsured motorists insurance and personal injury protection.⁶¹ Once the consumer chooses to engage in the activity of owning and driving an automobile, insurance is required. Workers’ compensation insurance is another form of required insurance.⁶²

56. Abraham, *supra* note 35 at 534.

57. *But see* Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 HARV. L. REV. 1173, 1177, 1180 (1983) (an influential study which does not include this aspect in its seven-factor definition of adhesion contract. Rakoff recognizes that lack of consumer understanding is a “normal concomitant” of the use of form contracts but argues that it is not an essential feature).

58. *See id.* at 1179-80 (this characteristic is part of the popular conception of adhesion contracts but is not, according to some commentators, essential).

59. Even second and third year law students, who might be expected to be more careful than the average consumer, and more capable of reading and understanding complex contracts, typically admit that they have never read their automobile, health, or property insurance policies.

60. WEST 50 STATE SURVEYS, INSURANCE – MOTOR VEHICLE INSURANCE, FINANCIAL RESPONSIBILITY AND REQUIRED MINIMUMS (West 2006); *See generally* <http://www.iii.org/individuals/auto/stateautolaws/>.

61. KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION 708, 721 (David Shapiro ed. The Foundation Press 1995); *See also* ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW 996-98 (Matthew Bender 3d ed. 2002); *See generally* WEST 50 STATE SURVEYS, INSURANCE – UNINSURED/ UNDERINSURED MOTORIST COVERAGE (West 2006); *See generally* ALAN WIDISS, UNINSURED AND UNDERINSURED MOTORIST INSURANCE 22,36 (Anderson Publishing 2d ed. 1985).

62. COUCH ON INS. §§ 1:36, 133:2, 133:4; 133:6 (Thomson/West 3d ed. 2005).

B. FREEDOM OF CONTRACT FROM THE INSURER'S
PERSPECTIVE: REGULATION OF POLICY FORMS,
RATES, AND OTHER MATTERS

State insurance codes are extensive. The codes prohibit certain provisions and make others mandatory, and authorize insurance commissioners to exercise significant control over insurance policy forms, rates, and other matters. Freedom of contract is thus significantly limited for companies as well for policyholders. These limitations obviously do not preclude invocation of the principle of freedom of contract in policy interpretation. However, the scope and extent of regulatory control over the content of insurance policies strongly suggests that freedom of contract is not an appropriate analytical starting point.

1. Rate Regulation

All states authorize rate regulation in some form, charging insurance commissioners with ensuring that insurance rates are not excessive, inadequate, or unfairly discriminatory.⁶³ Statutes prescribe various methods by which commissioners exercise this responsibility. The most common approach is monitoring rates through rate filings and approval, either prior approval, under which the commissioner must approve rates before they may be used, or file and use, under which rates become effective when filed but may be disapproved by the commissioner within a specified period.⁶⁴

A number of states have deregulated rates. Even those states, however, afford insurance commissioners significant residual authority by requiring insurance commissioners to monitor competition and to regulate rates in its absence. The NAIC Model Rating Law, for example, provides, like all rate regulation statutes, that “rates shall not be excessive, inadequate or unfairly discriminatory” but also specifies that a rate in a competitive market is

63. *See, e.g.*, NAIC MODEL LAWS, REGULATIONS AND GUIDELINES 375-1 CREDITOR-PLACED INSURANCE ACT (2007); 430-1 HEALTH MAINTENANCE ORGANIZATION MODEL ACT (2007); 626-1 FINANCIAL GUARANTY INSURANCE MODEL ACT (2007); 710-1 MASS MARKETING OF PROPERTY AND LIABILITY INSURANCE MODEL REGULATION (2006); 775-1 PROPERTY AND CASUALTY MODEL RATING LAW (FILE AND USE VERSION) (2007); 780-1 PROPERTY AND CASUALTY MODEL RATING LAW (PRIOR APPROVAL VERSION) (this is the language used by various NAIC Model Acts and it appears in most state codes).

64. *See, e.g.*, NAIC MODEL LAWS at 780-1; *See generally* WEST 50 STATE STATUTORY SURVEYS, FILING REQUIREMENTS—RATES AND RATING PLANS, *supra* note 60.

deemed not excessive, and creates a presumption that the insurance market is competitive.⁶⁵ The commissioner may, after hearings, rule that the market is not competitive and regulate rates for excessiveness in the ordinary way. Such ruling expires no later than one year after issue. In a competitive market, rates must be filed but are effective unless the commissioner finds after a hearing that the insurer's financial condition requires rate supervision or that rating practices are unfairly discriminatory.⁶⁶ In a noncompetitive market, rates become effective only after the commissioner has an opportunity to review and disapprove rates if they do not meet the requirements of the Act, typically within 15 to 90 days.⁶⁷ A number of states have adopted provisions similar to those in the NAIC Model.⁶⁸ Some states include provisions directing the insurance commissioner to assess the reasonableness of the coverage or benefits in relation to the premium charged, for all policies⁶⁹ or for specific types of insurance, usually health insurance.⁷⁰

2. Policy Forms

The laws of every state require regulatory review and approval of insurance policies prior to their use.⁷¹ Statutes typically provide that

65. NAIC MODEL LAWS, at 775-5 § 4 (there are no presumptions under the Model Law relating to the commissioner's assessment of adequacy and unfair discrimination); *Id.* §§ 5A.(2) 5A.(3) 6.D (a number of states have adopted provisions similar to those in the NAIC Model).

66. *Id.* at § 6C.

67. *Id.* at § 6D.

68. *See, e.g.*, ARK. CODE ANN. § 23-67-208 (2001); CONN. GEN. STAT. ANN. § 38a-686, 688 (West 1958); DEL. CODE ANN. tit. 18 § 2604 (1999); MO. REV. STAT. § 287.960 (West 2005); MONT. CODE ANN. § 33-16-1021 (2007); N.H. REV. STAT. ANN. § 412:15 (LexisNexis 2004); N.M. STAT. ANN. §59A-17-6; OKLA. STAT. ANN. tit. 36 § 985(West 2007); VT. STAT. ANN. tit. 8 § 4685; WYO. STAT. ANN. § 26-14-103 (2007).

69. NEV. REV. STAT. ANN. § 687B.130 (LexisNexis 2003); N.M. Stat. Ann. § 59A-1-14 (LexisNexis 2000); N.C. GEN. STAT. § 58-51-95 (2001); W. VA. CODE ANN. § 33-6-9 (LexisNexis 2006).

70. ARK. CODE ANN. § 23-79-110 (2004); CAL. INS. CODE § 779.9; 18 (West 2005); DEL. CODE ANN. tit. 18, § 2713 (1999); 215 ILL. COMP. STAT. ANN. 5/155.57 (West 1993); KY. REV. STAT. ANN. § 304.14-130 (West 2006); WASH. REV. CODE ANN. §48.18.110 (West 1999).

71. *See* WEST 50 STATE SURVEYS, *supra* note 60 (West ed. 2006); *See also* NAIC MODEL LAWS, *supra* note 63 (2007) (providing a listing of the states and references to filing requirements and approvals). Because of significant variations in state insurance codes and administrative regulations, generalizations are difficult. Some states impose a generally-applicable requirement of approval; others vary depending on the type of insurance.

regulators must disapprove a policy form that violates the insurance code; has titles or headings which are misleading; or is substantially illegible.⁷² A number of state statutes further require disapproval of a policy form where it contains inconsistent, ambiguous, or misleading clauses, or exceptions and conditions that deceptively affect the risk purportedly assumed.⁷³ Others mandate disapproval of any policy that contains provisions which are unjust, unfair, or inequitable, or contrary to public policy.⁷⁴

States also regulate the format and appearance of insurance policies, typically specifying the size of the type and requiring a table of contents or index. The statutes also require spacing and formatting to aid comprehension.⁷⁵ Many states impose “readability” standards.⁷⁶ Some of

72. *See, e.g.*, ALA. CODE § 27-14-9 (2006); ALASKA STAT. § 21.42.130 (2006); ARIZ. REV. STAT. ANN. § 20-1111 (2006); ARK. CODE ANN. § 23-79-110 (2004); DEL. CODE ANN. tit. 18, § 2713 (2006); FLA. STAT. § 624.4412 (2007); GA. CODE ANN. § 33-24-10 (2002); IDAHO CODE ANN. § 41-1813 (2007); 215 ILL. COMP. STAT. 5/155.57 (2007); KY. REV. STAT. ANN. § 304.14-130 (West 2006); LA. REV. STAT. ANN. § 22:621 (2007); ME. REV. STAT. ANN. tit. 24A, § 2413 (2006); MICH. COMP. LAWS § 500.2236 (2007); MONT. CODE ANN. § 33-1-502 (2006); NEV. REV. STAT. § 687B.130 (2005); N.M. STAT. § 59A-18-14 (2006); OHIO REV. CODE ANN. §3911.01.1 (LexisNexis 2007); OKLA. STAT. tit. 36, § 3611 (2007); S.D. CODIFIED LAWS § 58-11-21 (2007); VT. STAT. ANN. tit. 8, § 3542 (2006); VA. CODE ANN. § 38.2-316 (2007); V.I. CODE ANN. tit. 22, § 811 (2007); WASH. REV. CODE § 48.18.110 (2007); W. VA. CODE § 33-6-9 (2007); WIS. STAT. § 631.20 (2006); WYO. STAT. ANN. § 26-15-111 (2007). Most but not all of these statutes contain each of these three provisions. Other states (as well as some of those cited) have similar provisions applicable only to specific lines of insurance.

73. *See, e.g.*, ALASKA STAT. § 21.42.130 (2006); CAL. INS. CODE § 779.9 (West 2007); DEL. CODE ANN. tit. 18, § 2713 (2006); FLA. STAT. ANN. § 627.411 (West 2007); GA. CODE ANN. § 33-24-10 (2002); IDAHO CODE ANN. § 41-1813(2) (2007); 215 ILL. COMP. STAT. 5/155.57 (2007); KY. REV. STAT. ANN. § 304.14-130(1)(b) (West 2006); LA. REV. STAT. ANN. § 22:621(3) (2007); ME. REV. STAT. ANN. tit. 24A, § 2413(1)(B) (2006); MICH. COMP. LAWS § 500.2236 (2007); MONT. CODE ANN. § 33-1-502 (2006); NEV. REV. STAT. § 687B.130(2) (2005); N.M. STAT. § 59A-18-14(A)(2) (2006); OKL. STAT. tit. 36 § 3611(A)(2) (2007); S.D. CODIFIED LAWS § 58-11-21(2) (2007); VT. STAT. ANN. tit. 8, § 3542(2) (2006); VA. CODE ANN. § 38.2-316 (2007); V.I. CODE ANN. tit. 22, § 811(3) (2007); WASH. REV. CODE § 48.18.110(1)(c) (2007); W. VA. CODE § 33-6-9(b) (2007); WIS. STAT. § 631.20 (2006); WYO. STAT. ANN. § 26-15-111(B) (2007). Other states (as well as some of those cited) have similar types of provisions applicable only to specific lines of insurance.

74. *See, e.g.*, ALA. CODE § 27-14-9 (2006); CAL. INS. CODE § 779.9 (West 2007); FLA. STAT. § 624.4412 (2007); GA. CODE ANN. § 33-24-10 (2002); IDAHO CODE ANN. § 41-1813 (2007); 215 ILL. COMP. STAT. 5/155.57 (2007); N.C. GEN. STAT. § 58-51-95 (2007); OHIO REV. CODE ANN. § 3911.01.1 (LexisNexis 2007).

75. *See, e.g.*, ARK. CODE ANN. § 23-80-206(a) (2007); CONN. GEN. STAT. § 38a-297 (2007); FLA. STAT. § 627.4145 (2007) (requiring use of titles and headings in bold, prohibiting “unnecessarily long, complicated, or obscure words, sentences, paragraphs, or

these readability statutes require calculations involving syllable, word, and sentence counts, often specifying a particular maximum score on the Flesch Readability test (typically between 40-50; passages with scores of 90-100 are easily understandable by average 5th graders and passages with scores of 0-30 can be best understood by college graduates.⁷⁷).

3. Mandated Content

States control the content of insurance policies in significant and substantial ways. Many jurisdictions mandate the inclusion of various

constructions”); GA. COMP. R. & REGS. 120-2-42-.04 (2007); HAW. REV. STAT. § 431:10-104 (2006); ME. REV. STAT. ANN. tit. 24-A, § 2441 (2006); MASS. GEN. LAWS ANN. ch. 175, § 2B (West 2007); MINN. STAT. § 72C.05(2) (2007); MINN. STAT. § 72C.01-.13 (2007); MONT. CODE ANN. § 33-15-325 (2006); NEB. REV. STAT. § 44-3405 (2004); NEV. REV. STAT. § 687B.126 (2005); N.H. REV. STAT. ANN. § 420-H:5 (2006); N.J. STAT. ANN. § 17B:17-21 (West 2007); N.M. STAT. § 59A-19-4 (2006); N.Y. INS. LAW § 3102 (2007); N.C. GEN. STAT. § 58-38-20 (2007); N.D. CENT. CODE § 26.1-33-30 (2007) (life insurance); N.D. CENT. CODE § 26.1-36-14 (2007) (accident and health insurance); OHIO REV. CODE ANN. § 3902.04 (LexisNexis 2007); OKLA. STAT. tit. 36, § 3645 (2007) (life, accident and health insurance); OR. REV. STAT. § 743.106 (2005); S.C. CODE ANN. § 38-61-30 (2006); S.D. CODIFIED LAWS § 58-11A-6 (2007); TENN. CODE ANN. § 56-7-1605 (2006) (life and health insurance); TX. CODE ANN. § 1201.101 (2007) (accident and health insurance); WIS. STAT. § 631.22 (2006). *See generally* John A. Glenn, Annotation, *Validity and Construction of Statutes Relating to Style or Prominence with which Provisions must be Printed in Insurance Policy*, 36 A.L.R.3d 464 (1971).

76. *See, e.g.*, ARIZ. REV. STAT. ANN. § 20-1110.01 (2006); ARK. CODE ANN. § 23-61-115(b)(5) (2007); CONN. GEN. STAT. § 38a-297 (2007); DEL. CODE ANN. tit. 18, § 2740 (2006) (automobile insurance); D.C. CODE § 31-4725 (life insurance); FLA. STAT. §§ 626.9641(1)(f), 627.4145 (2007); GA. CODE ANN. § 33-3-25 (2002); GA. COMP. R. & REGS. 120-2-42-.04(g) (2007); HAW. REV. STAT. § 431:10-104 (2006); IND. CODE § 27-1-26-5 (2006); KY. REV. STAT. ANN. § 304.14-4401 (West 2006); ME. REV. STAT. ANN. tit. 24-A, § 2441 (2006); MASS. GEN. LAWS ch. 175, § 2B (2007); MICH. COMP. LAWS § 500.2236(3) (2007); MINN. STAT. § 72C.09-10 (2007); MONT. CODE ANN. § 33-15-325 (2006); NEB. REV. STAT. § 44-3405 (2004); NEV. REV. STAT. § 687B.126 (2005); N.H. REV. STAT. ANN. § 420-H:5 (2006); N.J. STAT. ANN. § 17B:17-21 (West 2007); N.M. STAT. § 59A-19-4 (2006); N.Y. INS. LAW § 3102 (2007); N.C. GEN. STAT. § 58-38-25 (2007); N.D. CENT. CODE § 26.1-33-30 (2007) (life insurance); N.D. CENT. CODE § 26.1-36-14 (2007) (accident and health insurance); OHIO REV. CODE ANN. § 3902.04 (LexisNexis 2007); OKLA. STAT. tit. 36, § 3645 (2007) (life, accident, and health insurance); Or. Rev. Stat. § 743.106 (2005); S.C. CODE ANN. § 38-61-30 (2006); S.D. CODIFIED LAWS § 58-11A-3 (2007); TENN. CODE ANN. § 56-7-1605 (2006) (life and health insurance); TX. CODE ANN. § 1201.101 (2007); WIS. STAT. § 631.22 (2006). *See generally*, *Insurance Policies and Premiums: Readability of Insurance Policies*, West’s 50 State Regulatory Surveys (2007).

77. This article has a Flesch readability score of approximately 18.5, as determined by Microsoft Word.

types of provisions in insurance policies. Some of these requirements are substantive, mandating various types of coverages or specific provisions; others deal with procedural issues, for example, by limiting an insurer's power to cancel the policy. There are a vast number of such requirements in every jurisdiction.

One of the best-known examples is the 1943 New York Standard Fire Insurance Policy,⁷⁸ which is used pursuant to statute in nearly every state (and is incorporated into standard homeowner's policies).⁷⁹ These statutes specify the form of the policy and the language which must be used. They require loss payment provisions; provisions relating to fraud and concealment by the policyholder; exclusions for certain types of property (for example, bills, currency, deeds, and money) and specified perils (including enemy attack, invasion, insurrection, civil war, neglect of the insured to use reasonable means to preserve property at and after loss, and theft); various conditions; cancellation provisions; a standard mortgage clause; other insurance provisions; notice and claim provisions; and valuation provisions, among others.⁸⁰

All states have some form of compulsory automobile liability insurance.⁸¹ The statutes require policy limits in at least a specified minimum amount,⁸² and typically mandate other provisions as well, such as notice and cancellation provisions.⁸³ Many states require omnibus coverage, that is, coverage for permissive users of the insured vehicle.⁸⁴ Uninsured motorists coverage is required in most states,⁸⁵ and various provisions are statutorily-mandated, including a basic coverage agreement,⁸⁶ policyholder's right to reject the coverage,⁸⁷ limitations on stacking,⁸⁸ permitted exclusions,⁸⁹ and subrogation rights.⁹⁰

78. N.Y. INS. LAW § 3404 (McKinney 2007).

79. *See* 1-2 APPLEMAN ON INS. § 2.2.

80. *Id.*

81. *See supra* text accompanying notes 60-61.

82. *See, e.g.,* GA. CODE ANN. § 33-34-4 (2002).

83. *See, e.g., Id.* at § 33-34-3(e).

84. 12 COUCH ON INS. §170:5; 8 COUCH ON INS. § 111:23.

85. *See supra* note 61 and accompanying text.

86. *See, e.g.,* KAN. STAT. ANN. §40-284(a).

87. *See, e.g., Id.* §40-284(c).

88. *See, e.g., id.* §40-284(d).

89. *See, e.g., id.* §40-284(e). These include exclusions where the insured is occupying or struck by an uninsured auto or trailer owned by or provided to the insured for regular use or owned by a self-insurer or government entity; where there is no physical contact and no reliable evidence of the facts of the accident from a disinterested witness; to the extent that

Many states mandate various types of provisions in disability insurance policies, including format and readability requirements;⁹¹ entire contract provisions;⁹² time limits on certain defenses;⁹³ grace periods;⁹⁴ reinstatement;⁹⁵ notice of claim;⁹⁶ claim forms;⁹⁷ proofs of loss;⁹⁸ time of payment of claims;⁹⁹ payment of claims;¹⁰⁰ physical examination and autopsy;¹⁰¹ legal actions;¹⁰² and change of beneficiary.¹⁰³ The statutes also include many optional provisions; if the policy includes provisions dealing with these issues, it must use the statutory language or a substitute approved by the commissioner of insurance.¹⁰⁴ Even the order of provisions is dictated.¹⁰⁵

Many states have statutes requiring that life insurance policies provide that the policy is incontestable after a certain number of years, typically one

workers' compensation or personal injury protection benefits apply; or when suit is filed against the uninsured motorist without notice to the insurer.

90. *See, e.g., id.* §40-284(f).

91. *See, e.g.,* ALA. CODE §27-19-2 (1998); MONT. STAT. §33-15-337 (1979).

92. *See, e.g.,* ALA. CODE §27-19-4 (1998).

93. *See, e.g.,* ALA. CODE §27-19-5 (1998); ARIZ. REV. STAT. ANN. §20-1342.02 (2002); MICH. CONS. LAW. ANN. 500.3408 (2001).

94. *See, e.g.,* ALA. CODE §27-19-6 (1998); ARIZ. REV. STAT. ANN. §20-1347 (2002); MICH. CONS. LAW. ANN. 500.3410 (2001).

95. *See, e.g.,* ALA. CODE §27-19-7 (1998); ARIZ. REV. STAT. ANN. §20-1348 (2002); MICH. CONS. LAW. ANN. 500.3411 (2001).

96. *See, e.g.,* ALA. CODE §27-19-8 (1998); ARIZ. REV. STAT. ANN. §20-1349 (2002); MICH. CONS. LAW. ANN. 500.3412 (2001).

97. *See, e.g.,* ALA. CODE §27-19-9 (1998); ARIZ. REV. STAT. ANN. §20-1350 (2002); MICH. CONS. LAW. ANN. 500.3413 (2001).

98. *See, e.g.,* ALA. CODE §27-19-10 (1998); ARIZ. REV. STAT. ANN. §20-1351 (2002); MICH. CONS. LAW. ANN. 500.3414 (2001).

99. *See, e.g.,* ALA. CODE §27-19-11 (1998); ARIZ. REV. STAT. ANN. §20-1352 (2002); MICH. CONS. LAW. ANN. 500.3416 (2001).

100. *See, e.g.,* ALA. CODE §27-19-12 (1998); ARIZ. REV. STAT. ANN. §20-1353 (2002); MICH. CONS. LAW. ANN. 500.3418 (2001).

101. *See, e.g.,* ALA. CODE §27-19-13; ARK. REV. STAT. §20-1354; MICH. CONS. LAW. ANN. 500.3420.

