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BAD POLICY FOR GOOD POLICIES: ARTICLE 9'S INSURANCE EXCLUSION

Andrew Verstein*

* * *

Article 9 of the Uniform Commercial Code excludes from its scope any transfer of an interest in a life insurance policy. Thus, any lender whose security is a life insurance policy may not look to the UCC to determine her rights. This Article argues that the exclusion should be eliminated because it leaves insurance governed by antiquated and problematic law. Three specific problems are considered: non-UCC law does not have a satisfactory alternative to UCC perfection; non-UCC law is insufficient to prevent lenders from abusively taking more than their share of value from defaulted policies; and non-UCC law allows insurance companies to hinder securitization through the "reservation problem." The result is that Americans borrow \$121 billion worth of policy loans, almost all of which comes without serious competition. Eliminating the life insurance exclusion will rationalize the law of lending in this area, and improve prospects for a secondary market.

* * *

* Associate Research Scholar in Law and John R. Raben/Sullivan & Cromwell Executive Director, Yale Law School Center for the Study of Corporate Law, Yale Law School. The author would like to thank Eric Brunstad, Matthew Grieder, Mitzi Huang, George Mullin and Debbie Cotton for their insightful comments. All errors remain the author's own.

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BAD POLICY FOR GOOD POLICIES: ARTICLE 9'S INSURANCE EXCLUSION

\$100 billion worth of American life insurance policies are "impaired," meaning that the insured would realize more money by selling the policy on the secondary market than by surrendering the policy to the insurance company.¹ Many consumers benefit from selling or surrendering their life insurance policies, but selling one's life insurance is a serious step that many people later regret. Rather than selling her policy, an insured could instead borrow against it, with less permanence and worry. Borrowing is not without its own risks.² Nevertheless, for many insureds, borrowing is a better choice than selling.

¹ Neil A. Doherty & Hal J. Singer, *The Benefits of a Secondary Market for Life Insurance Policies*, 38 REAL PROP. PROB. & TR. J. 449 (2003). See also DELOITTE-UCONN ACTUARIAL CTR., DELOITTE CONSULTING LLP & THE UNIVERSITY OF CONNECTICUT, *THE LIFE SETTLEMENT MARKET: AN ACTUARIAL PERSPECTIVE ON CONSUMER ECONOMIC VALUE* (2005), available at http://www.quatloos.com/uconn_deloitte_life_settlements.pdf.

² Recent events in the financial markets have shown that improvident borrowing and excessive indebtedness can lead to harms of all their own.

Borrowing against life insurance is widespread. Americans currently secure about \$121 billion dollars worth of loans with their life insurance policies.³ The vast majority of these loans were made by their issuing insurance company and without any serious competition from other lenders. This is in part because of difficulty and uncertainty in the law governing the assignments of life insurance policies. Though it is legal to sell or pledge a life insurance policy, life insurance policies may not serve as security for the purposes of an Article 9 lien.

Revised Article 9 of the Uniform Commercial Code is governing law for almost all security interest transactions in all states.⁴ The product of extensive scholarly drafting and professional insights, the UCC is lauded for its clarity, coherence and logic.⁵ Despite its potential benefits, Article 9 excludes from its scope transfers of interests in insurance policies.⁶ Forty-

Moreover, some insurance borrowing arrangements can be disadvantageous, fraudulent, or predatory. *See infra* Part III.D.

³ FED. RES., FLOW OF FUNDS ACCOUNTS OF THE UNITED STATES: FLOWS AND OUTSTANDING, FOURTH QUARTER 2009 32 (Mar. 11, 2010), *available at* <http://www.federalreserve.gov/releases/z1/current/z1r-1.pdf>.

⁴ U.C.C. § 9-109(a)(1) (2000) ("[T]his Article applies to a transaction, regardless of its form, that creates a security interest in personal property or fixtures by contract.").

⁵ *See, e.g.*, Steven L. Harris & Charles W. Mooney, Jr., *A Property-Based Theory of Security Interests: Taking Debtors' Choices Seriously*, 80 VA. L. REV. 2021, 2021 (1994) ("In embarking upon the revision of what many consider the most successful commercial statute ever . . ."); Donald J. Rapson, *Default and Enforcement of Security Interests under Revised Article 9*, 74 CHI.-KENT L. REV. 893, 893 (1999) ("Article 9 has been rightfully lauded as the 'jewel' of the Uniform Commercial Code . . ."); Edward L. Rubin, *Efficiency, Equity and the Proposed Revisions of Articles 3 and 4*, 42 ALA. L. REV. 551, 557 (1991) ("[T]he greatest conceptual achievement in the field was Article 9 of the U.C.C. Its drafters, Gilmore and Dunham, had unified the various forms of security instruments-chattel mortgages, trust receipts, field warehouses, pledges and so forth-into a single coherent framework with a new, generic terminology."); Karl N. Llewellyn, *Why We Need the Uniform Commercial Code*, 10 U. FLA. L. REV. 367, 379 (1957) ("[T]he whole of Article 9 brings into simplified and workable form the law of all chattel security.").