102. *See, e.g.,* ALA. CODE §27-19-14; ARK. REV. STAT. §20-1355; MICH. CONS. LAW. ANN. 500.3422.

103. *See, e.g.,* ALA. CODE §27-19-15; ARK. REV. STAT. §20-1356; MICH. CONS. LAW. ANN. 500.3424.

104. These provisions deal with change of occupation, misstatement of age, other insurance with the insurer or other insurers, relations of earnings to insurance, unpaid premiums, conformity with state statutes, illegal occupation, and intoxicants and narcotics. *See, e.g.,* ALA. CODE §§27-19-16-26.

105. *See, e.g.,* ALA. CODE §27-19-27.

or two, except for nonpayment of premiums.¹⁰⁶ Other statutorily-mandated provisions concern suicide. Some states require coverage for suicide which occurs after a certain number of years, typically one or two,¹⁰⁷ or prohibit exclusions for suicide unless the suicide is proven to have been contemplated at the time of the application for the policy.¹⁰⁸

There are vast numbers of mandated health insurance provisions and coverages. Some of these are clearly in the public interest, requiring minimum standard benefits for individual or group health plans.¹⁰⁹ Others require specific designated benefits. Some are common to many jurisdictions. Examples include coverage for newborn and adopted children,¹¹⁰ immunizations for dependent children,¹¹¹ mental health treatments,¹¹² and treatment of various forms of substance abuse.¹¹³ Others

106. *See, e.g.*, ARIZ. REV. STAT. §20-1204; CAL. INS. CODE §10113.5; COL. REV. STAT. §10-7-102(B); 18 DEL. C. §2908; D.C. ST. §31-4703; WEST'S F.S.A. §627.455; GA. CODE ANN. §33-25-3; WEST'S ID. CODE §41-1905; IL. COMP. STAT. ANN. §5/224; IOWA CODE ANN. §508.28; LA. STAT. ANN. 22:170; MD. CODE §16-203; MASS. GEN. LAWS ANN. 175 § 132; MICH. COMP. LAWS ANN. 500.4014; MINN. STAT. ANN. §61A.03; MONT. CODE ANN. §33-20-105; NEB. REV. STAT. §44-502; N.H. REV. STAT. §408:10; N.J.S.A. 17B:25-4; N.M.S.A. §59A-20-5; MCKINNEY'S N.Y. LAW §3203; N.C. GEN. STAT. ANN. §58-51-15; N.D. CODE 26.1-33-05; OHIO REV. CODE §3917.06; 36 OKLA. ST. ANN. §4004; O.R.S. §743.168; S.C. CODE §38-63-220; S.D. CODE §58-15-10; V. TEX. C.A. §884.354; VA. CODE ANN. §38.2-3107; REV. CODE WASH. 48.23.050. *See generally* 5 COUCH ON INS. §76; *see generally* 16 WILLISTON ON CONTRACTS §49:92 (4th ed.) (noting how unusual such restrictions are in contracts generally).

107. *See, e.g.* ALA. CODE §27-15-24(a)(2)(e).

108. *See, e.g.*, MO. ST. §376.620.

109. CONN. GEN. STAT. ANN. §38A-553; MASS. GEN. LAW ANN. 176M §2; CAL. ANN. CODE §1357.08 (for Small Employer Group plans); MO. ST. §376.426. The mandated minimum benefits are extensive and fairly detailed, including coverage for catastrophic illness with lifetime maximum benefits, including hospitalization; physician care; diagnosis and treatment of mental conditions; prescription drugs; nursing facility care; home health services; use of radium or other radioactive materials; oxygen; chemotherapy; anesthetics; prosthesis to replace anatomic structure lost during treatment for head and neck tumors; diagnostic xrays and lab tests; certain oral surgeries; physical therapy; ambulance transport; rehabilitation for alcoholism. Other provisions limit preexisting condition exclusions or require grace periods and provisions relating to incontestability, misstatement of age, notice of claim and proof of loss, timing of payments, limitation periods, and cancellation limits and requirements.

110. NAIC MODEL LAWS, REGULATIONS AND GUIDELINES, 155-1 NEWBORN AND ADOPTED CHILDREN COVERAGE MODEL ACT; NEV. REV. STAT. 689A.043.

111. LA. REV. STAT. §22:215.14; MO. STAT. §376.1215; N.M. STAT. ANN. §59A-22-34.3.

112. MO. STAT. §376.1550. S.C. ST. §38-71-290; NEV. REV. STAT. 689A.0455

113. NEV. REV. STAT. 689A.046 (including inpatient and outpatient treatment); CONN. GEN. STAT. ANN. §38A-533 (medical complications of alcoholism); MO. STAT.

are idiosyncratic, presumably resulting from the efforts of strong provider lobbies or from consumer interest groups centered on particular health care needs. Some of the more unique mandated coverages include costs of low protein food products for treatment of inherited metabolic diseases;¹¹⁴ hearing aids for minor children;¹¹⁵ required drugs and devices for contraception;¹¹⁶ scalp hair prostheses for hair loss resulting from alopecia areata or alopecia totalis for persons aged eighteen or younger;¹¹⁷ diabetes self-management training;¹¹⁸ chiropractic care;¹¹⁹ treatments relating to hemophilia,¹²⁰ smoking cessation,¹²¹ Wilm's tumor,¹²² attention deficit/hyperactivity disorder,¹²³ diabetes,¹²⁴ osteoporosis,¹²⁵ cancer,¹²⁶ and temporomandibular joint disease;¹²⁷ screening and testing for alpha-fetoprotein IV,¹²⁸ cytologic¹²⁹ and human papillomavirus,¹³⁰ colorectal cancer,¹³¹ cancer,¹³² breast cancer,¹³³ human leukocyte antigen,¹³⁴ and

§376.779 (same); N.J.ST. 17:48-6a (alcoholism); MO.STAT. §376.811 (chemical dependency treatment).

114. LA. REV. STAT. §22:215.22; MO. STAT. §376.1219; NEV. REV. STAT. 689A.0423; N.M.STAT.ANN. §59A-22-41.1.

115. LA. REV. STAT. ANN. §22:215.25 (2007).

116. NEV. REV. STAT. § 689A.0415 (2005); NEV. REV. STAT. § 689A.0417 (2005); N.M.STAT.ANN. §59A-22-42 (2006).

117. MO. ANN. STAT. §376.1222 (2007).

118. ARK. CODE ANN. §23-79-602 (2007); LA. REV. STAT. ANN. §22:215.21 (B) (2007); NEV. REV. STAT. §689A.0427(b) (2005).

119. MO. ANN. STAT. §376.1230 (2007).

120. N.J.STAT. ANN. §17:48:6d (2007).

121. N.M.STAT.ANN. §59A-22-44 (2006).

122. N.J.STAT. ANN. §17:48:6f (2007).

123. LA. REV. STAT. ANN. §22:215.15 (2007).

124. LA. REV. STAT. ANN. §22:215.21(A) (2007); NEV. REV. STAT. §689A.0427(a) (2005); N.M.STAT.ANN. §59A-22-41 (2006).

125. LA. REV. STAT. ANN. §22:215.16 (2007).

126. N.J. STAT. ANN. §17:48:6k (2007) (dose-intensive chemotherapy, autologous bone marrow transplants and peripheral blood stem cell transplants).

127. NEV. REV. STAT. 689A.0465 (2005).

128. N.M.STAT.ANN. §59A-22-45 (2006).

129. OHIO REV. CODE ANN. § 3923.52; N.M.STAT.ANN. § 59A-22-40.

130. N.M. STAT. ANN. § 59A-22-40.

131. ARK. CODE ANN. § 23-79-1202; LA. REV. STAT. ANN. § 22:215.12; NEV. REV. STAT. ANN. § 689A.04042.

132. MO. ANN. STAT. § 376.1250.

133. MO. ANN. STAT. § 376.782; NEV. REV. STAT. ANN. § 689A.0405; N.J. STAT. ANN. § 17:48-6g; N.M. STAT. ANN. § 59A-22-39; LA. REV. STAT. ANN. § 22.215.11; OHIO REV. STAT. § 3923.52.

134. MO. ANN. STAT. § 376.1275.

lead;¹³⁵ routine gynecological care;¹³⁶ maternity transport;¹³⁷ and care and treatment of loss or impairment of speech or hearing.¹³⁸ These mandated benefits are so pervasive and so costly that a number of state legislatures have enacted legislation requiring various impact assessments before such proposals are considered.¹³⁹

Other statutes mandate procedural protections, for example, requiring immediate emergency services¹⁴⁰ or prohibiting prior authorization for emergency services,¹⁴¹ ensuring a right to a second medical opinion,¹⁴² requiring payment of expenses for qualified interpreter for hearing impaired in connection with medical treatment or consultation,¹⁴³ and creating procedures for obtaining non-formulary drugs where the formulary's equivalent has been ineffective or is reasonably expected to cause adverse or harmful reactions in the patient.¹⁴⁴

There are also procedural restrictions applicable generally to multiple lines of insurance, such as notice requirements;¹⁴⁵ contractual limitation periods;¹⁴⁶ designations of governing law;¹⁴⁷ requirements that the application must be attached to policy if the insurer raises any defense to

135. MO. ANN. STAT. § 376.1290; N.J. STAT. ANN. § 17:48-6m.

136. LA. REV. STAT. ANN. § 22:215.17.

137. N.M. STAT. ANN. § 59A-22-35.

138. MO. ANN. STAT. § 376-781.

139. *See, e.g.*, FLA. STAT. ANN. § 624.215; HAW. REV. STAT. § 23-51; KAN. STAT. ANN. § 40-2248; KY. REV. STAT. § 6.948; LA. REV. STAT. ANN. § 24:603.1; ME. REV. STAT. ANN. tit. 24A, § 2752; MD. CODE ANN., [insurance] § 15-1501; MASS. GEN. LAWS ANN. ch. 3, § 38C; MINN. STAT. ANN. § 62J.26; MISS. CODE ANN. § 83-5-93; N.J. STAT. ANN. § 17B:27D-1 et seq.; N.D. CENT. CODE § 54-03-28. These statutes require that the state auditor or other state official or persons or organizations seeking mandated coverage submit to a state health care administration and to appropriate legislative committees an assessment of social and financial impacts of the proposed mandatory coverage, including consideration of factors such as the portion of the population needing the treatment, the availability of coverage, public demand for the treatment and for coverage and the interest of collective bargaining agents; affect on direct and indirect insurance costs and total health care costs.

140. GA. CODE ANN. § 33-21-18.1(1).

141. IDAHO CODE ANN. § 41-1846.

142. FLA. STAT. ANN. § 641.51.

143. LA. STAT. ANN. § 22.215.10.

144. GA. CODE ANN. § 33-21-18.1(1998).

145. 13 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INS. § 190:10 (3d ed. 2005).

146. 16 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INS. § 235:10 (3d ed. 2005).

147. 2 LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INS. § 24:3 (3d ed. 2005 & Supp. 2007).

coverage in the application;¹⁴⁸ free look provisions;¹⁴⁹ entire contract provisions, providing that policy, including endorsements and attached papers, if any, constitute the entire contract of insurance;¹⁵⁰ limitations on an insurer's ability to cancel;¹⁵¹ and required grace periods.¹⁵²

IV. STATUTORY AND REGULATORY FRAMEWORKS AND INTERPRETATION OF INSURANCE POLICIES

The implications of this extensive regulation of insurance policies for interpretation of the policies have not been fully explored. Courts often approach the task of interpretation of insurance provisions without acknowledgment of the legislative and administrative role in the drafting and approval of insurance policies. It might be argued that such acknowledgment is unnecessary: both freedom of contract and recognition of the regulatory involvement in insurance counsel enforcement of the policy language. But the principle of freedom of contract looks to the parties' intent and proposes to protect and enforce that intent. Acknowledgment of legislative and administrative involvement through mandated provisions and policy approvals shifts the interpretative focus from effectuating the parties' intent to effectuating regulatory goals.

Protecting the parties' bargain is a relatively straightforward and static task, requiring judicial interpretation and enforcement of contract language. The task of interpreting and enforcing regulator-approved policy provisions

148. See 3 JOHN ALAN APPLEMAN & ERIC MILLS HOLMES, *HOLMES'S APPLEMAN ON INSURANCE* § 15.1 (2d ed. 1998 & Supp. 2007).

149. Such provisions require that the policyholder, typically with respect to life insurance, Medicare supplement insurance, and long-term care insurance, has a specified time to examine and cancel the policy following delivery. See WESTLAW 50 STATE STATUTORY SURVEYS, *INSURANCE POLICIES & PREMIUMS, FREE LOOK PROVISIONS* (Sept. 2006).

150. MODEL LAWS REGULATIONS & GUIDELINES VOL. II, UNIF. INDIVIDUAL ACCIDENT & SICKNESS POLICY PROVISION LAW § 3 at 180-2 (Nat'l Ass'n of Ins. Comm'rs 2007); MODEL LAWS REGULATIONS & GUIDELINES VOL. III, GROUP LIFE INS. DEFINITIONS & GROUP LIFE INS. STANDARD PROVISIONS MODEL ACT § 5 at 565-6 (Nat'l Ass'n of Ins. Comm'rs 2007).

151. 2 LEE R. RUSS & THOMAS F. SEGALLA, *COUCH ON INS.* § 30:13 (3d ed. 2005); 3 JOHN ALAN APPLEMAN & ERIC MILLS HOLMES, *HOLMES'S APPLEMAN ON INS.* § 16.10 (2d ed. 1998 & Supp. 2007); See WEST 50 STATE STATUTORY SURVEYS, *CANCELLATION & NONRENEWAL—PERMITTED & PROHIBITED REASONS* (September 2006); 17 SAMUEL WILLISTON & RICHARD A. LORD, *A TREATISE ON THE LAW OF CONTRACTS* § 49:130 (4th ed. 2000 & Supp. 2007).

152. See generally 16 SAMUEL WILLISTON & RICHARD A. LORD, *A TREATISE ON THE LAW OF CONTRACTS* § 49:80 (4th ed. 2000).

is by contrast much more complex and dynamic, involving questions about the scope of judicial and administrative authority and the deference, if any, owed by the judiciary to the administrative regulator. The shape of the analysis in a particular case will depend on the structure and provisions of individual state insurance codes, administrative procedure acts, and regulations, as well as the particulars of the department's review and approval process. This section will sketch out some preliminary answers to these questions, and the last section will provide an example of this interpretive regime. The basic point is clear: freedom of contract is not an appropriate analytical starting point for interpretation of insurance policies. Instead, a recognition of the regulatory regimes surrounding insurance should inform judicial functioning in insurance cases.

It is clear that where policy provisions are mandated by statute or regulation, concerns about freedom of contract are irrelevant. Courts must interpret such provisions using principles of statutory construction and enforce them with the goal of effectuating the legislature's or regulator's intent. If a policy lacks a mandated term, courts must read the term into the policy.¹⁵³

By contrast, the case law dealing with the impact of administrative approval of policy forms is sparse. The most common issue arises when the Insurance Department approves a policy in violation of a statute.¹⁵⁴ In these cases, the courts typically afford no deference to the regulator:¹⁵⁵ statutory interpretation is a judicial function and the courts are not bound to accept an administrative interpretation.¹⁵⁶ Some cases hold that where the

153. See, e.g., 4 JOHN ALAN APPLEMAN & ERIC MILLS HOLMES, HOLMES'S APPLEMAN ON INSURANCE § 22.1, §22.2 (2d ed. 1998 & Supp. 2007).

154. Such violation may arise because the policy lacks a statutorily-mandated provision or because a provision fails to conform to statutory requirements. See cases cited *infra* note 156.

155. There are exceptions. See, e.g., *State Auto Prop. & Cas. Ins. Co. v. St. Louis Supermarket #3, Inc.*, No. 4:04CV1358 TCM, 2006 WL 27292 at *6-*8 (E.D. Mo. Jan. 5, 2006).

156. See, e.g., *Peachtree Cas. Ins. Co., Inc. v. Sharpton*, 768 So.2d 368, 373 (Ala. 2000) (stating that the fact that Insurance Department approved policy language did not preclude judicial invalidation of that language as contrary to statute); *Lindahl v. Howe*, 345 N.W.2d 548, 551 (Iowa 1984) (noting that Commissioner's approval does not divest courts of the duty to give statute its ultimate authoritative interpretation); *Mich. Chiropractic Council v. Comm'r of Fin. & Ins. Serv.*, 685 N.W.2d 428, 439 (Mich.App. 2004) (stating that the agency's decision to approve policy was inconsistent with statutory no-fault rules and thus reversible by court); *Cruz v. State Farm Mut. Auto. Ins. Co.*, 614 N.W.2d 689, 694 (Mich. App. 2000) (noting that approval of an insurance form by the Commissioner of Insurance is not conclusive proof that it complies with statute; instead, approval is "only

Insurance Department approves provisions contrary to statute, it exceeds its authority and its action is invalid.¹⁵⁷

Apart from the cases involving statutory violations, most courts have not addressed the effect of regulatory approval on judicial interpretation and construction of insurance policies. Courts generally interpret and construe insurance policies without acknowledgment that insurance regulators approved the language, often with a resulting focus on the intent of the parties and the public policy of protecting freedom of contract.

The few decisions considering the impact of regulatory approval on the judicial role have reached varying conclusions.¹⁵⁸ Not surprisingly,

somewhat persuasive” that form complies with statute); *Watson v. United Servs. Auto. Ass’n*, 566 N.W.2d 683, 692 (Minn. 1997); *Volquardson v. Hartford Ins. Co.*, 647 N.W.2d 599, 612 (Neb. 2002) (noting that the Director of Insurance had no authority to approve policy form which did not provide minimum coverage afforded by statute); *Spulak v. Tower Ins. Co., Inc.*, 601 N.W.2d 720, 725 (Neb. 1999) (finding that an exclusion for criminal acts by insured or others reduced coverage required by statute and therefore, Director’s approval exceeded his authority); *Rider Ins. Co. v. First Trenton Cos.*, 808 A.2d 143, 148 (N.J. Super. 2002); *McMillan v. Allstate Indem. Co.*, 84 P.3d 65, 70 (N.M. 2003); *Johnson v. Lincoln Nat’l Life Ins. Co.*, 590 N.E.2d 761, 764 (Ohio App. 1990); *Fleming v. United Servs. Auto. Ass’n*, 996 P.2d 501, 504 (Or. 2000) (noting that approval by Insurance Commissioner is not assurance that approved language is consistent with statute); *Brader v. Nationwide Mut. Ins. Co.*, 411 A.2d 516, 517 (Pa. Super. 1979) (finding that if provision approved by Commissioner is contrary to law, approval is also invalid since such approval exceeds power granted to Commissioner); *Mid-Century Ins. Co. v. Lyon*, 562 N.W.2d 888, 892 (S.D. 1997); *Fleming v. Yi*, 982 S.W.2d 868, 871 (Tenn. App. 1998) (stating that insurance commissioner’s approval is a factor to be considered, but not conclusive).

157. See cases cited *supra* note 156.

158. The decisions range from no deference to complete deference, as the text demonstrates. This variation in the level of judicial deference to regulatory authority is reflected in contexts other than insurance regulation. *Compare* *McKenzie Check Advance of Fla., LLC v. Betts*, 928 So.2d 1204, 1215 (Fla. 2006) (holding that a court must defer to an agency interpretation as long as the interpretation is consistent with the legislative intent and is supported by substantial, competent evidence) *with* *Bd. of Educ. of Town of Hamden v. State Bd. of Educ.*, 898 A.2d 170, 175 (Conn. 2006) (“When a state agency’s determination of a question of law has not previously been subject to judicial scrutiny. . . the agency is not entitled to special deference. . . . [I]t is for the courts, and not administrative agencies, to expound and apply governing principles of law.”) The Model State Administrative Procedure Act, 1961, 1981, and the 2005 Draft, §C5-109, contemplates broad judicial review, permitting judicial action where state agency action exceeds the authority or violates limits imposed by federal or state constitution, statute, common law, and any other source of law binding on the agency, fails to follow prescribed procedure, is arbitrary, capricious, or an abuse of discretion. This scope of review provision is substantially similar to the scope of review provisions of the Federal Administrative Procedure Act, 5 U.S.C. §706. But note APA does not apply to suit for damages where the agency does not have authority to determine the claim.

however, when a court acknowledges the regulatory context, it typically affords some level of deference to the regulator, indicating that contract is not an appropriate analytical frame. A few courts have ruled that regulatory approval binds the court, precluding judicial consideration of the reasonableness of policy provisions.¹⁵⁹ In these jurisdictions, regulatory approval functions like the principle of freedom of contract, precluding judicial analysis and resulting in the enforcement of policy language. This result is an inappropriate abdication of the judiciary's role in reviewing contract language and adjudicating disputes. The legislative requirement of regulatory approval is not a divestiture of ordinary judicial functions to interpret insurance policies and adjudicate insurance disputes.¹⁶⁰ The reality is that the approval process is pro forma in many instances; file and use is a common regulatory mechanism.¹⁶¹ The importance of the requirement of regulatory approval is not that it eliminates or minimizes judicial power, but rather that it focuses judicial efforts away from the interpretive paradigm of contract.

159. See, e.g., *Rory v. Continental Ins. Co.*, 703 N.W.2d 23, 35 (Mich. 2005) (“Reasonableness of insurance contracts is a matter for the executive, not judicial, branch of government....[T]he lower courts were not free to invade the jurisdiction of the Commissioner and determine de novo whether Continental’s policy was reasonable.”); *AMEX Assurance Co. v. Caripides*, 179 F.Supp.2d 309, 319 (S.D.N.Y. 2002) (holding that the Insurance Department’s review and approval of a policy is presumptively valid and cannot be challenged as unfair or violative of public policy); *McGraw v. Farm Bureau General Ins. Co.*, 731 N.W.2d 805, 808 Mich. Ct. App. 2007). See also *Wright v. Kelleher*, 21 Mass. L. Rptr. 686 (Mass. Dist. Ct. 2006) (questioning policyholder’s public policy argument given approval of the policy language by the Commissioner of Insurance); *Allen v. Prudential Property and Cas. Ins. Co.*, 839 P.2d 798, 804 (Utah 1992) (rejecting the reasonable expectations doctrine as undercutting executive approval of insurance policies). An interesting and, to my knowledge, unique variation of this approach appears in a decision of the Supreme Court, where the court ruled that because the Commissioner was required to approve auto policies, the court would not resolve ambiguities in favor of the insured. *Gilbert v. Hanover Ins. Co.*, 624 N.E.2d 621 (Mass App. Ct. 1993). Occasionally the legislature specifically answers this question. See *Firestone v. Acuson Corp. Long Term Disability Plan*, 326 F.Supp.2d 1040 (N.D. Cal. 2004) (holding that California statute enumerating requirements for disability policies provided that commissioner’s approval created conclusive presumption, as between the insured and the insurer, that the policy conformed to the statute, Cal. Ins. Code 10291.5(k)).

160. The statutes discussed *infra* at text accompanying notes 162-171 support this conclusion. See also *Rory v. Continental Ins.*, 703 N.W.2d 23, 50 (Mich. 2005), (Kelly, J., dissenting).

161. See WESTLAW 50 STATE STATUTORY SUREVEYS, INSURANCE, AGENTS, BROKERS, AND PROCEDURES, POLICIES AND APPLICATIONS (September 2006).

Other courts have found specifically that regulatory approval is not binding on the judiciary. Under this view, judges owe varying levels of deference to the insurance regulator's approval.¹⁶² Courts have ruled variously that the insurance regulator's approval is entitled to no deference;¹⁶³ "some consideration";¹⁶⁴ "great respect";¹⁶⁵ "great weight";¹⁶⁶ or simply, "deference".¹⁶⁷ The better-reasoned view, as outlined above, is that the filing and approval of a policy by the Insurance Commissioner does not constitute the type of administrative regulation which justifies judicial deference to the decision of the administrative agency.¹⁶⁸

162. See generally 1 COUCH ON INS. §2:8.

163. *Maska U.S., Inc. v. Kansa Gen. Ins.*, 198 F.3d 74, 80, 82 (2d Cir. 1999) (indicating that public policy as expressed in statute or common law directive may warrant invalidation of approved insurance policy provision); *Schneider v. UNUM Life Ins. Co. of America*, 149 F.Supp.2d 169, note 4 (E.D. Pa. 2001); *Reichardt v. Life Ins. Co. of North America*, 485 F.Supp. 56, 57 (N.D. Cal. 1979); *Parkway Ins. Co. v. N.J. Neck & Back*, 748 A.2d 1221, 1222 (N.J.Super. Ct. Ap. Div. 1998) (holding that the Commissioner's authority is absolute so long as the rules and regulations are consistent with the statutes and public policy); *Seligman v. Tucker*, 347 N.Y.S.2d 240 (N.Y. 1973) (administrative approval of a policy by the Superintendent of Insurance cannot defeat public policy of the state of New York). See also *S. Farm Bureau Life Ins. v. Banko*, 2006 WL 2935281 (M.D. Fla. 2006) (noting that plaintiff could cite no case indicating that regulatory approval of an insurance policy form bars suits over policy language).

164. *State Farm Mut. Auto. Ins. v. Barnard*, 156 S.E.2d 148 (1967).

165. *Am. Nat. Ins. v. Ingle*, 129 S.W.2d 426 (Tex. Civ. App. 1939).

166. *Lee v. John Deere Ins.*, 802 N.E.2d 774, 779 (Ill. 2003) (holding that the approval of a limitation period by an Insurance Department is not conclusive on courts, but is entitled to great weight against contention that such a provision is against public policy); *Kirk v. Fin. Sec. Life Ins.*, 389 N.E.2d 144, 148 (Ill. 1978) (holding that the approval of a 90 day limitations period by the Commissioner is entitled to great weight against contention that the provision is against public policy); *Kukoleck v. Minnesota Life Ins. Co.*, 2005 WL 3447623 (N.D.W.Va. 2005) (holding that where West Virginia Code explicitly required the commissioner of insurance to disapprove policies not in the public interest, the commissioner's approval is strong evidence that exclusionary language not contrary to public policy); *Am. Home Assurance v. Stone*, 61 F.3d 1321, 1328 (7th Cir. 1999) (holding that an Insurance Department's approval of "Sexual Misconduct" provision is not conclusive but is entitled to great weight against challenge on public policy grounds).

167. *Azar v. Prudential Ins. Co. of Am.*, 68 P.3d 909, 930 (N.M.App. 2003) (holding that where statute and regulations do not directly address the issue of modal premium charges, courts may make an independent determination that is unconstrained by the prior administrative approval of such a policy).

168. *Generette v. Donegal Mut. Ins.*, 884 A.2d 266, 280 (Pa. Super. Ct. 2005); *Allwein v. Donegal Mut. Ins.*, 671 A.2d 744, 753 (Pa. Super. Ct. 1996) (quoting Alan I. Widiss, UNINSURED AND UNDERINSURED MOTORIST INSURANCE §32.3); *Lindahl v. Howe*, 245 N.W.2d 548, 551 (Iowa 1984) ("Assuming the policy was approved . . . we have no reason to treat acquiescence in the form of the policy as an adjudication by the

In jurisdictions affording some deference, the level of that deference may depend on the nature and extent of the approval process. For example, regulatory approval of a policy form without explicitly passing on the issue of the form's compliance with a statutory requirement is entitled to little weight.¹⁶⁹ The level of deference may also take account of the scope of the regulator's power and obligations. For example, some state statutes require disapproval of a policy form where it contains "an inconsistent, ambiguous, or misleading clause, or exception and condition that deceptively affects the risk purported to be assumed in the general coverage of the contract."¹⁷⁰ It is the function of the courts to interpret and apply legislative requirements.

Where contract is the analytical frame, courts focus on the intent of the parties and the value of freedom of contract, and enforcement of the plain language of an insurance policy is inescapable. Where courts focus instead the nature of insurance as invested with public policy, through legislative and executive controls, even clear policy language need not be enforced if it conflicts with regulatory goals.

In addition to the case law, state statutes provide ample ground for a court to examine, interpret, and even to disregard, policy language approved by insurance regulators. Many state insurance codes include specific provisions relevant to the issue of the effect of regulatory approval. Some codes provide that the insurance commissioner "shall" or "must" disapprove a policy form if it contains or incorporates by reference any inconsistent, ambiguous, or misleading clause, or exceptions and conditions which deceptively affects the risk purported to be assumed in the general coverage of the contract.¹⁷¹

commissioner of the validity of the exclusion. Such acquiescence could not in any event divest the courts of their duty to give the statute its ultimate authoritative interpretation."), *overruled by* *Miller v. Westfield Ins.*, 606 N.W.2d 301 (Iowa 2000).

169. *Burke v. First UNUM Life Ins.*, 975 F.Supp. 310, 316 n.13 (S.D.N.Y. 1997) (holding that correspondence between Insurance Department and insurer reflected no consideration of whether the language of the policy's incontestability clause conformed to statutory requirements); *Durant v. Motor Vehicle Acc. Indem. Corp.*, 20 A.d.2d 242, 247-249, (N.Y. App. 1964) (holding that the lack of an express as opposed to implicit approval of policy form was relevant in determining the weight to be given to Superintendent's view of conformity to statutory requirements).

170. See *infra* text accompanying note 171.

171. See, e.g., ALASKA ST. §21.42.130 (2007); DEL.CODE ANN, tit 18, §2713 (1999); FLA.STAT. §627.411 (2005); GA.CODE ANN. §33-24-10 (1998); IDAHO CODE ANN. §41-1813(2) (2004); KY.REV.STAT.ANN. §304.14-130(1)(b) (2006); LA.REV.STAT.ANN. §22:621(3) (2004); ME.REV.STAT.ANN. 24-A §2413(1)(B) (2006); MONT. CODE ANN. §33-1-502 (2006); NEV.REV.STAT. §687B.130(2) (2003); N.M. LAWS. §59A-18-14 (1978);

Similar statutes require disapproval of a form if it contains provisions which are unfair, inequitable, or contrary to the state's public policy.¹⁷² These statutes do not specify who makes the determination of ambiguity or unfairness or whose determination prevails.¹⁷³ The normal exercise of judicial power permits a court to determine that policy provisions are ambiguous, deceptive, unfair, or contrary to public policy within the meaning of the statute and to construe the provisions to avoid statutory violations occasioned by an insurance regulator's approval, accomplishing the legislative objective of protecting insurance consumers. There are almost no cases addressing the construction and application of these statutes. However, at least one case recognized that their goal is to protect policyholders by permitting courts to extend appropriate coverage where the commissioner approved a policy in contravention of the statute's requirements.¹⁷⁴ A few similar statutes explicitly assign the determination to the insurance regulator, apparently leaving no room for substantive judicial evaluation.¹⁷⁵

OKLA.STAT.ANN. tit. 36 §3611(A)(2) (2004); S.D. CODIFIED LAWS §58-11-21(2) (2004); VT. STAT. ANN. tit. §3542(2) (2001); V.A.CODE ANN. 38.2-316(1950); WASH.REV.CODE §48.18.110(1)(c) (1999); W.VA.CODE §33-6-9(b) (2006); WYO. STAT. ANN. §26-15-111(B) (2007). One statute appears to contemplate both judicial review of the commissioner's action, with respect to ambiguous or deceptive clauses, and unreviewable exercise of the commissioner's discretion, with respect to rates. *Compare* WYO. STAT. ANN. §26-15-111(a)(i) ("The commissioner . . . shall disapprove any form . . . if the form contains . . . any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which deceptively affect the risk") with (a)(ii) ("The commissioner . . . shall disapprove any form if *he finds* that the benefits provided in the policy are unreasonable in relation to the premiums charged, or the rates or classification are excessive, inadequate or unfairly discriminatory.").

172. *See, e.g.*, ALA. CODE §27-14-9(54) (1974) (form contains provisions which are "unfair, or inequitable or contrary to the public policy of this state or which would, because such provisions are unclear or deceptively worded, encourage misrepresentation"); GA. CODE ANN. §33-24-10(5) (1960) (form contains "provisions which are unfair or inequitable or contrary to the public policy of this state"); IDAHO CODE ANN. §41-1813(2) (1961) (form contains clause which is "unfairly prejudicial to the policy holder"); (NEV. REV. STAT. §687B.130(2) (1971) (form contains "any provision or provisions prejudicial to the interest of the insured or policyholder"); W. VA. CODE §33-6-9(f) (1957) (if coverages provided in form "are not sufficiently broad to be in the public interest").

173. *See* WYO. STAT. ANN. §§25-15-111(A), (B) (1957), *supra* note 171.

174. *Excelsior Ins. Co. v. Pomona Park Bar & Package Store*, 369 So.2d 938, 941 (Fla. 1979). *See also* *Strickland v. Gulf Life Ins. Co.*, 242 S.E.2d 148, 151 n.4 (Ga. 1978). Some decisions caution that these provisions do not give judges a mandate to rewrite insurance policies. *American Fidelity Co. v. Mahoney*, 174 A.2d 446, 450 (Me. 1961).

175. HI. REV. STAT. §431:10A-406 (1987) ("the commissioner shall disapprove the forms for such insurance *if the commissioner finds* that they are unjust, inequitable, misleading, or deceptive.") (emphasis added); OR. REV. STAT. §§742.005(3), (4) (1991) (the

Judges may also avoid binding effects of the commissioner's approval of problematic policy language by determining that approval exceeded the commissioner's statutorily prescribed authority. In delineating the Insurance Commissioner's powers, some state statutes provide that the Commissioner may not take action which "extends, modifies, or conflicts with any law of the state."¹⁷⁶ These statutes typically refer to Commissioners' powers to make rules or regulations. It is not clear from the cases or the statutes whether approval of policy forms constitutes rulemaking or adjudication. The APA defines "rule" to include "the approval . . . of services,"¹⁷⁷ which may be reasonably interpreted to include approval of insurance policy forms for use in a state.¹⁷⁸ The new Revised Model State Administrative Procedure Act provides a broad definition of "rule"¹⁷⁹ and then excludes a number of specific agency actions, none of which resemble approval of policy forms by insurance regulators.¹⁸⁰ At least one case suggests that approval is rulemaking rather than adjudication.¹⁸¹ If this view is correct, approval of a policy which

Director shall disapprove any form "if, *in the director's judgment*, its use would be prejudicial to the interests of the insurer's policyholders", or "if *the director finds* it contains provisions which are unjust, unfair, or inequitable." (emphasis added). *See also* Starr-Gordon v. Mass. Mut. Life Ins. Co., 2006 WL 3218778 (E.D. Cal.2006) (holding that policy approved by commissioner is "conclusively presumed to be unambiguous" based on CAL.INS. CODE §10291.5 (West 1941), which provides (The commissioner shall not approve any disability policy . . . if the commissioner finds that it contains any provision, or has any label, description of its contents, title, heading, backing, or other indication of its provisions which is unintelligible, uncertain, ambiguous, or abstruse, or likely to mislead a person to whom the policy is offered.) The Alabama statute accomplishes the same result by making the decision to approve or disapprove discretionary. ALA. CODE §27-14-9 (1975) ("The commissioner *may* disapprove any form . . . if it contains . . . any inconsistent, ambiguous or misleading clauses or exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract.") (emphasis added).

176. *See, e.g.*, ALA. CODE §27-2-17 (1075); DEL. CODE tit. 18 §311 (1953); WYO.STAT. ANN §26-2-110 (1931). *Pa. Dental Ass'n v. Commonwealth*, 441 A.2d 1379 (Pa. Commw. Ct. 1982) (action of Department of Insurance in approving comprehensive dental plan was not an adjudication). Under that view, the statutes would apply.

177. Administrative Procedure Act 5 U.S.C. §551(4) (1946).

178. It is also possible to read the APA such that approval of a policy form would constitute an "adjudication." Under the APA, "adjudication" means the formulation of an "order", 5 U.S.C § 511(7); "orders" include final dispositions of agencies in matters other than rulemaking but including licensing, 5 U.S.C. §551(6); and "license" includes an agency approval, 5 U.S.C. §551(8).

179. Revised Model State Administrative Procedure Act §102 (26) (2007).

180. *Id.*

181. *Pa. Dental Ass'n*, 441 A.2d at 1382 (action of Department of Insurance in approving comprehensive dental plan was not an adjudication).

conflicts with “any law” is beyond the power of the regulator. Cases in which courts refuse to enforce approved policy language which contravenes statutory requirements,¹⁸² fall within the scope of such statutes. These statutes have a much broader reach, however, given the breadth of the language, “any law,” which is typically interpreted to include not only statutory and regulatory law, but also decisional law. If a policy provision contravened a judicial ruling, it would be beyond the power of the regulator to approve it and within the judiciary’s responsibilities to override any approval. Again, there are no cases construing these statutes.¹⁸³

In short, application of contract doctrine to insurance disputes minimizes the judicial role in furthering the goals of insurance regulation, while recognition that insurance policies are highly regulated documents expands that role.

V. INTERPRETATION: CONTRACT DOCTRINE AND THE REGULATORY PERSPECTIVE COMPARED

This section provides contrasting examples of policy interpretation from contract and regulatory perspectives. The section focuses on the problem of innocent co-insureds. The issue arises when one of the persons insured under a homeowners policy engages in an act which voids the policy coverage. Arson is a common example; the question is whether the policy is also void with respect to an innocent co-insured, who is often a victim of domestic violence. If so, the innocent co-insured loses not only his or her insurance coverage, but as a practical matter, may lose the family home. Where the court’s interpretive frame is contract, the innocent co-insured loses coverage. Where the court acknowledges the regulated nature of insurance, the result is the opposite.

Standard homeowners policies typically cover the named insured and a resident spouse and relatives who reside in the household or dependent persons in care of named insured.¹⁸⁴ Policies also typically exclude injury or damage which is expected or intended by “an insured,”¹⁸⁵ “the

182. *See id.*

183. There is some case law holding that an administrative act of approving the form of an insurance policy cannot overcome the law settled by state courts. *Seligman v. Tucker*, 347 N.Y.S.2d 240, 243 (N.Y. App. Div. 1973).

184. *See, e.g.,* INSURANCE SERVICES OFFICE, INC., HOMEOWNERS 3 SPECIAL FORM, DEFINITIONS, B.5. (1999)

185. *Id.*

insured,”¹⁸⁶ “any insured person,”¹⁸⁷ or “any insured.”¹⁸⁸ Other policies are more detailed, precluding coverage for “any loss caused intentionally by you or a family member, or by a person directed by you or a family member to cause a loss.”¹⁸⁹

The contract-based approach to the innocent co-insured problem is simple. The intent of the parties controls, so the court’s objective is to determine that intent as manifested by the policy language. Whether the intentional acts of a co-insured will defeat coverage for an innocent co-insured turns on the exclusionary language used in the policy. A policy excluding losses caused by intentional acts of “any insured” or “an insured” creates a joint obligation among co-insureds and bars coverage for both the malefactor and innocent co-insureds.¹⁹⁰ Where the policy uses the

186. This is the language of the standard Allstate Insurance policy. *Allstate Ins. Co. v. Callahan*, No. 3:CV-04-2246, 2006 WL 1626651 at *5-6 (M.D.Pa. June 7, 2006)

187. *Id.* at * 3.

188. *Id.*

189. *Yerardi v. Pac. Indem. Co.*, 436 F.Supp.2d 223,232 (Mass. Dist. Ct. 2006)

190. *Pagett v. Allied Mut. Ins. Co.*, No. 2:05CV00042, 2006 WL 2246428, at *5 (E.D. Mo. Aug. 4, 2006) (holding that an unambiguous intentional loss exclusion was enforceable against an innocent co-insured); *N.J. Mfr Ins. Co. v. Carney*, No. 3:04-CV-2465, 2006 WL 2092571 at *3-4 (M.D. Pa. July 26, 2006) (holding that under language “an insured” or “any insured”, the intentional act of one insured excludes coverage for the innocent co-insured; however, where the husband was the sole owner, the wife’s arson did not prevent coverage); *Allstate Ins. Co. v. Callaghan*, No. 3:CV-04-2246, 2006 WL 1626651 at *6 (M.D. Pa. June 07, 2006) (holding that the insurer had no duty to defend where the plaintiff sued for deviate sexual behavior by her minor son against a child in daycare operated by the mother and for negligent supervision by the father; the policy excluded injury resulting from intentional or criminal acts of “any insured person”); *Bonin v. Westport Ins. Corp.*, 930 So. 2d 906, 916 (La. 2006) “This policy shall not apply to any claim arising out of, attributable to, or directly or indirectly resulting from: any criminal, dishonest, malicious or fraudulent act, error, omission or personal injury committed by an insured.”); *Yerardi*, 436 F.Supp.2d at 248 (holding that there is no recovery available if either spouse engaged in intentional conduct under an exclusion for loss that was caused intentionally by insured or a family member); *Stand. Fire Ins. Co. v. Proctor*, 286 F.Supp.2d 567, 573 (D. Md. 2003); *McEwin v. Allstate Tex. Lloyds*, 118 S.W.3d 811, 815 (Tex. App. 2003). The Eastern District of Missouri recently considered and rejected the regulatory approach. *State Auto Property and Cas. Ins. Co. v. St. Louis Supermarket #3, Inc.*, No. 4:04CV1358, 2006 WL 27292 at *6 (E.D. Mo. Jan. 05, 2006) (upholding a broad exclusion when the Director of Insurance approved a policy not in conformance to the required 1943 Standard Form Insurance Policy of the State of New York under authority of 20 C.S.R. 500-1.100(1)(B), relying on case law upholding exclusion without considering regulatory issues. Case law indicates form consistent with Missouri law; no discussion of whether provision “as favorable”); *but see Childers v. State Farm Fire & Cas. Co.*, 799 S.W.2d 138, 140 (Mo. App. 1990) “Under the law the court must accept the written policy as the expression of the agreement made by the parties, and give effect to the intentions of the parties as disclosed

words, “the insured”, the obligation is several, and the exclusion applies only to the insured who intended the act and caused injury, not an innocent co-insured.¹⁹¹

When a court faced with an innocent co-insured focuses on the nature of the policy as a regulated document, the result may change. Most jurisdictions require by statute a standard fire policy.¹⁹² The provisions of this standard, or substitute provisions affording at least the same level of coverage, must appear in commercial and personal property policies. The statutory standard policy does not contain an exclusion for intentional acts, so there is no argument that the exclusion conflicts with the standard.¹⁹³ However, the standard includes provisions voiding coverage in cases of fraud¹⁹⁴ and excluding coverage for losses resulting from increased risk¹⁹⁵ or neglect following a loss.¹⁹⁶ These and other provisions (dealing with cancellation, renewal, and other issues) use the phrase “the insured” rather than “an insured” or “any insured.” Reasoning that the consistent use of “the insured” evinces a general legislative intent to apply the limiting provisions only to the insured at fault, a number of courts have protected

by clear and unambiguous language.”); *see also* *Amick v. State Farm Fire & Cas. Co.*, 862 F.2d 704, 706 (8th Cir. 1988) (applying Missouri law and upholding the exclusion as clear and unambiguous and approved by the director of insurance).