⁶ U.C.C. § 9-109(d)(8) (2000) ("This article does not apply to . . . a transfer of an interest in or an assignment of a claim under a policy of insurance, other than an assignment by or to a health-care provider of a health-care-insurance receivable and any subsequent assignment of the right to payment, but Sections 9-315 and 9-322 apply with respect to proceeds and priorities in proceeds"). Notice an *ad hoc* exception for health-care insurance receivables. *See id.* Moreover the code does not exclude the proceeds of insurance policies from its scope. *Id.*; *see also* U.C.C.

eight of the fifty states follow the UCC in excluding insurance policies from the scope of their state's version of Article 9.⁷ A lender who accepts a life insurance policy as collateral to secure a debt may not look to Article 9 to determine her rights and responsibilities. But as states adopted Article 9, they repealed their other security statutes. So while the practice of

§§ 9-315, -322. But this inclusion is meant to allow secured parties whose collateral is destroyed to maintain their interest in the subsequent insurance money. See Peter Coogan, *The New UCC Article 9*, 86 HARV. L. REV. 477, 515 (1973). Neither exception is relevant to the discussion at hand.

⁷ ALA. CODE § 7-9A-109 (D)(8) (LexisNexis 2006); ALASKA STAT. § 45.29.109(d)(8) (LexisNexis 2010); ARIZ. REV. STAT. ANN. § 47-9109 (West 2005); ARK. CODE ANN. § 4-9-109(d)(8) (LexisNexis 2001); COLO. REV. STAT. ANN. § 4-9-109(d)(8) (LexisNexis 2010); CONN. GEN. STAT. ANN. § 42a-9-109 (West 2009); DEL. CODE. ANN. tit. 6, § 9-109 (2005); DC CODE § 28:9-109 (LexisNexis 2001); FLA. STAT. ANN. § 679.1091(4)(h) (West 2003); GA. CODE ANN., § 11-9-109(d)(8) (West 2010); HAW. REV. STAT. § 490:9-109(d)(8) (2008); IDAHO CODE ANN. § 28-9-109(d)(8) (2001); 810 ILL. COMP. STAT. 5/9-109(d)(8) (West 2004); IND. CODE ANN. § 26-1-9.1-109(d)(8) (LexisNexis 2005); IOWA CODE ANN. § 554.9109(4)(h) (West 2004); KAN. STAT. ANN. § 84-9-109(d)(8) (1996); KY. REV. STAT. § 355.9-109 (4)(h) (West 2006); LA. REV. STAT. § 10:9-109(d)(8) (West 2002); ME. REV. STAT. ANN. tit. 11, § 9-1109(4)(h) (West Supp. 2010); MD. CODE ANN., COM. LAW, § 9-109(d)(8) (LexisNexis 2002); MICH. COMP. LAWS ANN. § 440.9109(h)(4) (LexisNexis 2001); MINN. STAT. ANN. § 336.9-109(d)(8) (West 2002); MISS. CODE ANN. § 75-9-109(d)(8) (LexisNexis 1972); MO. ANN. STAT. § 400.9-109 (d)(8) (West 2003); MONT. CODE ANN. § 30-9A-109(4)(h) (2009); NEB. REV. STAT. § 9-109(D)(8) (2006); NEV. REV. STAT. § 104.9109(4)(h) (LexisNexis 2007); N.H. REV. STAT. § 382-A:9-109(d)(8) (LexisNexis 2009); N.J. STAT. ANN. § 12A:9-109(d)(8) (West 2004); N.M. STAT. ANN. § 55-9-109 (d)(8) (West 2001); N.C. GEN. STAT. ANN. § 25-9-109(d)(8) (LexisNexis 2001); N.D. CENT. CODE § 41-09-09(4)(h) (LexisNexis 2001); OHIO REV. CODE ANN. § 1309.109(d)(8) (West 2010); OKLA. STAT. ANN. tit. 12A, § 1-9-109(d)(8) (West 2001); OR. REV. STAT. § 79.0109(4)(h) (2009); 13 PA. CONS. STAT. ANN. § 9109 (d)(8) (West 2002); R.I. GEN. LAWS § 6A-9-109(d)(8) (LexisNexis 2001); S.C. CODE ANN. § 36-9-109(d)(8) (West 2003); S.D. CODIFIED LAWS § 57A-9-109(d)(8) (West 2004); TENN. CODE ANN. § 47-9-109(d)(8) (LexisNexis 2001); TEX. BUS. & COM. CODE ANN. § 9.109(d)(8) (West 2002); UTAH CODE ANN. § 70A-9a-109(d)(8) (LexisNexis 2009); V.I. CODE ANN. tit. 11A, Art. 9 § 9-109(d)(8) (West 2009); VT. STAT. ANN. tit. 9A, § 9-109(d)(8) (LexisNexis 2001); VA. CODE ANN. § 8.9A-109(d)(8) (LexisNexis 2001); WASH. REV. CODE ANN. § 62A.9 A-109(d)(8) (West 2003); W. VA. CODE § 46-9-109 (d)(8) (LexisNexis 2007); WIS. STAT. ANN. § 409.109(4)(h) (West 2003); WYO. STAT. ANN. § 34.1-9-109 (d)(vii) (LexisNexis 2009). But see CAL. COM. CODE § 9109 (West 2002); LA. REV. STAT. § 10:9-109(d)(8) (West 2002).

borrowing on insurance policies grows exponentially,⁸ there is less statutory law than ever. In that absence of statutory law, the common law governs from subterranean obscurity.