191. *Osborn v. Nat’l Union Fire Ins. Co.*, 632 So.2d 1158, 160 (La. 1994) (holding that when the husband intentionally set fire to the house, the wife recovered under a policy excluding specified acts by “the insured.”).

192. New York adopted a standard fire policy in 1943 and mandated its use. N.Y. CONSOL. LAW §3404 (McKinney 2007). Many other states followed New York’s example and enacted the 1943 standard or a similar policy. 10A COUCH ON INS. §149:3 (2007).

193. This type of case, in which the policy violates a statute, is discussed *supra*, text accompanying notes 154-56.

194. The New York Standard Fire Policy provides: “This entire policy shall be void if, whether before or after a loss, *the insured* has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto.” N.Y. CONSOL. LAWS §3404 (2007) (emphasis added).

195. The New York Standard Fire Policy provides: “Unless otherwise provided in writing added hereto this Company shall not be liable for loss occurring (a) while the hazard is increased by any means within the control or knowledge of *the insured*.” *Id.* (emphasis added).

196. The New York Standard Fire Policy provides: “This Company shall not be liable for loss by fire or other perils insured against in this policy caused, directly or indirectly, by: . . . (i) neglect of *the insured* to use all reasonable means to save and preserve the property at and after a loss, or when the property is endangered by fire in neighboring premises.” N *Id.* (emphasis added).

innocent co-insureds in the face of unambiguous language dictating the opposite result.¹⁹⁷

The application of other approaches discussed in Section IV to the problem of the innocent co-insured would permit the same result. A policy which excludes coverage for an innocent co-insured by using the article “an” rather than “the” in the intentional loss exclusion could easily be considered misleading or deceptive regarding the risk to be assumed within the meaning of various state statutes which require disapproval of a policy form in such instances.¹⁹⁸ Judicial correction of an insurance commissioner’s failure to disapprove such language is permissible. Similarly, such an exclusion might be considered unfair, inequitable, or contrary to a state’s public policy under state statutes which also mandate disapproval under such conditions.¹⁹⁹ Again, the statutes permit a court to override the commissioner’s decision to approve the language.

VI. CONCLUSION

The extensive regulation of insurance policy language, ranging from legislatively-mandated provisions to required administrative approval

197. *Sager v. Farm Bureau Mut. Ins. Co.*, 680 N.W.2d 8, 15 (Iowa 2004); *Icenhour v. Cont’l Ins. Co.*, 365 F.Supp.2d 743, 751 (S.D.W.Va. 2004) (holding that a West Virginia court would refuse to enforce unambiguous policy language excluding coverage for loss “involving intentional or criminal acts of or at the direction of one or more covered persons”); *Nangle v. Farmers Ins. Co. of Arizona*, 73 P.2d 1252, 1258 (Ariz. App. 2003); *Trinity Univ. Ins. Co. v. Kirsling*, 73 P.3d 102, 107 (Idaho 2003); *Volquardson v. Hartford Ins. Co. of the Midwest*, 647 N.W.2d 599, 607 (Neb. 2002); *Lane v. Sec. Mut. Ins. Co.*, 747 N.E.2d 1270, 1271 (N.Y. 2001); *Watson v. United Serv. Auto Ass’n*, 566 N.W.2d 683, 692 (Minn. 1997). *See also* *Yerardi v. Pac. Indem. Co.*, 436 F.Supp.2d 223, 232, 247 (Mass. Dist. Ct. 2006) (refusing to consider statutory fire insurance policy where Massachusetts had not considered the issue); *Spulak v. Tower Ins. Co., Inc.*, 601 N.W.2d 720, 725 (Neb. 1999) (holding that an exclusion was invalid because the director of insurance exceeded his authority in approving an exclusion where §44-501 specified a standard policy and permitted variation only if the variation was substantially equivalent to the standard). Following a decision by the Iowa Supreme Court protecting an innocent co-insured under this analysis, *Sager*, 680 N.W.2d 8, the Iowa legislature revised the statute to read “an insured” in provisions dealing with fraud, increased risk, and neglect in protecting property after loss. Iowa Code Ann. §515.138; Acts 2005, ch. 70, S.F. 360 §§19 and 20. The state Legislature thereafter amended the language of Iowa Code §515.138 to abrogate the *Sager* decision. 2005 Iowa Acts (Senate File 360 at §§19-21).

198. *See supra* text accompanying note 171. The insurance commissioner must disapprove a form which is misleading or contains an exception which “deceptively affects the risk purported to be assumed”.

199. *See supra* text accompanying notes 172-75.

of policies, renders the model of private contract and the principle of freedom of contract irrelevant in interpretation of insurance policies. Courts should approach the construction of insurance policies mindful that they are not individually negotiated bargains but highly regulated documents; the judicial goal should be ascertaining and effectuating regulatory goals, rather than the illusory intent of the parties.

BAD FAITH IN ALABAMA’S CIVIL JUSTICE SYSTEM: “TORT HELL” OR REFORMED JURISDICTION?

Kristen LeBlond

I. INTRODUCTION

The perception of Alabama in the late 1980s and early 1990s as “tort hell” for corporate defendants has left many insurance companies reluctant to write business and thereby take on litigation exposure in the state.¹ Since that time period meaningful and significant changes have taken place. The combination of a dramatic shift in the composition of the Alabama Supreme Court, punitive damage reform, tort reform and the evolution of the bad faith cause of action has produced an environment vastly different from that of the late 1980s and early 1990s. This note examines Alabama’s transition from tort hell to a jurisdiction where plaintiffs carry a heavy burden in asserting bad faith and where punitive damages are regularly and significantly reduced on appeal.

II. ALABAMA AS TORT HELL

Alabama’s reputation as “tort hell on a monumental level”² developed in the late 1980s and early 1990s as juries began to routinely return verdicts characterized by large punitive damage awards,³ often for conduct that fell “far short of the kinds of ‘reprehensible’ behavior that had been required for punitive damages in the past.”⁴ A study done in the 1990s revealed that, in general, multi-million dollar punitive damage verdicts were

1. Nathan C. Prater, Comment, *Punitive Damages in Alabama: A Proposal for Reform*, 26 CUMB. L. REV. 1005, 1016 (1995-1996); Linda Himmelstein, *Jackpots from Alabama Juries*, BUS. WK., Nov. 28, 1994, at 83; Jerry Underwood, *Big-Money Verdicts Scare State Farm Bypasses State for New Site*, BIRMINGHAM NEWS, Dec. 6, 1995, at 6D.

2. Chad E. Stewart, Comment, *Damage Caps in Alabama’s Civil Justice System: An Uncivil War Within the State*, 29 CUMB. L. REV. 201, 213 (1998-1999).

3. George L. Priest, *Punitive Damages Reform: The Case of Alabama*, 56 LA. L. REV. 825, 826-27 (1996).

4. Michael DeBow, *The Road Back from “Tort Hell”: The Alabama Supreme Court, 1994-2004*, THE FEDERALIST SOCIETY FOR LAW AND PUBLIC POLICY WHITE PAPERS, at 3-4 (Oct. 15, 2004), http://www.fed-soc.org/doclib/20070325_alabama2004.pdf.

extremely rare.⁵ However, that rule did not hold true for Alabama where between 1991 and 1994 there were 60 punitive damage verdicts equal to or greater than \$1 million.⁶ Individual verdicts reached magnitudes of \$25 million, \$33.5 million, \$45 million and \$65 million.⁷ A study conducted by George Priest, a professor of law and economics at Yale Law School,⁸ indicated that Alabama juries awarded over \$767 million in punitive damages between 1989 and 1996 and that civil awards in Alabama increased by 400% from 1985 to 1994.⁹ Priest commented that Alabama's punitive damage awards were "unparalleled in the history of American jurisprudence."¹⁰

The refusal of the appellate courts to interfere with these verdicts also facilitated the unusual trend. Between the years 1987 and 1994 the Alabama Supreme Court affirmed \$53.2 million in punitive damage awards.¹¹ According to Gibson, Dunn & Crutcher, a law firm that studied the punitive damages issue on behalf of an insurance company, the amount of punitive damages upheld in Alabama for those years was three times the amount upheld by its three neighboring states combined (Georgia, Mississippi and Tennessee).¹² These excessive punitive damage verdicts during the 1980s and early 1990s would soon be charged with having deleterious consequences to Alabama's populace, and especially to its business community.

III. IMPACT OF TORT HELL ON BUSINESS IN ALABAMA

During the late 1980s and early 1990s, the largest criticism of punitive damage law in Alabama was that it was driving businesses to leave the state.¹³ During the 1994 gubernatorial election, the spokesman for gubernatorial candidate Fob James, stated that, "Alabama has gained a very unfortunate reputation as being a place where you can get sued out of business."¹⁴ The result of the business community's fear and anxiety over

5. Priest, *supra* note 3, at 827.

6. *Id.*

7. *Id.*

8. Yale Law School Faculty Biographies, <http://www.law.yale.edu/faculty/GPriest.htm> (last visited Nov. 15., 2007).

9. Stewart, *supra* note 2, at 213-14.

10. Prater, *supra* note 1, at 1016.

11. Priest, *supra* note 3, at 829.

12. Himelstein, *supra* note 1, at 84.

13. Prater, *supra* note 1, at 1016.

14. *Id.*

large punitive damage verdicts was particularly felt by Alabama's insurance industry. In the early 1990s, as many as ten insurance companies announced plans to no longer write new business in Alabama, eliminate plans to invest further in the state, or cease operating in Alabama altogether.¹⁵ One example occurred in 1995 when State Farm, an insurance company, was considering Birmingham as a site for its life and health insurance operations.¹⁶ A spokeswoman for the insurer cited the state's "unfriendly reputation for big-money verdicts against insurers" as one of the main reasons why the company ultimately decided to forego a location in Birmingham.¹⁷ The insurance industry was dealt such a blow from Alabama's runaway juries that even the state's insurance regulatory arm spoke up. By late 1994, Alabama insurance regulators spoke out against the disproportionate verdicts and their impact on business at the post trial proceedings of as many as 13 cases.¹⁸

The large punitive damage verdicts were not the only reason why insurers and other corporate defendants were fleeing Alabama. The impact that these verdicts had on the cost of settlement also impacted the bottom line for these corporations. As citizens repeatedly witnessed multi-million dollar punitive damage verdicts, they became more comfortable granting such awards when on sitting on juries themselves.¹⁹ These awards in turn drove up the cost a corporate defendant would have to pay to settle a case.²⁰ If a plaintiff anticipated a large punitive damage award they would be less likely to settle their case for a lower sum. As a result, legal costs began to eat into profits and Alabama became a less and less attractive jurisdiction in which to do business.

IV. THE TORT OF BAD FAITH & ITS ORIGINS IN ALABAMA

A. BRIEF HISTORY OF THE TORT OF BAD FAITH

One reason why Alabama's civil justice system and its position on punitive damages impacted the insurance industry so greatly was because of the tort of bad faith. The insurance business revolves around the insurance contract and as a result many lawsuits brought against insurance

15. *Id.*; Himelstein, *supra* note 1, at 83.

16. Underwood, *supra* note 1, at 6D.

17. *Id.*

18. Himelstein, *supra* note 1, at 84.

19. *Id.*

20. *Id.*

companies are based on the tenets of contract law. However, the amount one can recover from a contract-based cause of action is not comparable to that which is recoverable in tort.²¹ This is because punitive damages are not recoverable for breach of contract or other contract-based actions.²² Thus, the tort of bad faith became an important avenue through which a plaintiff could seek punitive damages in a lawsuit against an insurance company.²³

Historically, the tort of bad faith originated from liability insurance and the insurer's duty to defend its insured.²⁴ In the early 1900s courts began to hold insurers liable when they "unreasonably" refused to settle a lawsuit within the policy limits.²⁵ The rationale behind the imposition of liability in this context was that the insurer controlled the litigation on behalf of its insured and could pursue its own interests by refusing a settlement offer within the policy limits in hopes of being found not liable at trial.²⁶ This left the insured "at the mercy" of the insurance company because if the trial resulted in damages greater than the policy limit the insured would be responsible for the excess.²⁷ The courts reacted by imposing a duty on the insurer to acknowledge its insured's interests when faced with the opportunity for settlement.²⁸ If the insurer breached that duty by unreasonably refusing to settle within the policy limits it would be liable for any excess judgment that resulted.²⁹

The above concept was then imported into the first party insurance context in the California case of *Gruenberg v. Aetna Insurance Company*.³⁰ In *Gruenberg* the California Supreme Court identified a similar duty not to unreasonably withhold benefits due under an insurance policy in the first party context.³¹ The court held that breach of this duty would give rise to a

21. RESTATEMENT (SECOND) OF CONTRACTS § 355 (1981).

22. *Id.*

23. It should be noted that the Alabama Supreme Court has ruled that "the tort of bad faith is only available in the insurance context" thereby making insurance companies the sole defendants in bad faith actions. See Stephen D. Heninger & Nicholas W. Woodfield, *A Practitioner's Guide to Alabama's Tort of Bad Faith*, 57 ALA. LAW. 277, 282 (1996).

24. John H. Bauman, *Insurance Law Annual: Emotional Distress Damages and the Tort of Insurance Bad Faith*, 46 DRAKE L. REV. 717, 733 (1998).

25. *Id.* at 734.

26. *Id.* at 734-35.

27. *Id.*

28. *Id.* at 735.

29. *Id.*

30. 510 P.2d 1032 (Cal. 1973).

31. *Id.* at 1037.

tort action for breach of the covenant of good faith and fair dealing.³² Many other courts followed the California Supreme Court's lead in imposing tort liability for bad faith in the first party insurance context.³³ One of these courts was the Alabama Supreme Court.

B. THE BEGINNINGS OF BAD FAITH IN ALABAMA

The Alabama Supreme Court adopted the first party bad faith cause of action in 1981 in *Chavers v. National Security Fire and Casualty Company*.³⁴ In doing so, the court adopted the following standard of proof which the plaintiff must meet to recover on a claim for bad faith:

[A]n actionable tort arises for an insurer's intentional refusal to settle a direct claim where there is either '(1) no lawful basis for the refusal coupled with actual knowledge of that fact or (2) intentional failure to determine whether or not there was any lawful basis for such refusal.'³⁵

Shortly thereafter, in *Gulf Atlantic Life Insurance Co. v. Barnes*,³⁶ the court clarified the two tier test for bad faith which it articulated in *Chavers*. As to the first tier of the test, the court defined "no lawful basis" to mean lacking "a legitimate or arguable reason for failing to pay the claim."³⁷ The court further noted that, "when the claim is not fairly debatable, refusal to pay will be bad faith" and that "bad faith...is not simply bad judgment or negligence. It imports a dishonest purpose and means breach of known duty...through some motive of self interest or ill will."³⁸ As to the second tier the court indicated that the critical question before the jury was "whether a claim was properly investigated and whether the results of the investigation were subjected to a cognitive evaluation and review."³⁹ The court also stated that "reckless indifference to facts or to proof submitted by the insured" on the part of the insurer would establish the inference needed to meet the second tier of the test.⁴⁰

32. *Id.*

33. Bauman, *supra* note 24, at 741.

34. 405 So.2d 1, 6 (Ala. 1981).

35. *Id.* at 7.

36. 405 So.2d 916 (Ala. 1981).

37. *Id.* at 924.

38. *Id.*

39. *Id.*

40. *Id.*

The following year, in *National Security Fire and Casualty Co. v. Bowen*, the Alabama Supreme Court defined the elements of a prima facie bad faith case.⁴¹ Under *Bowen* the plaintiff had the burden of proving the following:

- (a) an insurance contract between the parties and a breach thereof by the defendant;
- (b) an intentional refusal to pay the insured's claim;
- (c) the absence of any reasonably legitimate or arguable reason for that refusal (the absence of a debatable reason);
- (d) the insurer's actual knowledge of the absence of any legitimate or arguable reason;
- (e) if the intentional failure to determine the existence of a lawful basis is relied upon, the plaintiff must prove the insurer's intentional failure to determine whether there is a legitimate or arguable reason to refuse to pay the claim.⁴²

Plaintiff's burden in bad faith cases was subsequently characterized as "heavy."⁴³ Yet under this heavy burden plaintiffs were able to capitalize on the new cause of action to the tune of millions of dollars in punitive damages. In *Nationwide Mutual Life Insurance Co. v. Clay* the plaintiff brought suit for bad faith failure to pay an insurance claim under his disability insurance policy and was awarded \$1.25 million in damages on the bad faith count.⁴⁴ On appeal the Alabama Supreme Court upheld the award stating that the actions of Nationwide constituted the type of behavior that the bad faith cause of action was intended to eliminate.⁴⁵ The court conceded that the award was large, but concluded it was not the result of jury bias or prejudice, and accordingly, must stand.⁴⁶

A similar verdict was upheld in *United American Insurance Co. v. Brumley*.⁴⁷ In *Brumley* the plaintiff asserted claims of breach of contract

41. 417 So.2d 179, 183 (Ala. 1982).

42. *Id.*

43. Nat'l Sav. Life Ins. Co. v. Dutton, 419 So.2d 1357, 1362 (Ala. 1982).

44. 469 So.2d 533, 534, 541 (Ala. 1985). It should be noted that the same jury only awarded \$46,165 on the breach of contract claim. *Id.* at 541.

45. *Id.* at 546.

46. *Id.*

47. 542 So.2d 1231, 1239 (Ala. 1989).

and bad faith failure to pay benefits under his Medicare Supplement policy.⁴⁸ The jury returned a verdict of \$5,000 in compensatory damages and \$1 million in punitive damages which was upheld on appeal by the Alabama Supreme Court.⁴⁹

Similarly, in *United Services Automobile Ass'n v. Wade* the insurer brought suit seeking a declaratory judgment regarding its liability under the plaintiff's homeowner's policy.⁵⁰ The plaintiffs counterclaimed seeking to recover under the policy for the loss of their house and the personal property contained therein, as well as punitive damages for USAA's bad faith failure to pay.⁵¹ The trial court entered judgment for the plaintiffs and awarded \$166,795 plus interest on the contract claim and \$3.5 million in damages on the bad faith claim.⁵² On appeal, the Alabama Supreme Court deemed the punitive damages excessive, but only reduced the award by \$1 million, leaving a total of \$2.5 million in punitive damages to be paid by the defendant.⁵³

The substantial punitive damage awards levied against insurers in these early bad faith cases are exemplary of how this newly established cause of action provided plaintiffs with a vehicle for capitalizing on Alabama's pro-punitive damage climate in the first party insurance context.

V. DEVELOPMENTS IN ALABAMA'S CIVIL JUSTICE CLIMATE

Several developments have occurred in Alabama since the "tort hell" of the late 1980s and early 1990s that led to a change in Alabama's civil justice climate. The combination of a dramatic change in the Alabama Supreme Court bench, efforts at tort reform, punitive damage reform and subsequent developments in the law of bad faith has contributed significantly to a less hostile legal climate for insurance companies.

48. *Id.* at 1233-34.

49. *Id.* at 1235, 1239.

50. 544 So.2d 906, 907 (Ala. 1989).

51. *Id.*

52. *Id.* at 907-08.

53. *Id.* at 917.

A. THE ALABAMA SUPREME COURT

From 1989 to 1994, the Alabama Supreme Court was led by Chief Justice “Sonny” Hornsby.⁵⁴ The “Hornsby Court,” as it was called, was largely identified with the hostile litigation climate towards corporate defendants that existed during Hornsby’s tenure.⁵⁵ This was likely due not only to the upsurge of large punitive damage verdicts awarded during those years, but also to the court’s dismantling of early attempts at tort reform.⁵⁶ In 1987 the Alabama Legislature passed a tort reform package that included among its provisions a cap on punitive damages.⁵⁷ Since 1987 the Alabama Supreme Court has struck down most of the provisions of the 1987 Tort Reform Legislation,⁵⁸ with the punitive damage caps being declared unconstitutional by the Hornsby Court.⁵⁹

The entirely Democratic bench of the Alabama Supreme Court began to change in 1994.⁶⁰ In that year supporters of civil justice reform, including members of the defense bar and representatives of Alabama’s business community, contributed to and campaigned for Republican Perry Hooper Sr. in the election for the Supreme Court’s chief justice.⁶¹ One of the major issues of the 1994 chief justice election was tort reform.⁶² During that election incumbent Sonny Hornsby was depicted as part of the problem of litigation abuse in Alabama.⁶³ By contrast Perry Hooper communicated that he was in favor of tort reform and punitive damage caps in particular.⁶⁴ Perry Hooper was sworn in as the new chief justice of the Alabama Supreme Court in 1995.⁶⁵

54. Alabama Department of Archives and History - Supreme Court Justice Biographies, <http://www.archives.state.al.us/judicial/hornsby.html> (last visited Nov. 15, 2007); DeBow, *supra* note 4, at 2.

55. DeBow, *supra* note 4, at 1-2.

56. *Id.* at 4.

57. Prater, *supra* note 1, at 1025-26.

58. *Id.* at 1026.

59. *Henderson ex. rel. Hartsfield v. Ala. Power Co.*, 627 So.2d 878, 893-94 (Ala. 1993); *Moore v. Mobile Infirmary Ass’n*, 592 So.2d 156, 173 (Ala. 1991); DeBow, *supra* note 4, at 4.

60. DeBow, *supra* note 4, at 1, 2.

61. Prater, *supra* note 1, at 1029.

62. *Id.* at 1029-30.

63. *Id.* at 1030.

64. Stewart, *supra* note 2, at 228.

65. DeBow, *supra* note 4, at 3.

In the election of 1996 another Republican, Harold See Jr., was added to the Alabama Supreme Court bench.⁶⁶ Harold See was known as an “outsoken critic” of the Hornsby Court,⁶⁷ as well as a supporter of the business community and tort reform.⁶⁸ After the 1998 elections a Republican majority presided over the Alabama Supreme Court for the very first time since its establishment in 1820.⁶⁹ In 2000 an additional four Republicans were added to the bench and in 2004 the governor appointed another, Drayton Nabers Jr., to succeed the former Chief Justice, Roy Moore, when he was removed from office.⁷⁰ Drayton Nabers is the former chief executive officer of Protective Life Corporation, a financial services company, and a former chairman of the American Council of Life Insurers.⁷¹ Coming into the elections of 2007 the Alabama Supreme Court bench remained entirely Republican with Drayton Nabers serving as Chief Justice.⁷²

The new conservative composition of the court and the pro-business background of its chief justice illustrate the dramatic change that has taken place in the judicial environment in Alabama since 1989. It is this new court that is poised to re-evaluate various legal issues of great concern to the business community, such as the constitutionality of punitive damage caps and excessive punitive damage awards.

B. TORT REFORM – PUNITIVE DAMAGE CAPS

In the mid-1980s a growing trend of tort reform swept through 42 states.⁷³ In 1987, the Alabama Legislature joined the majority of states and enacted a tort reform package, chief among its provisions a set of

66. *Id.*

67. *Id.*

68. Stewart, *supra* note 2, at 228.

69. *A History of the Alabama Judicial System*, Alabama Judicial System Online, http://www.judicial.state.al.us/documents/judicial_history.pdf (last visited Nov. 15, 2007); DeBow, *supra* note 4, at 3.

70. DeBow, *supra* note 4, at 3.

71. Alabama Judicial System Online - Supreme Court Justice Biographies, <http://www.judicial.state.al.us/supreme.cfm?Member=118> (last visited Nov. 15, 2007).

72. Alabama Judicial System Online - Members of the Alabama Supreme Court, <http://www.judicial.state.al.us/supreme.cfm>, last visited (Jan. 10, 2007); DeBow, *supra* note 4, at 2.

73. George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1587 (1987).

legislatively imposed punitive damage caps.⁷⁴ The 1987 punitive damage caps imposed a limit of \$250,000 on all forms of punitive damages unless the damages were premised on one of the following:

- (1) A pattern or practice of intentional wrongful conduct, even though the damage or injury was inflicted only on the plaintiff; or
- (2) Conduct involving actual malice other than fraud or bad faith not a part of a pattern or practice; or
- (3) Libel, slander or defamation.⁷⁵

It did not take long for the Alabama courts, known for taking a pro-punitive damages stance, to address the punitive damages provisions of the tort reform package.⁷⁶ In *Moore v. Mobile Infirmary Ass'n* the Alabama Supreme Court held that Alabama Code Section 6-5-544(b), which limited the amount of non-economic damages recoverable in a medical malpractice case to \$400,000, violated the right to a trial by jury guaranteed by the Alabama Constitution.⁷⁷ The court stated that courts should not interfere with the damages awarded by a jury unless the jury's assessment is "flawed by bias, passion, prejudice, corruption, or other improper motive."⁷⁸ The court further explained that the jury's determination of damages is integral to the right to trial by jury as provided by the Alabama Constitution and that because Section 6-5-544(b) "caps the jury's verdict automatically and absolutely" it impinges on the jury's function and in doing so violates the right provided in the Alabama Constitution.⁷⁹

Less than two years later, the Hornsby Court addressed the constitutionality of Alabama Code Section 6-11-21 which capped punitive damages at \$250,000 unless premised on one of the three varying situations noted earlier. In *Henderson ex. rel. Hartsfield v. Alabama Power Co.* the Alabama Supreme Court ruled that Section 6-11-21 also violated the right to trial by jury as provided in the Alabama Constitution.⁸⁰ The court explained that *Moore* was controlling precedent and because the limitations

74. Stewart, *supra* note 2, at 201.

75. ALA. CODE § 6-11-21 (LexisNexis 1997).

76. *Henderson ex. rel. Hartsfield v. Ala. Power Co.*, 627 So.2d 878, 885-86 (Ala. 1993); *Moore v. Mobile Infirmary Ass'n*, 592 So.2d 156, 164 (Ala. 1991).

77. 592 So.2d at 164.

78. *Id.* at 161.

79. *Id.* at 161, 164.

80. 627 So.2d at 893-94.

imposed by Section 6-11-21, like those of Section 6-5-544(b), rendered the jury's function meaningless they also were unconstitutional as violative of the right to trial by jury.⁸¹ Through *Moore* and *Henderson*, the Alabama Supreme Court authoritatively stated that legislatively imposed punitive damage caps violated the right to trial by jury and that the only means by which to impose them was through a constitutional amendment.⁸²

However, despite unmistakable precedent the Alabama Legislature continued its efforts to institute punitive damage caps. After several unsuccessful attempts in 1996 and 1997,⁸³ in 1999 both the House of Representatives and the Senate passed legislation to limit punitive damages by votes of 98-0 and 33-2 respectively.⁸⁴ The new legislation capped punitive damages at three times the compensatory damages or \$500,000, whichever is greater.⁸⁵ The outcome of the new legislation would inevitably come before the high court again. However, optimists speculated that the court that struck down previous damage caps was not the one that would address the new legislation and therefore, the outcome would likely be different this time.⁸⁶

The Alabama Supreme Court has yet to address whether *Henderson* was correctly decided in the civil context, but has questioned its soundness.⁸⁷ In the case of *Oliver v. Towns* the court stated:

Given the post-Henderson developments in the concept of due process law and the forceful rationale of the dissents in Henderson we question whether Henderson remains good law...However we decline to address this issue before the trial court rules on the

81. *Id.* at 885-86.

82. *Id.* at 893.

83. Stewart, *supra* note 2, at 216-19.

84. David White, *Punitive Damages Cap OK'd*, BIRMINGHAM NEWS, June 2, 1999, at 1A. It should be noted that the Business Counsel of Alabama, a political group representing over 5,000 Alabama businesses, "spearheaded" the repeated legislative attempts at instituting punitive damage caps. Stewart, *supra* note 2, at 215-16.

85. ALA. CODE § 6-11-21 (LexisNexis 2005).

86. Stewart, *supra* note 2, at 227-28.

87. *Oliver v. Towns*, 738 So.2d 798, 804 n.7 (Ala. 1999). It is important to note that in *Ex Parte Apicella*, the court held, in the context of a criminal case, that *Henderson* was wrongly decided to the extent it held that the Alabama Constitution "restricted the Legislature from removing from the jury the unbridled right to punish." 809 So.2d 865, 873-74 (Ala. 2001).

applicability of §6-11-21 to the punitive damages award in this case.⁸⁸

The court also avoided addressing the issue of *Henderson* in 2004 in *Alfa Life Insurance Co. v. Jackson*.⁸⁹ The court specifically noted that it did not need to address the issue of whether *Henderson* was correctly decided because the damage caps contained in Alabama Code Section 6-11-21 did not apply to the case.⁹⁰

From the perspective of an insurance company, or any corporate defendant, legislatively imposed punitive damage caps are a step in the right direction. However, such restrictions have engendered significant tension between the Alabama Legislature and the judiciary since the initial decimation of the 1987 Tort Reform Package.⁹¹ Despite the earlier caps being ruled unconstitutional a new set of caps is on the books and it is possible that the new conservative Alabama Supreme Court, if given the opportunity, will uphold them this time around.

C. PUNITIVE DAMAGE REFORM

Alabama has been described by its own legislators as “the worst state in America for punitive damages.”⁹² Accordingly, it is not surprising that many of the large awards imposed on corporate defendants in Alabama are appealed. Therefore, it is critical to the defendant that the appellate courts of the state have a framework in place that allows them to effectively review the punitive awards for excessiveness. In the 1980s the Alabama Supreme Court issued two opinions that assisted in establishing this framework.⁹³

In *Hammond v. City of Gadsden* the Alabama Supreme Court reached two conclusions regarding the review of punitive damages. The first holding was that trial courts must state, on the record, the reasons for interference or non-interference with the jury verdict when the issue is the excessiveness of the award.⁹⁴ The rationale behind the court’s finding was

88. *Oliver*, 738 So.2d at 804 n.7 (citations omitted).

89. No. 1001854 & 1002002, 2004 Ala. LEXIS 118 (Ala. May 7, 2004).

90. *Id.* at *35.

91. Stewart, *supra* note 2, at 203-04, 216-220; DeBow, *supra* note 4, at 4.

92. Stewart, *supra* note 2, at 215.

93. *Green Oil Co. v. Hornsby*, 539 So.2d 218 (Ala. 1989); *Hammond v. City of Gadsden*, 493 So.2d 1374 (Ala. 1986).

94. *Hammond*, 493 So.2d at 1379.

that appellate courts were increasingly being called upon to review the excessiveness of punitive damage awards and the fact that trial courts often did not articulate their reasons for interfering or not interfering with such awards put the appellate courts at a distinct disadvantage as inevitably numerous aspects of the trial were not included in the record.⁹⁵ This holding arguably benefited those defendants appealing punitive damage verdicts as it gave the appellate courts a more complete understanding of the trial court's logic, or lack thereof.

The second holding of *Hammond* was that certain factors should be considered by appellate courts when reviewing punitive damage awards for excessiveness.⁹⁶ These factors included the culpability of the defendant's conduct, the desirability of discouraging similar conduct by others, the impact upon the parties, and the impact on innocent third parties.⁹⁷ These four factors were the beginning of a larger list of factors that would be compiled over time and would be used by the Alabama Supreme Court to evaluate the excessiveness of punitive damage awards.

In *Green Oil Co. v. Hornsby* the Alabama Supreme Court expanded the list of factors for consideration in punitive damage appeals to seven.⁹⁸ The factors as described by the court are the following:

- (1) Punitive damages should bear a reasonable relationship to the harm that is likely to occur from the defendant's conduct as well as to the harm that actually has occurred. If the actual or likely harm is slight, the damages should be relatively small. If grievous, the damages should be much greater.
- (2) The degree of reprehensibility of the defendant's conduct should be considered. The duration of this conduct, the degree of the defendant's awareness of any hazard which his conduct has caused or is likely to cause, and any concealment or 'cover up' of that hazard, and the existence and frequency of similar past conduct should all be relevant in determining this degree of reprehensibility.
- (3) If the wrongful conduct was profitable to the defendant, the punitive damages should remove the profit and should be in excess of the profit, so that the defendant recognizes a loss.

95. *Id.*

96. *Id.*

97. *Id.*

98. 539 So.2d 218, 223-24.

- (4) The financial position of the defendant would be relevant.
- (5) All the costs of litigation should be included so as to encourage plaintiffs to bring wrongdoers to trial.
- (6) If criminal sanctions have been imposed on the defendant for his conduct, this should be taken into account in mitigation of the punitive damages award.
- (7) If there have been other civil actions against the same defendant, based on the same conduct, this should taken into account in mitigation of the punitive damages award.⁹⁹

This new list of factors, called the “Hammond-Green Oil” factors, was the basis on which today’s more complicated review process for excessiveness of punitive damages was built.

Despite initial approval from the United States Supreme Court,¹⁰⁰ Alabama’s method of reviewing punitive damages was dealt a heavy blow in 1996. In *BMW of North America v. Gore* the United States Supreme Court reviewed an Alabama case on the issue of excessiveness of punitive damages and ruled that the punitive damages awarded against the defendant were so excessive as to violate the Due Process Clause of the Fourteenth Amendment.¹⁰¹ The Court held that “[e]lementary notions of fairness enshrined in our constitutional jurisprudence dictate that a person receive fair notice not only of the conduct that will subject him to punishment, but also of the severity of the penalty that a State may impose.”¹⁰² The Court then provided three “guideposts” to use in

99. *Id.*

100. In *Pacific Mutual Life Insurance Co. v. Haslip*, the United States Supreme Court reviewed the Hammond-Green Oil factors and determined that this method of “postverdict review ensures that punitive damages awards are not grossly out of proportion to the severity of the offense and have some understandable relationship to compensatory damages” and that the standards are a “sufficiently definite and meaningful constraint on the discretion of Alabama factfinders in awarding punitive damages.” 499 U.S. 1, 22 (1991).

101. 517 U.S. 559, 562, 585-86 (1996). The jury verdict in this case was \$4,000 compensatory damages and \$4 million in punitive damages. *Id.* at 565. The trial court denied BMW’s post trial motion and stated the award was not excessive. *Id.* at 566. The Alabama Supreme Court remitted the punitive damage award to \$2 million based on findings that the jury incorrectly calculated punitive damages by taking into account the amount of similar incidents in other states. *Id.* at 567. It should be noted that the \$2 million punitive damage awarded survived a Hammond-Green Oil analysis by the Alabama Supreme Court. *BMW of N. Am. v. Gore*, 646 So.2d 619, 624-29 (Ala. 1994).

102. *BMW of N. Am. v. Gore*, 517 U.S. 559, 574 (1996).

evaluating whether a defendant was given the required fair notice.¹⁰³ The first guidepost was the “degree of reprehensibility of the defendant’s conduct.”¹⁰⁴ The Court did not give specifics as to what level of reprehensibility dictated a larger award of punitive damages, but did make several observations as to what types of conduct were considered more reprehensible than others.¹⁰⁵ For example, violent crimes were considered more serious than non-violent crimes and “trickery and deceit” was considered more reprehensible than negligence.¹⁰⁶ The second BMW guidepost was the ratio of the punitive damage award to the “actual harm inflicted on the plaintiff.”¹⁰⁷ Again, the Court declined to draw a bright line standard stating it would be impossible to draw a line that appropriately fit all cases, but it did state that the ratio in this case, 500:1, was “breathtaking” and warranted additional review.¹⁰⁸ The final BMW “guidepost” was the civil or criminal penalties available to punish similar conduct.¹⁰⁹ The Court noted that the Alabama Deceptive Trade Practices Act would impose a fine of \$2,000 for similar conduct and accordingly, did not give BMW fair notice that it may be subjecting itself to a multi-million judgment.¹¹⁰ After considering the three guideposts together the Court concluded that the \$2 million punitive damage award was excessive and unconstitutional and remanded the case to the Alabama Supreme Court.¹¹¹ On remand, the Alabama Supreme Court remitted the punitive damages to \$50,000 and stated that when reviewing punitive damage awards challenged as excessive Alabama courts should apply the Hammond-Green Oil factors as well as the BMW guideposts and make their determinations on a case-by-case basis.¹¹²

103. *Id.* at 574-75.

104. *Id.* at 575.

105. *Id.* at 575-77.

106. *Id.* at 575-76. Two additional observations made by the Court were that repeated conduct was more reprehensible than one instance of misconduct and that causing financial injury to a financially disadvantaged individual would warrant a higher award. *Id.* at 576-77.

107. *Id.* at 580.

108. *BMW of N. Am. v. Gore*, 517 U.S. 559, 582-83 (1996). The Court noted that it was possible to have a case where a particularly deplorable act generated a small amount of compensatory damages, but supported a large punitive award. *Id.* at 582.

109. *Id.* at 583.

110. *Id.* at 584.

111. *Id.* at 585-86.

112. *BMW of N. Am. v. Gore*, 701 So.2d 507, 515 (Ala. 1997). The Alabama Supreme Court indicated in its interpretation that the first two of the BMW guideposts were already included in the Hammond-Green Oil factors. *Id.* at 511.

In the aftermath of the *BMW* decision, the United States Supreme Court remanded four additional cases to the Alabama Supreme Court for review under *BMW*.¹¹³ In each case the punitive damages award was substantially reduced after being reviewed in light of the *BMW* guideposts and the Hammond-Green Oil factors.¹¹⁴ In addition, after *BMW* the bad faith cases that reached the Alabama Supreme Court, illustrated a new understanding on the part of Alabama juries and courts that excessive punitive damage awards would no longer be tolerated unless they could survive a demanding review.¹¹⁵

This new legal framework used to review potentially excessive punitive damage awards in Alabama is another development that makes the litigation climate of Alabama less intimidating to corporate defendants as

113. *Id.* at 519 (Houston, J., concurring). The cases were: *Life Ins. Co. of Ga. v. Johnson*, 519 U.S. 923 (1996); *Ford Motor Co. v. Sperau*, 517 U.S. 1217 (1996); *Union Sec. Life Ins. Co. v. Crocker*, 517 U.S. 1230 (1996); *Am. Pioneer Life Ins. Co. v. Williamson* 517 U.S. 1231 (1996).

114. In *Life Insurance Co. of Georgia v. Johnson*, the jury awarded punitive damages in the amount of \$15 million which was reduced by the trial judge to \$12.5 million and was reduced again by the Alabama Supreme Court to \$5 million. 701 So.2d 524, 526 (Ala. 1997). On remand from the United States Supreme Court, the Alabama Supreme Court reduced the award again to \$3 million. *Id.* In *Ford Motor Co. v. Sperau*, the jury awarded \$6 million in punitive damages which was upheld by the trial court and the Alabama Supreme Court. 708 So.2d 111, 114-15 (Ala. 1997). On remand from the United States Supreme Court, the Alabama Supreme Court reduced the punitive damage award to \$1,792,000. *Id.* at 115. In *Union Security Life Insurance Co. v. Crocker*, the jury granted a verdict of \$5 million which was subsequently reduced to \$2 million by the trial court and then upheld by the Alabama Supreme Court. 667 So.2d 688, 690, 695 (Ala. 1995). On remand from the United States Supreme Court, the Alabama Supreme Court reduced the award to \$1 million. 709 So.2d 1118, 1123 (Ala. 1997). In *American Pioneer Life Insurance Co. v. Williamson*, the jury awarded punitive damages in the amount of \$3 million which was reduced by the Alabama Supreme Court to \$2 million. 704 So.2d 1361, 1361-62 (Ala. 1997). On remand from the United States Supreme Court, the Alabama Supreme Court further reduced the punitive award to \$750,000. *Id.* at 1362.

115. The initial jury verdicts in the post *BMW* bad faith cases were substantially lower than earlier bad faith cases and the punitive damages were regularly remitted on appeal. *Compare* *Nat'l Ins. Ass'n v. Sockwell*, 829 So.2d 111 (Ala. 2002); *Acceptance Ins. Co. v. Brown*, 832 So.2d 1 (Ala. 2001); *Liberty Nat'l Life Ins. Co. v. Sanders*, 792 So.2d 1069 (Ala. 2000); *Alfa Mut. Fire Ins. Co. v. Thomas*, 738 So.2d 815 (Ala. 1999); *Employees' Benefit Ass'n v. Grissett*, 732 So.2d 968 (Ala. 1998); *Loyal Am. Ins. Co. v. Mattiace*, 679 So.2d 229 (Ala. 1996), *with* *Affiliated FM Ins. Co. v. Stephens Enter.*, 641 So.2d 780 (Ala. 1994); *Thomas v. Principal Fin. Group*, 566 So.2d 735 (Ala. 1990); *Intercontinental Life Ins. Co. v. Lindblom*, 571 So.2d 1092 (Ala. 1990); *United Serv. Auto. Ass'n v. Wade*, 544 So.2d 906 (Ala. 1989); *United Am. Ins. Co. v. Brumley*, 542 So.2d 1231 (Ala. 1989); *Aetna Life Ins. Co. v. Lavoie*, 505 So.2d 1050 (Ala. 1987); *Nationwide Mut. Ins. Co. v. Clay*, 469 So.2d 533 (Ala. 1985).

they can be assured that excessive awards will be subjected to thorough and exacting review on appeal.

D. DEVELOPMENTS IN THE LAW OF FIRST PARTY BAD FAITH

Alabama has become a less hostile environment for insurers, not only due to the three factors previously discussed, but also due to several developments in the law of first party bad faith. The bad faith cause of action has developed over time to provide heightened protection to insureds while simultaneously ensuring that not every refusal to pay an insurance claim will land an insurance company in court.

In Alabama a plaintiff can prove bad faith by one of two approaches; by establishing the elements of an ordinary/normal case or those of an extraordinary/abnormal case.¹¹⁶ Under the normal case of bad faith failure to pay an insurance claim the plaintiff has a heavy burden of proof and must establish:

- (1) The existence of an insurance contract;
- (2) An intentional refusal to pay the claim; and
- (3) The absence of any lawful basis for the refusal and the insurer's knowledge of that fact or the insurer's intentional failure to determine whether there is any lawful basis for its refusal.¹¹⁷

The plaintiff has to show more than simple nonpayment on the part of the insurance company.¹¹⁸ The plaintiff has to show the insurer refused to pay without a reasonable ground for disputing the claim.¹¹⁹ In the normal case, in order for the bad faith claim to stand, the plaintiff must also be entitled to a directed verdict on his breach of contract claim.¹²⁰ If evidence is produced which creates a factual issue as to the contract claim, the bad faith claim must be dismissed.¹²¹

A different standard is applied to certain cases that qualify as "extraordinary" or abnormal.¹²² This is because of policy concerns

116. *State Farm Fire & Cas. Co. v. Slade*, 747 So.2d 293, 306 (Ala. 1999); *Grissett*, 732 So.2d at 976.

117. *Brown*, 832 So.2d at 16.

118. *Nat'l Sec. Fire & Cas. Co. v. Bowen*, 417 So.2d 179, 183 (Ala. 1982).

119. *Id.*

120. *Nat'l Sav. Life Ins. Co. v. Dutton*, 419 So.2d 1357, 1362 (Ala. 1982).

121. *Id.*

122. *Brown*, 832 So.2d at 16.

regarding the insured's right to prompt and thorough claim evaluation and payment.¹²³ Under the abnormal case of bad faith failure to investigate an insurance claim the plaintiff must prove:

- (1) that the insurer failed to properly investigate the claim or to subject the results of the investigation to a cognitive evaluation and review; and
- (2) that the insurer breached the contract for insurance coverage with the insured when it refused to pay the insured's claim.¹²⁴

Abnormal or "extraordinary" cases have largely been restricted to situations where the plaintiff is able to produce substantial evidence demonstrating the insurer acted in one of the following four ways:

- (3) Intentionally or recklessly failed to investigate the plaintiff's claim;
- (4) Intentionally or recklessly failed to properly subject the plaintiff's claim to a cognitive evaluation or review;
- (5) Created its own debatable reason for denying the plaintiff's claim; or
- (6) Relied on an ambiguous portion of the policy as a lawful basis to deny the plaintiff's claim.¹²⁵

In all bad faith cases the plaintiff must be able to show he was entitled to benefits under the insurance policy in question.¹²⁶

The development of these two distinct forms of bad faith illustrates the differing policy concerns that the Alabama Supreme Court was grappling with when molding the bad faith cause of action. On one hand, the court saw the need to preserve the ability of insurance companies to effectively review claims and refuse payment on those that were invalid.¹²⁷ It did not intend, nor would it tolerate, plaintiff's abuse of this cause of action to sue insurance companies for every denial of a claim. Justice Shores, writing for the court, discussed this concern in *Affiliated FM Insurance Co. v. Stephens Enterprises* when he stated:

123. *Id.*

124. *State Farm Fire & Cas. Co. v. Slade*, 747 So.2d 293, 318 (Ala. 1999).

125. *Id.* at 306-07.

126. *Acceptance Ins. Co. v. Brown*, 832 So.2d 1, 16 (Ala. 2001).

127. *Thomas v. Principal Fin. Group*, 566 So.2d 735, 742 (Ala. 1990).

The recognition of the tort of bad faith does not, as Affiliated asserts, give a unilateral right to plaintiffs to pursue a claim for punitive damages against an insurer for an alleged breach of contract. The burden of proof in a bad faith case is such that sufficient protection is afforded to defendants in these cases.¹²⁸

The heavy burden of proof placed on plaintiffs in the normal bad faith case functioned to preserve the insurers' right to debate questionable claims.

However, the court was also concerned with enforcing the right of the insured to have his claim adequately evaluated and paid in a timely fashion.¹²⁹ Accordingly, the court established a different standard for the abnormal case of bad faith failure to investigate.¹³⁰ The court noted in these abnormal cases that the plaintiff was not required to be entitled to a directed verdict on the contract claim because it was too great of a burden and would often allow the insurer to avoid liability for bad faith where it may be properly imposed.¹³¹ For example, in *Jones v. Alabama Farm Bureau Mutual Casualty Co.* the plaintiff insureds had a homeowner's policy that covered damage caused directly by lightning, but did not cover damage indirectly caused by power surges.¹³² The insurer and the plaintiffs disagreed as to the cause of the damage.¹³³ The adjuster for the insurance company claimed that the plaintiff told him the damage was caused by a tree that had fallen onto a power line and made his decision to deny the claim based on that alleged conversation.¹³⁴ The plaintiff denied stating the tree was the cause of the damage.¹³⁵ The insurer made the argument that because there was a difference between the two accounts of the conversation the plaintiff was not entitled to a directed verdict on the contract claim and therefore, the bad faith claim could not stand.¹³⁶ The

128. 641 So.2d 780, 784 (Ala. 1994).

129. *Thomas*, 566 So.2d at 742-43.

130. *Id.* at 743.

131. *Jones v. Ala. Farm Bureau Mut. Cas. Co.*, 507 So.2d 396, 401 (Ala. 1986) ("Precluding a plaintiff's bad faith action by application of the 'directed verdict on the contract claim' test when the disputed factual issue arises solely from a contradicted oral conversation between the insurer and the insured or a third person puts too onerous a burden on the plaintiff."); *Cont'l Assurance Co. v. Kountz*, 461 So.2d 802, 806 (Ala. 1984) ("in an extraordinary case like this the directed verdict standard is inapplicable.").

132. 507 So.2d 396, 397 (Ala. 1986).

133. *Id.*

134. *Id.*

135. *Id.*

136. *Id.* at 400.

Alabama Supreme Court held that this case was not the normal or ordinary bad faith case and that the directed verdict standard was not applicable.¹³⁷ In support of its holding the court reasoned that:

Although the plaintiff's burden of proof in a bad faith action is great, it should not be insurmountable. Precluding a plaintiff's bad faith action by application of the "directed verdict on the contract claim" test when the disputed factual issue arises solely from a contradicted oral conversation between the insurer and the insured or a third person puts too onerous a burden on the plaintiff. Moreover, it would frustrate the purpose of the bad faith action by allowing an insurer simply to misrepresent the content of an oral conversation to avoid liability.¹³⁸

Therefore, the courts have allowed a less burdensome standard to prevail in abnormal cases of bad faith failure to investigate. This lesser standard functions to hold insurance companies to a higher standard of claims investigation.

Despite the fact that plaintiffs have two means by which to establish bad faith, it is clear that the courts were concerned about the impact the cause of action would have on an insurer's ability to deny invalid claims. Accordingly the court saddled the plaintiff with a high burden of proof in normal bad faith failure to pay situations. Additional protection is provided for insurers by the imposition of the directed verdict standard in the normal case. Therefore, the bad faith cause of action in the normal bad faith case does not pose as much of a threat to an insurer as it could have had the law developed in a different way.

It may appear as though the abnormal case of bad faith failure to investigate would continue to pose a large risk to insurance companies in Alabama. In many respects the abnormal case is more of a problem for insurers in that the burden placed on the plaintiff is less arduous. However, the Alabama Supreme Court has, through a number of cases, clearly laid out some of the issues with which insurers need to be concerned under the abnormal bad faith cause of action.¹³⁹ Well advised insurers are able to

137. *Id.* at 400-01.

138. *Jones v. Ala. Farm Bureau Mut. Cas. Co.*, 507 So.2d 396, 401 (Ala. 1986).

139. *See White v. State Farm Fire & Cas. Co.*, 953 So.2d 340 (Ala. 2006); *State Farm Fire & Cas. Co. v. Slade*, 747 So.2d 293 (Ala. 1999); *United Serv. Auto. Ass'n v. Wade*, 544 So.2d 906 (Ala. 1989); *Nationwide Mut. Ins. Co. v. Clay*, 525 So.2d 1339 (Ala. 1987);

internalize these issues and modify their claims handling processes accordingly. One of these issues involves the information an insurer has before it when the claims decision is made. The only information that will be taken into account by the court in determining whether the insurer was justified in denying the claim is that which was before the insurer at the time the claims decision was made.¹⁴⁰ In court an insurance company cannot rely on information discovered after the denial to justify its decision.¹⁴¹ Knowing this, an insurer would be well advised to incorporate standards of information gathering into its claims handling manuals and provide training on the importance of gathering all relevant information prior to adjudicating the claim.

Another issue brought to the attention of insurance companies by the court addresses ambiguous policy provisions. An insurer cannot claim it had a justifiable basis for denying the claim and point to ambiguity in its own policy as that basis.¹⁴² This rule dovetails with the *contra proferentem* principle of insurance law which states that when interpreting documents ambiguity is construed against the drafter.¹⁴³ As this principle is a general tenet of insurance law all insurance companies should be aware that reliance on ambiguity in their policies will not win the day for them in a courtroom.

One final example of an issue to which the court has spoken in terms of the abnormal case of bad faith is that of “reckless indifference to facts or proof submitted by the insured.”¹⁴⁴ In *Gulf Atlantic Life Insurance Co. v. Barnes* the court stated, “knowledge or reckless disregard of the lack of a legitimate or reasonable basis may be inferred or imputed to an insurance company when there is a reckless indifference to facts or to proof submitted by the insured.”¹⁴⁵ The question remained, what did that mean for insurance companies? The court has since provided examples of what constitutes such reckless indifference. In *Aetna Life Insurance Co. v. Lavoie*, the insurance company made its claim denial based on an incomplete medical file (the file was missing the patient’s progress notes

Aetna Life Ins. Co. v. Lavoie, 505 So.2d 1050 (Ala. 1987); Chavers v. Nat’l Sec. Fire & Cas. Co., 405 So.2d 1 (Ala. 1981).

140. *Lavoie*, 505 So.2d at 1053.

141. *Id.*

142. *White*, 953 So.2d at 349.

143. BLACK’S LAW DICTIONARY 352 (8th ed. 2004).

144. *Gulf Atl. Life Ins. Co. v. Barnes*, 405 So.2d 916, 924 (Ala. 1981).

145. *Id.*

and nurses' notes from her hospitalization).¹⁴⁶ The insurer's witnesses admitted documentation like that missing from the file in question was "of critical importance" in the review of a claimant's medical file.¹⁴⁷ The Alabama Supreme Court ruled that because the insurer denied the claim while missing critical sections of the claimant's medical file a jury could find they acted with "reckless indifference to facts or proof."¹⁴⁸ Additional guidance was provided by the Alabama Supreme Court in *United Services Automobile Ass'n v. Wade*.¹⁴⁹ In that case, the claimants were denied coverage under their homeowner's policy based on grounds of arson.¹⁵⁰ The court ruled that the record established the investigation conducted by the insurer was incomplete and therefore the insurer's reliance on that incomplete investigation constituted "reckless indifference to the facts."¹⁵¹ Some of the problems with the investigation included the following: (1) the insurer's investigator did not examine the house's electrical system to rule out electrical issues as the cause of the fire; (2) the insurer's investigator did not move debris from the entire basement floor to determine whether a trail left by flammable liquid was actually a trail or present throughout the basement; (3) the insurer's investigator did not ask the insureds if flammable liquids were routinely kept in their basement; (4) the insurer was aware of a second investigator's opinion that the fire started in a different area of the house from which the insurer's investigator stated the fire started; (5) the insurer was aware that the fire marshal did not suspect the insureds of arson; and (6) the insurer relied largely on statements made by the insured's ex-wife as to his involvement in other fires when there was clearly ill feelings present between the two.¹⁵² By examining the court's clear and detailed explanations of the problems involved in claims investigations, such as those articulated in the two cases discussed above, an insurer can educate itself and its claims handling departments on the types of issues that will put the insurer at risk for suits based on a claim of bad faith failure to investigate. By doing so, the insurer can insulate itself against the more intimidating form of first party bad faith in Alabama.

146. 505 So.2d 1050, 1051 (Ala. 1987).

147. *Id.* at 1053.

148. *Id.*

149. 544 So.2d 906 (Ala. 1989).

150. *Id.* at 907-08.

151. *Id.* at 913-14.

152. *Id.* at 914-15.

VI. CONCLUSION

The changes that have taken place within Alabama's civil justice system over the past 25 years have been remarkable. These changes have made the jurisdiction one in which insurance companies should no longer be fearful to write business.

Despite the fact that the bad faith cause of action is alive and well in Alabama, it has been shaped into an even handed cause of action that requires a heavy burden of plaintiffs and cannot be used as an unlimited vehicle for obtaining punitive damages against insurance companies. This ensures that bad faith cases brought by plaintiffs today meet a certain standard of validity and protects insurers from being saddled with unjustified lawsuits. For those bad faith claims that are successfully asserted, the magnitude of punitive damages is controlled through a system of exacting appellate punitive damage review which has been increasingly utilized to substantially remit large awards. The existence of such appellate review affects a plaintiff's ability and desire to bring a bad faith cause of action as it is more difficult to prove and less profitable than it once was. In addition, punitive damage caps, though previously ruled unconstitutional, are back on the books and the newly conservative Supreme Court bench has openly questioned whether holding such caps unconstitutional remains good law.

The Legislature, the courts and the pro-business interests in Alabama have worked hard to create meaningful change in its civil justice system. In response to this change the insurance industry should take another look at Alabama and reconsider whether it is more dangerous than profitable to insure its citizens.

**BREAKING THE CHAIN: HOW STATE
LEGISLATURES CAN LEARN FROM THE
MISTAKES OF MARYLAND’S FAIR SHARE ACT
AND STOP BENEFIT DUMPING**

*Fallon DePina**

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* J.D. Candidate, University of Connecticut School of Law, 2008; B.A., Northeastern University, 2000. I am grateful to professors Kaaryn Gustafson, Alexandra Lahav, and Jon Bauer for their invaluable insights and assistance to me in writing this article. I am also indebted to my mother, Lenda Young, whose unwavering support, encouragement, and love always seem to make the impossible possible.

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It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.¹

I. INTRODUCTION

Spiraling health care costs provide Wal-Mart Stores, Inc. (“Wal-Mart”) with a convenient excuse not to offer affordable health care coverage for their employees; forcing many of the working poor to turn to Medicaid. One state tried, and failed, to put Wal-Mart’s benefit-shifting to an end. On November 30, 2006, attorneys for the State of Maryland argued before the Fourth Circuit Court of Appeals to preserve the Fair Share Health Care Fund Act (“the Fair Share Act” or “the Act”).² The Act would help legislatures force Wal-Mart to pay its fair share of health care costs and stop overburdening states. The Act drew national attention amid mounting

1. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311(1932) (Brandeis, J., dissenting).

2. Matthew Dolan & Andrew A. Green, *Wal-Mart Bill Debated. As Appeals Court Hears Case, Md. Politicians Look to Other Ways to Expand Health Care*, THE BALTIMORE SUN, Dec. 1, 2006.

pressure for Wal-Mart to provide better employee benefits.³ The Act required that companies with more than 10,000 workers devote at least eight percent of their payroll to employee health care costs.⁴ If employers failed to meet the eight percent requirement, they had to pay Maryland the difference. The express purpose of the legislation was to support “the operations of the [Medicaid] Program.”⁵

The Fair Share Act survived a veto from Maryland governor Robert L. Ehrlich and was set to take effect on January 1, 2007.⁶ However, it was struck down in *RILA v. Maryland*⁷ on the grounds that the federal Employment Retirement Income Security Act of 1974 (“ERISA”),⁸ which demands national uniformity in employer benefits regulation, preempted it.⁹

This paper will explore the fight for the Fair Share Act, ERISA preemption jurisprudence, and how legislatures may draft successful legislation to stop big box retailers from over burdening states. Part II provides background information on the factors that contributed to the drafting of Maryland’s Fair Share Act, including Wal-Mart’s health care policies and the high costs of Medicaid. Part III discusses *RILA v. Fielder*, the case that found that Maryland’s Fair Share Act was preempted by ERISA. Part IV discusses ERISA’s history and how it has become a major barrier to local legislative innovation. Part V discusses the mistakes that Maryland’s Fair Share Act made. Part VI discusses one successful Fair Share Act. Part VII explains how legislatures may draft successful Fair Share Acts and avoid the mishaps of the Maryland Fair Share Act.

II. WAL-MART’S HEALTH CARE POLICIES

A. CYNTHIA’S STORY

Cynthia Murray desperately needed the Fair Share Act. She is one of 17,000 Wal-Mart employees that work in Maryland.¹⁰ She was partially

3. *Id.*

4. *Id.*

5. Fair Share Health Care Fund, MD. CODE ANN., HEALTH-GEN. §15-142(c) (2006).

6. *Id.*

7. 435 F. Supp. 2d 481, 484 (D. Md. 2006).

8. 29 U.S.C. § 1001 et seq (1974).

9. *Id.*

10. Mary Otto, *For One Clerk, Fight for Wal-Mart Bill Is Personal*, WASH. POST, Jan. 12 2006, at B05.

disabled in a car accident, but she cannot afford the health care necessary to rehabilitate her injuries.¹¹ Despite her five-year tenure with the company, her wages cannot cover the high cost of Wal-Mart health insurance.¹² In the wake of Maryland Governor Ehrlich's veto of the Act, she wrote a letter to Maryland legislatures urging them to override his veto. She said:

Big business and special interests want to kill Fair Share Health Care, but I can tell you, personally, workers like me need this bill. We can't afford health care and this bill would go a long way to make Wal-Mart spend a minimum amount of money to provide health care for its workers.¹³

Cynthia Murray's story is not unique. There are many more Wal-Mart associates whose story will not ever be heard. They too are drowning in health care costs.

B. WAL-MART'S HEALTH CARE BENEFITS

Wal-Mart intentionally evaded their responsibilities to their employees by shifting health care costs to state and federal governments. A 2005 internal memo¹⁴ sent by Susan Chambers, then Wal-Mart's Executive Vice President of Risk Management and Benefits Administration,¹⁵ exposed the grim realities of Wal-Mart's inadequate health care coverage.¹⁶ The

11. Cynthia Murray, *Open Letter to the Maryland State Legislature from a Current Wal-Mart Associate*, WAL-MART WORKERS OF AMERICA, Jan. 11, 2006, <http://www.wakeupwalmart.com/wwa/fair-share.html>.

12. *Id.*

13. *Id.*

14. See Steven Greenhouse & Michael Barbaro, *Wal-Mart Memo Suggests Ways to Cut Employee Benefit Costs*, N.Y. TIMES (Oct. 26, 2005) ("A draft memo to Wal-Mart's board was obtained from Wal-Mart Watch, a nonprofit group, allied with labor unions, that asserts that Wal-Mart's pay and benefits are too low. Tracy Sefl, a spokeswoman for Wal-Mart Watch, said someone mailed the document anonymously to her group last month. When asked about the memo, Wal-Mart officials made available an updated copy that actually went to the board.").

15. Susan Chambers has since been promoted to Executive Vice President of People Division.

16. Susan Chambers, *Reviewing and Revising Wal-Mart's Benefits Strategy*, Supplemental Benefits Documentation, BOARD OF DIRECTORS RETREAT FY06, WAL-MART STORES, INC., available at <http://www.nytimes.com/2005/10/26/business/26walmart.ready.html?ex=1287979200&en=e9a0f5d466bb026e&ei=5088&partner=rssnyt&emc=rss>.

memo, which was sent to the Board of Directors, revealed that most Wal-Mart associates spent eight percent of their income on health care, nearly twice the national average.¹⁷ In 2004, thirty-eight percent of enrolled Wal-Mart associates spent more than sixteen percent of their earnings¹⁸ on health care.¹⁹

The high cost of health care compels significant portions of Wal-Mart's workforce to seek health insurance from public assistance programs.²⁰ Five percent of Wal-Mart associates are on Medicaid, or 1.2 million people.²¹ Forty-six percent of Wal-Mart associates' children are either on Medicaid or uninsured.²² These startling figures are not lost on Wal-Mart employees. Wal-Mart associates rank health insurance as the most important benefit that their employer offers, yet it is also the one benefit that they are most disappointed with.²³

C. WAL-MART DUMPS UNINSURED EMPLOYEES IN PUBLICLY FUNDED PROGRAMS

Wal-Mart refuses to release a state by state report of the number of their employees covered by Medicaid.²⁴ However, according to an American Federation of Labor and Congress of Industrial Organizations ("AFL-CIO") report, Wal-Mart ranks high on the list of companies shifting employees into state programs for the uninsured in nineteen out of the twenty-three states surveyed.²⁵ This is especially troubling considering that "Medicaid is the fastest growing expense for most states, accounting for sixteen percent of state budgets."²⁶ At the National Governors Association

17. *Id.* at 7.

18. *See* Greenhouse & Barbaro, *supra* note 14, at 2 ("Full time Wal-Mart employees...earn on average around \$17,500 a year.").

19. *Id.*

20. *Id.* at 8.

21. *Id.*

22. *Id.*

23. *Id.* at 6.

24. Otto, *supra* note 10, at B05. ("[Maryland Speaker of the House, Michael e. Busch] could not provide figures for how many of Maryland's Wal-Mart workers are on Medicaid, and the AFL-CIO sued unsuccessfully to get that information.")

25. AFL-CIO REPORT, THE WAL-MART TAX: SHIFTING HEALTH-CARE COSTS TO TAXPAYERS 1 (2006), www.aflcio.org/corporatewatch/walmart/upload/walmartreport_031406.pdf (Quantifies the impact of Wal-Mart's refusal to provide affordable employee health care insurance on publicly funded state health care programs in twenty-three states).

26. *Id.*

meeting held in Washington, DC, in February 2005, Medicaid was identified as the number one problem facing state governments.²⁷ Medicaid accounts for twenty-two percent of total state spending and has become the second largest item in most state budgets after elementary and secondary education.²⁸ Maryland's Department of Budget and Management reported that "Maryland's Medicaid and Children's Health Program spending has increased by \$1.25 billion since 2003."²⁹ Due to Medicaid's continued growth, it is expected to absorb funding from other vital state funded programs. Over the next five years, Medicaid costs are expected to rise eight percent annually, while general fund revenues are forecast to grow at only five percent.³⁰

The burden on states is only getting worse. During 2006, the federal government required states to pay an additional \$527 million for Medicaid.³¹ Federal Medicaid spending also jumped by more than fifty percent between 2000 and 2004.³²

Wal-Mart also pays lower premiums than the national average. Most national employers paid eighty-four percent of premiums for individual coverage and seventy-three percent of premiums for family coverage in 2003.³³ Sixty-six percent of employees at national companies receive health benefits; only forty-one to forty-six percent of Wal-Mart employees enjoy the same.³⁴

27. James P. Baker, *Can Maryland Make Wal-Mart Pay or Play?*, 19 BENEFITS L.J. 84, 84-101 (2006) (discussing the affects of the Fair Share Act).

28. *Id.*

29. MARYLAND DEPT. OF BUDGET & MANAGEMENT, MARYLAND FY 2007 BUDGET HIGHLIGHTS, 34-35 (2007), available at www.dbm.maryland.gov/dbm_taxonomy/budget/publications/budget_highlights/fy07_budgethighlights.pdf.

30. ISSUE PAPERS, 2006 LEGISLATIVE SESSION, PRESENTATION TO THE MARYLAND GENERAL ASSEMBLY, DEPARTMENT OF LEGISLATIVE SERVICES OFFICE OF POLICY ANALYSIS, ANNAPOLIS, MARYLAND 113-117 (Dec. 2005), mlis.state.md.us/Other/IssuePapers/2006/Issue%20Papers%202006%20Legislative%20Session.pdf.

31. FEDERAL FUNDS INFORMATION FOR STATES, ISSUE BRIEF 04-41: FY 2006 FMAPs, September 28, 2004.

32. *Id.*

33. *Everyday Low Wages: The Hidden Price We All Pay for Wal-Mart: Hearing Before the Comm. on Education and the Workforce*, 108th Cong., 2d sess., (Feb. 2004). http://www.agribusinessaccountability.org/pdfs/285_The%20Hidden%20Price%20We%20Pay%20for%20Wal-Mart.pdf

34. *Id.* at 1.

Wal-Mart's relentless lobbying has helped it evade state laws mandating minimum health care expenditures. In Maryland alone, the company hired twelve top lobbyists to combat the Fair Share Act,³⁵ including the highest paid lobbyists in the state.³⁶ "They've hired the largest cadre of lobbyists in recent history in Annapolis to try to influence this legislation," said Maryland House Speaker Michael E. Busch. "It really comes down to whether the legislature is going to succumb to the money and the special interests."

Wal-Mart is willing to spend money on legislatures to avoid spending money on health-care. It made a \$10,000 "donation" to the Legislative Black Caucus of Maryland to help pay for one of the organization's conferences.³⁷ The company admitted that the donation was a lobbying effort designed to inform lawmakers about the bill.³⁸ It also "contributed at least \$4,000 to Governor Ehrlich's re-election campaign, prior to his veto of the Fair Share Act."³⁹

D. THE MARYLAND FAIR SHARE ACT

Fourteen percent of Maryland residents, including over nine percent children, have no health insurance of any kind.⁴⁰ By 2004, providing uninsured care cost Maryland more than half a billion dollars annually.⁴¹ In reaction to these growing costs, a coalition of citizens' groups, including civic organizations, religious congregations, labor and business leaders, public foundations, and medical organizations created the Maryland

35. John Wagner, *Wal-Mart Girds for Battle on Md. Bill*, THE WASH. POST, Nov. 17, 2005, at A01.

36. *Id.* ("Among the new recruits were Joseph A. Schwartz III and J. William Pitcher, both among the ten highest-paid lobbyists in Annapolis last year, receiving more than \$500,000 each from clients.")

37. *Id.*

38. *Id.* (Spokesman Nate Hurst said that "There are several legislators out there who have requested that [Wal-Mart] continue to educate them.")

39. Michael Barbaro, *Maryland Sets a Health Cost for Wal-Mart*, N.Y. TIMES, Jan. 13, 2006.

40. Susan Sangree et al., Brief Amicus Curiae of The Maryland Citizens' Health Initiative Education Fund, Inc., in support of Secretary Fielder's Motion for Summary Judgment, and in Opposition to the Retail Industry Leader's Association's Motion for Summary Judgment, 13.

41. Health Services Cost Review Commission, *Maryland Hospital Community Benefit Report 2005-Final Report*, available at http://www.hsrc.state.md.us/financial_data_reports/documents/CommunityBenefits/2004%20Report.pdf.

Citizens' Health Initiative Education Fund, Inc. (the "Initiative")⁴². The organization's goal was to research economically feasible, politically viable solutions to address Maryland's health care dilemma.⁴³

The Fair Share Act was conceived and drafted by the Initiative in order to secure a source of funding for state Medicaid.⁴⁴ The Fair Share Act sought to lessen the burden some companies impose on other employers, taxpayers, and the State treasury when they fail to pay their fair share of health care costs.⁴⁵ The Act addressed the issue by more equitably distributing the cost of funding state Medicaid.⁴⁶ Large employers, like big box retailers, are better able to afford a payroll tax to support health care for low-income residents than small employers.⁴⁷ Numerous Maryland businesses were eager for change. A large group of business, many of which provide sufficient health care coverage for their employees, told legislators that they were tired of subsidizing large corporations that did not pay their fair share of health care benefits.⁴⁸

Between 1999 and 2002, the Initiative led studies on Maryland's private and public health care infrastructure, compared different methods of addressing health care issues, and worked with local business and labor leaders, government officials, and constituents while drafting the Fair Share Act.⁴⁹ The final product was a representation of the wants and needs of the Maryland community and a weapon to combat health care disparities.

On January 12, 2006, the Maryland General Assembly enacted the Fair Share Act.⁵⁰ Maryland was the first state to pass such legislation.⁵¹ The Act applied to non-governmental employers of 10,000 or more employees.⁵²

42. The Maryland Citizens' Health Initiative Education Fund, Inc. ("the Initiative"), was incorporated on March 15, 1999, and was recognized by IRS as exempt under Section 501(c)(3) of the Tax Code on August 14, 1999. The primary purpose of the Initiative is "To educate the public with respect to the need for universal health coverage," and "to engage in voter education, and to attempt to influence passage of legislation in the public interest, through all legitimate means, to secure universal health benefits or health insurance coverage for all the residents of Maryland. *See* Article of Incorporation Third, §§ A. and B.

43. Sangree, *supra* note 40, at 17.

44. *Id.* at 22.

45. *Id.*

46. *Id.*

47. *Id.* at 25.

48. *Id.*

49. *Id.* at 19.

50. Labor and employment Title 8.5. Health Care Payroll Assessment, MD. CODE ANN., LAB. & EMPL. § 8.5-103(a)(1) (2006).

51. Baker, *supra* note 27, at 85.

52. *See* § 8.5-102.

Maryland's Fair Share Act was set to establish a Fair Share Health Care Fund that would subject large employers to health care payroll assessments to help support the state's Medicaid program.⁵³ It required for-profit employers that failed to spend up to eight percent of total wages on employee health insurance costs, to pay the Secretary "an amount equal to the difference."⁵⁴ Covered employers would have to report their health care expenditures to determine whether or not they satisfied the requirements and pay the tax if there was a shortfall.⁵⁵

There were only four non-governmental employers of 10,000 or more people in Maryland: Johns Hopkins University ("Johns Hopkins"), the Northrop Grumman Corporation ("Northrop Grumman"), Giant Food Inc. ("Giant Food"), and Wal-Mart.⁵⁶ Johns Hopkins is a non-profit institution that met the lower 6 percent standard the legislature set for such institutions. Northrop Grumman successfully lobbied for a provision in the Act that permitted employers to exclude, for purposes of calculating the percentage of payroll spent on health care, compensation paid to its employees above the median household income in Maryland.⁵⁷ This exclusion permitted Northrop Grumman to meet the requirement. Giant Food, which actively lobbied for enactment of the legislation, consistently spent more than eight percent of its total wages on employee health insurance costs. Gregory Goggans, Wal-Mart's Director of United States Benefits Design, stated that "Wal-Mart has never [since July 2003] made contributions to the health care plans offered to its Maryland employees that were equal to or greater than eight percent of the 'total compensation' (as that term is defined in the Act) paid to Maryland employees."⁵⁸ Thus, in practice, the Fair Share Act only affected Wal-Mart because the other covered employers "already provided [health] benefits that cost them more than 8 percent of payroll."⁵⁹

53. Baker, *supra* note 27, at 84.

54. *See* § 8.5-104(b).

55. Sangree, *supra* note 40, at 23.

56. *See* RILA v. Fielder, 435 F. Supp. 2d 481, 485 (D. Md. 2006).

57. *See* § 8.5-103(b).

58. Goggans Decl. P 3, RILA Mot. for Summ. J. ex. D.

59. Edward A. Zelinsky, *Maryland's "Wal-Mart" Act: Policy and Preemption*, 28 CARDOZO L. REV. 847, 849 (quoting Joanne Wojcik, "Wal-Mart Bill" Spurs Coverage Mandates, *Bus. Ins.*, Jan. 23, 2006, at 1.)

III. RILA V. FIELDER

The Retail Industry Leaders Association (“RILA”), a trade association of which Wal-Mart is a member, brought an action for declaratory and injunctive relief against James Fielder, Jr. (“Fielder”), as Maryland Secretary of Labor. RILA sought a declaration that the Fair Share Act was preempted by ERISA and that the Act violated the Equal Protection Clause of the U.S. Constitution.⁶⁰

The Court determined that RILA had standing to litigate Wal-Mart’s interest because (1) Wal-Mart was an RILA member; (2) Wal-Mart was affected by the Act’s spending requirement, (3) RILA was opposed to health care mandates on its retail members, and (4) Wal-Mart’s direct participation in the action was not required.

The Court found for RILA, holding that the Fair Share Act had referred to an ERISA plan; thus had a “connection with” the plan and as such was preempted.⁶¹ A state statute has a “reference to” ERISA where it “acts immediately and exclusively upon ERISA plans” or “where the existence of ERISA plans is essential to the law’s operation.”⁶²

The Fair Share Act was scheduled to become effective January 1, 2007, however by July 19, 2006, federal district Judge Frederick Motz struck it down.⁶³ In his opinion, Motz wrote:

The Act imposes legally cognizable injury upon Wal-Mart by requiring it to make a report to the Secretary about the amount of its payroll and health care contributions and by requiring it to track and allocate benefits for its Maryland employees in a manner different from that in which it tracks and allocates benefits for its employees in other States.⁶⁴

Motz agreed that the Maryland law was preempted by ERISA, but held that under existing law RILA’s equal protection challenge was unavailing.⁶⁵ The Supreme Court made it clear that “equal protection is not a license for courts to judge the wisdom, fairness, or logic of legislative choices.”⁶⁶

60. *See RILA*, 435 F. Supp. at 484.

61. *Id.* at 494.

62. *Id.*

63. *Id.* at 481.

64. *Id.* at 488.

65. *RILA*, 435 F. Supp. 2d at 500.

66. *Id.*

On appeal, Assistant Maryland Attorney General Steven Sullivan argued that “Wal-Mart, like any other employer, had an option under the new law to pay a tax to the state, estimated at \$6 million a year, in lieu of additional health care payments for employees.”⁶⁷ The fact that Wal-Mart had an alternative meant the Maryland statute would not conflict with federal law.⁶⁸ Attorneys for the RILA countered that there was no *real* choice, because no rational employer would choose to pay Maryland a tax rather than spend more on health care for its own employees.⁶⁹ “That’s really a Hobson’s choice,” said the RILA’s attorney William J. Kilberg, stating that Wal-Mart’s only viable option would be to increase health care spending.⁷⁰

Judge Paul V. Niemeyer, head of the panel, expressed skepticism that the Maryland law did not violate federal legislation protecting employers from a nationwide patchwork of local laws on health care benefits.⁷¹ Judge M. Blane Michael, asked Wal-Mart’s lawyer why the state should be stopped from making Wal-Mart pay for a part of its employees’ trips to the emergency room instead of foisting those costs onto Maryland taxpayers.⁷²

IV. ERISA

A. THE PURPOSE OF ERISA

In 1963, the Studebaker Automotive plant closed its doors forever, leaving over ten thousand employees unemployed and unable to receive pension plan benefits.⁷³ Studebaker terminated the pension plan for hourly workers and defaulted on its obligations to the remaining workers because the pension plan had not been adequately funded.⁷⁴ “The plight of Studebaker employees quickly emerged as a symbol of the need for pension reform.”⁷⁵

67. Dolan & Green, *supra* note 2, at 1.

68. *Id.*

69. *Id.*

70. *Id.*

71. *Id.*

72. *Id.*

73. James A. Wooten, *The Most Glorious Story of Failure in the Business: The Studebaker-Packard Corporation and the Origins of ERISA*, 49 BUFF. L. REV. 683 (2001) (discussing the connection between the plant closing and the enactment of ERISA).

74. *Id.* at 684.

75. *Id.* at 683.

Congress enacted ERISA in 1974 to protect citizens from the unexpected loss of promised benefits, like the Studebaker employees suffered. ERISA was intended to guarantee that “American working men and women receive private pension plan benefits which they have been led to believe would be theirs upon retirement from working lives.”⁷⁶ The Act was drafted to mandate protective measures, and prescribe minimum standards for promised benefits.⁷⁷ Congress’s goal was to prescribe legislative remedies for the various deficiencies existing in private pension plan systems.⁷⁸

B. THE ERISA PREEMPTION

ERISA § 514(a) preempts any and all State laws that relate to any employee benefit plan” covered by ERISA.⁷⁹ “State law” is defined as “all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.”⁸⁰ A state law “relates to” an employee benefit plan if it has either a “connection with” or a “reference to” such a plan.⁸¹ The preemption clause states that “[ERISA] shall supersede any and all State laws insofar as they relate to any employee benefit plan.”⁸² These benefits include health care.⁸³ State reforms have often come into conflict with ERISA because they relate, directly or indirectly, to employee benefits and conflict with the federal law.⁸⁴ States cannot mandate that employers pay for health insurance, directly tax benefit plans, or require reports on cost or use of the plans from employers.⁸⁵ ERISA only allows states to “regulate the business of insurance.”⁸⁶

ERISA’s preemption provision is intended to promote uniformity among the states. It ensures that plans and plan sponsors will be subject to a uniform body of benefits law. Congress’s goal was to minimize the

76. PUB. L. NO. 93-406, 88 Stat. 829 (1974).

77. *Id.*

78. *Id.*

79. 29 U.S.C. § 1144(a).

80. *See* 29 U.S.C. § 1144(c)(1).

81. *See* *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983).

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.*

86. *Id.*

administrative and financial burden of complying with conflicting directives among states, thereby maximizing the efficiency of the plans.⁸⁷

Since enactment, ERISA has confounded both state regulators and the courts concerning the appropriate extent of its preemption of state law.⁸⁸ “Questions of the extent of federal preemption under ERISA necessarily implicate larger issues concerning the proper relationship between state and federal law.”⁸⁹ Where Congress explicitly states that the law is preempted, courts must still examine the statute’s structure and history to determine the precise boundaries of the preempted field.⁹⁰ The result is that preemption decisions have an ad hoc quality.

Congress anticipated that ERISA may be litigious and would require clarification. Senator Javits, a principal drafter of ERISA, proposed a Congressional Pension Task Force that would study and evaluate the preemption in connection with state authorities and report its findings to Congress.⁹¹ If the task force determined that the preemption policy was problematic at either the State or Federal level, appropriate modifications would be made.⁹²

The patchwork of Court interpretations of § 514(a) undermines the section’s application as a general rule.⁹³ Courts must balance ERISA, Supreme Court interpretations, and the specific facts of the case at bar to determine ERISA challenges. This is the only method of analysis until Congress decides to assist the courts by amending the language of this confusing section.

C. THE SUPREME COURT’S TREATMENT OF THE ERISA PREEMPTION

Following the Supreme Court’s first ERISA preemption decision in *Alessi v. Raybestos-Manhattan, Inc.*,⁹⁴ it has handed down an average of

87. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).

88. Stephen F. Befort & Christopher J. Kopka, *The Sound of Silence: The Libertarian Ethos of ERISA Preemption*, 52 FLA. L. REV. 1, 3 (2000).

89. James D. Hutchinson & David M. Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974*, 46 U. CHI. L. REV. 23 (1978).

90. *Id.* at 36.

91. 120 Cong. Rec. 29,942 (1974), reprinted in III Legislative History, *supra* note 1, at 4771.

92. *Id.*

93. See Jay Conison, *ERISA and The Language of Preemption*, 72 WASH. U. L. Q. 619, 668 (1994).

94. 451 U.S. 504 (1981).

one opinion on the subject per year.⁹⁵ The flux of litigation is an inadvertent consequence of § 514(a)'s broad language.⁹⁶ That provision is framed as a general standard, however it can only attain definiteness through the case decision process.⁹⁷ ERISA demands the very litigation over "the validity of state action" that it supposedly was designed to avoid.⁹⁸ While there have been numerous Supreme Court preemption cases, three illustrate where the court has been and where they are heading in ERISA preemption rulings.

D. SHAW

In *Shaw v. Delta Airlines*,⁹⁹ the Supreme Court held that New York's Disability Benefits Law ("NYDBL") was preempted because it "related to" employee benefit plans under § 514(a) of ERISA by connecting with or referring to such plans.¹⁰⁰ NYDBL required employers to pay sick-leave benefits to employees unable to work because of pregnancy or other non-occupational disabilities. § 514(a) pre-empts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA.¹⁰¹

Shaw offers a two-pronged preemption test. The first prong preempts state laws that make reference to ERISA plans or that single out ERISA plans.¹⁰² The second prong is the "relate to" test. It preempts state laws that have a sufficient connection with ERISA plans, even if the statute does not

95. See Conison, *supra* note 93 at 620 ("The cases following Alessi that deal with preemption are: Franchise Tax Bd. v. Construction Laborers Vacation Trust, 463 U.S. 1 (1983); Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983); Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724 (1985); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987); Metropolitan Life Ins. Co. v. Taylor, 481 U.S. 58 (1987); Fort Halifax Packing Co. v. Coyne, 482 U.S. 1 (1987); Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825 (1988); Massachusetts v. Morash, 490 U.S. 107 (1989); FMC Corp. v. Holliday, 498 U.S. 356 (1990); Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990); District of Columbia v. Greater Washington Bd. of Trade, 113 S. Ct. 580 (1992); John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank, 114 S. Ct. 517 (1993)").

96. *Id.* at 621.

97. *Id.*

98. *Id.*

99. 463 U.S. 85 (1983).

100. *Id.* at 88.

101. *Id.* at 91-92.

102. See, e.g., Ingersoll-Rand Co. v. McClendon 498 U.S. 133 (1990); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41 (1987).

expressly refer to ERISA plans.¹⁰³ A state law that “relates to” ERISA plans is preempted even if the law is consistent with ERISA’s policies and substantive requirements.¹⁰⁴ Employing this definition, the Court found that a law which prohibits employers from structuring their employee benefit plans in a manner that requires employers to pay employees specific benefits, clearly “relate to” benefit plans.¹⁰⁵ “We must give effect to this plain language unless there is good reason to believe Congress intended the language to have some more restrictive meaning.”¹⁰⁶ *Shaw* demonstrates that state laws attempting to regulate the terms of ERISA plan benefits are preempted because, under the *Shaw* test, such laws have a “connection” to ERISA plans.

Under *Shaw* and its progeny, the Supreme Court preempted a host of state laws under § 514(a) on the grounds that such state laws had “a connection with or reference to” ERISA-governed pension or welfare plans.¹⁰⁷ “Under this expansive approach to § 514(a) and its ‘relate to’ terminology, ERISA preemption was nearly automatic whenever a state law touched an ERISA-regulated plan.”¹⁰⁸

E. MACKEY

Shaw and its progeny had an impressive run, however the Supreme Court has subsequently narrowed the broad scope of § 514(a). In *Mackey v. Lanier Collection Agency & Serv., Inc.*,¹⁰⁹ the Court found that a state law did not “relate to” an ERISA plan, thus overcoming preemption under the second prong of the *Shaw* test. In *Mackey*, a creditor of several ERISA plan beneficiaries sought to garnish money that an ERISA plan owed to those beneficiaries.¹¹⁰ Two Georgia statutes were implicated.¹¹¹ The first statute was preempted because it expressly referred to and solely applied to ERISA plans.¹¹² However, Georgia’s general garnishment statute, which allowed ERISA funds to be garnished, was found not to be preempted.¹¹³

103. See *Shaw*, 463 U.S. at 98.

104. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985).

105. *Id.*

106. *Id.*

107. See *Zelinsky*, *supra* note 59, at 851.

108. *Id.*

109. 486 U.S. 825, 829 (1988)

110. *Mackey*, 486 U.S. at 831-32.

111. *Id.*

112. *Id.*

113. *Id.*

The Court reasoned that ‘the garnishment statute was merely a procedural mechanism for enforcing judgments and found that Congress did not intend to forbid such mechanisms.’¹¹⁴ The Court held that “state-law methods for collecting money judgments must, as a general matter, remain undisturbed by ERISA .”¹¹⁵ The Court reasoned that because the ERISA plans ultimately owed the same amount of money whether they paid it to the beneficiaries or to the beneficiaries’ creditors, Georgia’s garnishment statute did not have a sufficient connection with ERISA plans for the purposes of preemption under the second prong of the *Shaw* test.¹¹⁶

F. TRAVELERS

The Supreme Court further delineated the boundaries encompassed by the phrase “relate to” in *New York Blue Cross Plans v. Travelers Insurance Co.* Before its decision in *Travelers* the Supreme Court had defined “relates to” as a “connection with or reference to ERISA plans.” In *Travelers*, the Court reversed and remanded because the provisions for surcharges did not relate to employee benefit plans within the meaning of the preemption provision and accordingly suffered no preemption. While § 514(a) provides that ERISA “shall supersede any and all state laws insofar as they . . . relate to any employee benefit plan” covered by the statute, the preemption does not apply to “any law of any State which regulates insurance.”¹¹⁷ “*Travelers* and its progeny represent an important effort by the Court to reform the overly-expansive *Shaw*-based approach to ERISA preemption.”¹¹⁸

The Court in *Travelers* reasoned that “if a law authorizing an indirect source of economic cost is not [subject to] preemp[tion], it should follow that a law operating as an indirect source of . . . economic influence on administrative decisions . . . should not [be enough] to trigger preemption either.”¹¹⁹

114. *Id.* at 831-32.

115. *Mackey*, 486 U.S. at 834.

116. *Id.*

117. § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). (This exception for insurance regulation is itself limited, however, by the provision that an employee welfare benefit plan may not “be deemed to be an insurance company or other insurer . . . or to be engaged in the business of insurance”); *See also*, § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B).

118. *See Zelinsky*, *supra* note 59, at 867.

119. *Id.*

G. THE SUPREME COURT'S GENERAL ERISA PREEMPTION APPROACH

The Supreme Court will consider the following factors in any preemption analysis under § 514(a). First, courts ask whether the state law makes reference to a covered employee benefit plan by (a) directly referring to an ERISA covered plan or (b) relying on the existence of ERISA plans to take effect.¹²⁰ Second, courts ask whether the state law has a “connection with” a covered employee benefit plan by (a) belonging to a field not typically regulated by the state and intended to be field-preempted by ERISA,¹²¹ (b) affecting the structure or administration of employee benefit plans covered by ERISA,¹²² (c) providing alternative enforcement mechanisms to ERISA plans,¹²³ or (d) offering no means by which the effects of the state law on ERISA benefit plans are optional or avoidable.¹²⁴

V. WHERE MARYLAND'S FAIR SHARE ACT WENT WRONG

The primary errors that the Maryland Fair Share Act made were that it (1) relates to an ERISA covered plan and (2) it targets Wal-Mart. Future Fair Share Acts must have a broader application and cannot refer to ERISA plans if they want to survive.

A. THE FAIR SHARE ACT RELATES TO AN ERISA COVERED PLAN

According to the Initiative, which drafted the Act, “as a tax on payroll, the Fair Share Act neither explicitly mentions ERISA, nor requires the existence of an ERISA plan for its operation.”¹²⁵ Even under the more relaxed preemption standards announced in *Travelers*, the Fair Share Act unacceptably coerces covered employers to provide a certain amount of

120. Maureen McOwen, *Through the Eye of the Needle: How the New York City Health Care Security Act Will Escape ERISA Preemption*, 40 COLUM. J.L. & SOC. PROBS. 37, 59 (2006); *See also*, Mackey 486 U.S. at 828-29.

121. *See* Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., 519 U.S. 316, 325 (1997).

122. *See Travelers*, 514 U.S. at 657-58.

123. *See Id.* at 658; *Ingersoll-Rand*, 498 U.S. at 144-45.

124. *See, e.g.*, *Burgio & Campofelice, Inc. v. N.Y.S. Dep't of Labor*, 107 F.3d 1000, 1009 (2d Cir. 1997).

125. Sangree, *supra* note 40, at 5.

health care coverage and regulate how employers report on the process.¹²⁶ Any regulation of ERISA covered plans is expressly preempted.

The Fair Share Act is targeted specifically at employer-provided medical plans, not at a broad class of health care consumers or providers.¹²⁷ The Act is much more than an “indirect economic influence.”¹²⁸ The evident purpose of the Act is “a direct, focused financial impact on the covered employer and its ERISA-regulated medical plan, i.e., to force an increase in medical outlays to an eight percent minimum of payroll.”¹²⁹

Fair Share Acts cannot regulate ERISA covered plans in anyway. Maryland’s Act does just that. Legislatures must carefully draft their Fair Share Acts so that they do not have any bearing on how plan administrators run their health care plans.

B. THE FAIR SHARE ACT DIRECTLY TARGETS WAL-MART

The Initiative claims that the Fair Share Act “applies equally to every employer with 10,000 or more employees without restriction.”¹³⁰ However the other covered employers either already satisfy the plan’s eight percent health care spending requirement or they have been afforded special loopholes. John’s Hopkins only had to make six percent contributions to health care because it was a non-profit. Northrop Grumman successfully lobbied for a provision in the Act that permits employers to exclude, for purposes of calculating the percentage of payroll spent on health care, compensation paid to its employees above the median household income in Maryland.¹³¹

Successful Fair Share Acts must be generally applicable if they have any hopes of surviving. Maryland’s Fair Share Act is a thinly veiled attack on Wal-Mart. Legislatures will never be able to ensure that Wal-Mart pays adequate health care benefits, if they draft legislation that appears to target just Wal-Mart. The best way to attack big box health care disparities is to enact Fair Share Acts that apply to large businesses uniformly.

126. *Id.* at 866.

127. *See Zelinsky, supra* note 59, at 863.

128. *Id.*

129. *Id.*

130. Sangree, *supra* note 40, at 23.

131. *See RILA*, 435 F. Supp. 2d at 485 (quoting § 8.5-103(b)).

VI. LOCAL INNOVATION—FAIR SHARE ACTS IN OTHER STATES

Since the death of the Clinton Administration's Health Security Act of 1993 ("HSA"),¹³² there has been a gross lack of Congressional dialogue on health care reform.¹³³ In the wake of HSA's demise, Congress has failed to consider other system-wide reforms.¹³⁴ "A decade of incremental change has left the United States with large numbers of uninsured, increasing costs, questions about quality, and dissatisfaction with managed care."¹³⁵ Congress's silence has compelled states and localities to begin discussions themselves.¹³⁶ The Fair Share Act was one such initiative bore from these discussions. The Act was a significant test case that served as a catalyst for similar bills in more than thirty states.¹³⁷ Twenty-three such bills have already been defeated by legislators, and none has been passed into law.¹³⁸

The 2005 resurgence of state interest in Fair Share Acts is attributable to meager state budgets,¹³⁹ booming Medicaid costs, and growing numbers of uninsured workers. States are desperate to guarantee worker health benefits without dipping into their dwindling coffers. Across the country, these initiatives comprise a national effort to push local policy innovation despite Federal policy stagnation. Even though there have been many failed attempts, local legislators are still at the forefront of providing health care solutions for Americans.

A. STATE HEALTH CARE LEGISLATION

Few Fair Share Acts have survived ERISA preemption challenges because they are never able to mount the many hurdles of § 514. The first hurdle under § 514 is to determine whether the particular state law "relates

132. *Proposed Legislation: The Health Security Act of 1993*. Washington, DC: US GOVERNMENT PRINTING OFFICE, HOUSE DOCUMENT 103-174; 1993.

133. See Peter P. Budetti, *10 Years Beyond the Health Security Act Failure, Subsequent Developments and Persistent Problems*, 292 J. AM. MED. ASSOC. 16, 2000 Oct. 27, 2004. See also Maureen McOwen, *supra* note 120, at 51-52.

134. Budetti, *supra* note 133, at 2000.

135. *Id.*

136. McOwen, *supra* note 120, at 52.

137. National Conference of State Legislatures. *2006 'Pay or Play' Bills. Can States Mandate Employer Health Insurance Benefits?* available at <http://www.ncsl.org/programs/health/payorplay2006.htm>.

138. *Id.*

139. *Id.*

to” ERISA plans.¹⁴⁰ The Act will survive if it does not relate or falls under another exemption category.¹⁴¹ The four protected categories are banking, securities, insurance, and general criminal laws.¹⁴² The Act will also fail if it is “connected with” an ERISA plan.

The “relate to” and “connected with” standards as applied under Shaw, Mackey, and Travelers will often defeat tradition Fair Share Acts, however New York City’s modified Fair Share Act exhibit the positive results from such legislation and offer a model for other states. The New York City Health Care Security Act (“HCSA”) is an exemplary piece of legislation that States would be wise to model themselves after because it conquers the hurdles of ERISA preemption. Both Acts successfully ensure that employers carry the burden of their employees’ health care needs.

New York City legislators developed their own version of the Fair Share Act, which may be the most effective legislation to date. HCSA took effect in July 2006.¹⁴³ HCSA applies to “grocery employers” that (1) operate one or more retail stores in New York City with at least 50 employees at any one store, or (2) contain 12,500 square feet of retail space devoted to groceries, such as a “big box” retail store.¹⁴⁴

HCSA further stipulates that such employers must meet the required health care expenditure for its employees. Employers are not required to demonstrate minimum expenditure per employee. “Instead, the employer’s total health care expenditure is calculated as the sum of all health care expenditures made on behalf of employees or the public.”¹⁴⁵ Employers calculate their “‘required health care expenditure’ by multiplying the ‘prevailing health care expenditure rate’ by the total number of hours worked by their employees.”¹⁴⁶ The “prevailing health care expenditure rate” is “set by the administering agency, based on collective bargaining agreements in the industry.”¹⁴⁷ Further, employers never have to contribute any funds towards an ERISA benefit plan.¹⁴⁸

“Health care expenditures” include contributions to health savings accounts, reimbursements to employees and their families, and

140. See § 514(b)(2)(B)

141. *Id.*

142. See §§ 514(b)(2)(A) and (b)(4), 29 U. S. C., §§ 1144(b)(2)(A) and (b)(4), §§ 514(d), and 29 U. S. C. 1144(d); see also, Zelinsky, *supra* note 59, at 870.

143. N.Y. ADMIN. CODE § 22-506(c)(1) (2006).

144. *Id.* § 22-506(b)(12).

145. McOwen, *supra*, note 120 at 56 (quoting § 22-506(b)(13)).

146. *Id.* (quoting § 22-506(c)(3) (2006)).

147. *Id.* (quoting § 22-506(c)(2)).

148. *Id.*

contributions to local public hospitals and community health care clinics.¹⁴⁹ The proportion of the employer's contribution to each, qualified health care expenditure vehicle is unimportant as long as the employer's total contributions equal the "required health care expenditure" specified under HCSA.¹⁵⁰

An employer who fails to make the required health care expenditures during the fiscal year is liable for a civil penalty equal to the amount of the shortfall.¹⁵¹ If the offending employer fails to pay the difference within ninety days, they will be fined an additional \$500 per day until the employer meets the required health care expenditure.¹⁵² Unlike other traditional "pay or play" legislation, fines for non-compliance can exceed the original health care burdens.¹⁵³ The civil penalties are deposited into New York City's general treasury, as opposed to investments into a public health care fund, like other "pay or play" legislation.¹⁵⁴

The New York City HCSA is perfectly suited to survive an ERISA challenge under *Shaw* and *Travelers*. The Act never refers to ERISA covered plans, nor relies on ERISA plans to be effective. The Act does not require employers to provide certain specific types of benefits. The Act is generally applicable. The Act does not have a connection with, or reference to, covered employee benefit plans within the meaning of the preemption provision of ERISA § 514(a). Most importantly, the Act never dictates how employers administer their ERISA covered plans.

The Shaw Court's strict interpretation of § 514(a), preempts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan covered by ERISA."¹⁵⁵ A law "relates to" an employee benefit plan, if it has a "connection with" or reference to such a plan.¹⁵⁶ While the

149. *See id.* (quoting § 22-506(b)(13)).

150. *See* § 22-506(c).

151. *Id.* § 22-506(e)(1).

152. *Id.* § 22-506(e)(2).

153. *See* McOwen, *supra* note 120, at 56. ("There is a subtle flexibility in the New York City HCSA with respect to the "pay or play" analysis. The law is drafted such that section 22-506(e)(1) provides a classic "pay or play" option: the non-complying employer "shall be liable for a civil penalty equal to the amount of the shortfall." *Id.* § 22-506(e)(1). The subsequent paragraph, however, subjects the non-complying employer to an additional penalty of \$ 500 per day, destroying the "pay or play" parity. *Id.* § 22-506(e)(2). The law is therefore structured so that section 22-506(e)(2) could be severed from the local law under an ERISA preemption challenge, leaving a "pay or play" type statute in its place.")

154. *Id.*

155. *See Shaw*, 463 U.S. at 91; *see also*, 29 U. S. C. § 1144(a)

156. *Id.* at 96-97 (U.S. 1983).

Supreme Court has since moved away from this severe, two prong approach, HCSA would still survive it. The language of the Act is careful never to directly or indirectly refer to ERISA covered plans; however this measure is not mere semantic trickery. HCSA legitimately avoids “relating to” or “connecting with” ERISA plans because it never mandates how covered plans are to be run. Instead it remains within its legislative sphere of authority; health regulation.

Under *Travelers*, ERISA pre-empted state laws that mandated employee benefit structures or their administration.¹⁵⁷ The New York City HCSA requires only that covered employers meet a health expenditure minimum. Employers are free to meet these requirements in numerous ways. While HCSA does require that covered employers report their health expenditures, it is to an administering agency, not the City.

Unlike most Fair Share Acts, the New York City HCSA provides covered employers with a plethora of ways to meet the required health care expenditure without creating or contributing to health benefit plans covered by ERISA.¹⁵⁸ Covered employers can also comply by funding ERISA benefit plans for its employees, however “because this connection is optional or ancillary to the operation of the local law, the courts should find that the laws do not have a ‘connection with’ ERISA plans for the purpose of § 514(a).”¹⁵⁹

Covered ERISA employee benefit plans are those “established or maintained by an employer or by an employee organization.”¹⁶⁰ As noted above, health care expenditures include contributions to health savings accounts, reimbursements to employees and their families, and contributions to local public hospitals and community health care clinics. The term “health savings account” means “a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary.”¹⁶¹ Notably, there is no requirement that such accounts are maintained or run by employers. Reimbursements to employees and to their families can only be made for “incurred health care expenses where such recipients had no entitlement to have expenses reimbursed under any plan, fund or program maintained by such employer.”¹⁶² Contributions to local hospitals and

157. *Travelers*, 514 U.S. at 668.

158. McOwen, *supra* note 120, at 68.

159. *Id.*

160. See ERISA § 3(1), 29 U.S.C. § 1002(1).

161. See IRC § 223

162. See § 22-506(b)(13)(ii).

community health care clinics cannot include “payments made directly or indirectly for worker’s compensation, Medicare benefits, or any other health care costs, taxes or assessments that such employer is required to pay pursuant to any federal, state or local law.”¹⁶³ HCSA specifically bars any payment type that would relate to an ERISA covered plan. None of HCSA three alternative forms of health care contributions are “established or maintained by an employer.” Thus none of the options qualify as an ERISA covered plan.

HSCA also avoids challenges to whether it is a fee in tax clothing by imposing a civil fine instead fees like traditional Fair Share Acts.¹⁶⁴ The law avoids the pitfalls of Fair Share Acts by carefully tailoring itself to both ERISA exemption and ERISA jurisprudence. HSCA ensures that covered employers spend a minimum amount on health care equal to the rates set by an industry administering agency and imposes civil fines on violating employers equal to the amount of the shortfall.¹⁶⁵ This careful structuring shows that HSCA is cognizant of the mistakes of its predecessors while still maintaining the failed Fair Share Act’s ultimate goal; more health care coverage for employees.

VII. HOW TO DRAFT SUCCESSFUL HEALTH CARE LEGISLATION

A. FACTORS FOR SUCCESSFUL PAY OR PLAY PLANS

Since *Retail Industry Leaders Association v. Maryland*, similar bills have been struck down across the country. The high failure rate is primarily due legislatures’ failure to draft bills that (1) are applicable to a broad class of large employers and (2) do not relate to ERISA. For Fair Share Acts to succeed ERISA preemptions, they must be broadly applicable. If they appear to target Wal-Mart or hinder ERISA regulation, they will never survive.

Legislators should establish health care programs that tax a broad base of employers. However, the Act should never regulate or mandate employee health care coverage.¹⁶⁶ Legislators should never expressly refer

163. See § 22-506(b)(13)(iii).

164. See § 22-506(b)

165. See §§ 22-506(b), 22-506 (2005)(e)(1)

166. *Id.*

to ERISA plans.¹⁶⁷ State laws are easily invalidated if they refer specifically to private-sector, employer covered health plans.¹⁶⁸ Further, Fair Share Acts must be imposed directly upon employers not on the employer-sponsored plan.¹⁶⁹

Fair Share Acts must maintain neutral language regarding whether employers offer health coverage or contribute to the health care fund.¹⁷⁰ The legislative objective should be to provide universal coverage. Neutrality must be maintained regarding whether an employer pays the tax or pays employee health benefits.¹⁷¹ Failure to do so may result in the Act being deemed a mandate.

Fair Share Acts should not impose any standards on qualifications to satisfy the health care expenditure, except in the broadest terms. “Conditioning the tax credit on meeting certain state qualifications will affect ERISA plan benefits and structure and therefore raise preemption problems.”¹⁷²

B. MODEL FAIR SHARE ACT LEGISLATION—MODELED AFTER NEW YORK CITY’S HCSA

- (1) Employers of fifty employees or more shall make required health care expenditures on behalf of their employees and or the families of their employees each fiscal year.
- (2) “Health care expenditures” means any amount paid by a covered employer to its employees or to another party on behalf of its employees and or the families of its employees for the purpose of providing health care services or reimbursing the cost of such services for its employees including, but not limited to, (i) contributions by such employer to a health savings account; (ii) reimbursement by such employer to its employees and or the families of its employees for incurred health care expenses where such recipients had no entitlement to have expenses reimbursed under any plan, fund or program maintained by such employer; (iii) contributions to a federally qualified hospital or health care facility where a majority of the employer’s employees reside or near the

167. *Id.*

168. *Id.*

169. *Id.*

170. *Id.*

171. *Id.*

172. *Id.*

employer's place of business provided that such contributions shall not be designated for a particular individual or group of individuals; provided that no payment be made directly or indirectly for worker's compensation, Medicare benefits or any other health care costs, taxes, or assessments that such employer is required to pay pursuant to any federal, state or local law other than this section, or any amount deducted from an employee's wages and not reimbursed by such employer.

- (3) An Administering agency shall annually determine the prevailing health care expenditure rate for employees; provided that where thirty percent or more of covered employees are covered by a valid collective bargaining agreement, the prevailing health care expenditure rate for such employees shall be equal to the health care expenditure rate for full-time employees as provided under such collective bargaining agreement.
- (4) Any covered employer found to be in violation of this section by failing to make health care expenditures during the fiscal year at least equal to the required health care expenditure for such employer shall correct such violation within ninety days of such determination. The administering agency shall serve notice to correct such violation. Failure to correct such violation pursuant to this paragraph shall subject a covered employer to a civil penalty of not less than five hundred dollars for each day such violation continues.
- (5) Any covered employer found to be in violation of this section by failing to make health care expenditures during the fiscal year at least equal to the required health care expenditure for such employer shall be liable for a civil penalty equal to the amount of the shortfall.
- (6) The administering agency shall take appropriate action to enforce this section, including but not limited to, periodically auditing covered employers to monitor compliance with this section.

VIII. CONCLUSION

Legislatures across the country are eager to enact Fair Share Acts because they know how deadly being uninsured is. The uninsured receive less preventive care, are diagnosed at more advanced disease stages, and once diagnosed, tend to receive less therapeutic care (drugs and surgical

interventions).¹⁷³ Uninsured women are more likely to have poor outcomes during pregnancy and delivery than are women with insurance, and the same is true for uninsured newborns.¹⁷⁴ Uninsured children are at higher risk for hospitalization for conditions amenable to timely outpatient care and for missed diagnoses of serious and even life threatening conditions.¹⁷⁵ Having health insurance would reduce mortality rates for the uninsured by ten to fifteen percent.¹⁷⁶

Unfortunately, ERISA greatly impedes local legislatures' ability to draft Acts that will address health care benefit disparities. ERISA's preemption clause intended to minimize employer-sponsored plan's administrative and financial burdens of complying with varying state laws.¹⁷⁷ In doing so, it has allowed national employers to shift huge health care related administrative and financial burdens to states. States cannot cover all their uninsured residents without additional revenue sources.¹⁷⁸ The statutory hurdles created by ERISA place restraints on states that reflect deep federalism concerns and Congressional ambivalence about governmental regulation on the health care market. Local innovation is stifled and Congressional apathy is ubiquitous. The only way for states to ensure that big box retailers, like Wal-Mart, pay their fair share of health care costs is to walk the maze of ERISA preemption jurisprudence. In doing so, legislatures must strike a balance between protecting the uninsured and avoiding the pitfalls of ERISA preemption. Modeling legislation after New York City's HCSA will satisfy both goals.

173. Jack Hadley, *Sicker and Poorer: The Consequences of Being Uninsured* (Kaiser Commission on Medicaid and the Uninsured 2002); available at <http://www.kff.org/uninsured/upload/Full-Report.pdf>.

174. INSTITUTE OF MEDICINE, COMMITTEE ON THE CONSEQUENCES OF UNINSURANCE, *Health Insurance is a Family Matter* (Nat'l Academy Press, 2002).

175. *Id.*

176. Hadley, *supra* note 173.

177. *Id.*

178. *Id.*

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