Article 9's Official Comments rationalize the insurance policy exclusion by stating, "Such transactions are often quite special, do not fit easily under a general commercial statute and are adequately covered by existing law."⁹ However, by the late 1960s, the Drafting Committee was criticizing the exclusion and the above-stated rationale:

It is hard to see where loans made by outsiders 'are adequately covered by existing law' and why they did not 'fit easily under a general commercial statute.' Indeed, it would appear that the law needs some rules to cover the growing practice of insurance premium financing where the loan by an outsider is always secured by a pledge of the insurance policy."¹⁰

This Article argues that security interests in life insurance policies can and should be within a general commercial statute, the Uniform Commercial Code's Article 9 and its concomitant state enactments.

The law as it currently operates is woefully inadequate. This is because the exclusion does more than decline UCC-specific legal procedures. It causes interests in life insurance policies to tumble down the rabbit hole into the pre-statutory common law. Economic innovation and industry practice have far outpaced the law in this area, and that has

⁸ The target market for life settlements, a subset of the impaired policies most attractive for a policy loan, is anticipated to grow at three times the rate of population growth in the coming decades. *See* SUNEET KAMATH & TIMOTHY SLEDGE, BERNSTEIN RESEARCH CALL, LIFE INSURANCE LONG VIEW – LIFE SETTLEMENTS NEED NOT BE UNSETTLING 6 (Sanford C. Bernstein & Co.) (2005).

⁹ Uniform Commercial Code: 1962 Official Text with Comments (Article 3 to End), 621 (1963), *reprinted in* XXIII Uniform Commercial Code Drafts, 401 (Comp., Elizabeth Slusser Kelly, 1984). The Comments to the current draft of the UCC no longer explain the policy exclusion at all.

¹⁰ Homer Kripke, Associate Reporter of the Review Committee for Article 9 of the Uniform Commercial Code, Memorandum Re: Problems of Inclusion and Exclusion, 4-5 (Feb. 16, 1968). Permanent Editorial Board for the Uniform Commercial Code, Document No. 10 in VI Uniform Commercial Code: Confidential Drafts, (Comp., Elizabeth Slusser Kelly & Ann Puckett, 1995). Kripke's comments were primarily directed at the exclusion of third party loans to the insured.

potentially harsh consequences for the consumers whose finances are impacted by the insurance industry.

Part I explains the basics of insurance financing transactions, emphasizing the importance of policy loans and sales to insurance customers, and how a vibrant secondary market serves those interests. Part I gives the reader a sense of what is at stake.

Part II explains the trouble with UCC § 9-109(d)(8) by showing three areas where the law is irregular, unfair, or at odds with modern business practice. Section A considers the “perfection problem,” which are those difficulties a party may experience in trying to perfect her security interest in an insurance policy. The current law grants priority in an uncertain and inefficient manner, to the detriment of secured parties, insureds, and insurers alike. The perfection problem is well known to those who follow these issues,¹¹ though the growing importance of an efficient secondary market makes it more important than ever.

Sections B and C present new problems with the exclusion. No previous scholarship has noticed or addressed these issues. Section B, the “surplus problem,” explains the law regarding the division of surplus from sale, surrender, or maturity of the policy. An important question that emerges in any insurance policy financing is “upon default, who gets what?” The rise of the secondary market has seen a variety of creditors who hope to receive the full maturity or resale value of the policy upon which the loan is secured. Because the policy is often worth more than the loan it secures, there is often a windfall to the creditors. These creditors are often unjustly enriched, and the present legal regime is insufficient to deter them.

Section C explains how the secondary market is threatened by a particularly bedeviling combination of draftsmanship and old law. Nearly all existing insurance policies are assigned in a manner that impedes the creditor’s ability to resell the policy. The resale is impeded as a result of a reservation clause in the policy assignment, and so is referred to as “the reservation problem.”

Each of these problems would be solved if security interests in life insurance policies were included within the scope of Article 9 of the UCC. Because interests in insurance policies are choses in action or things in

¹¹ Gerald T. McLaughlin, “*Seek but You May Not Find*”: *Non-UCC Recorded, Unrecorded and Hidden Security Interests under Article 9 of the Uniform Commercial Code*, 53 *FORDHAM L. REV.* 953, 959 (1985); Stephen Knippenberg, *Insurance Policies as Collateral Under Article 9: Withdrawal of the Section 9-104(g) Exclusion*, in *APPENDICES TO REPORT OF THE ARTICLE 9 STUDY COMMITTEE OF THE PERMANENT EDITORIAL BOARD FOR THE UNIFORM COMMERCIAL CODE*, 219 (1992).

action,¹² Article 9 would treat insurance policies as general intangibles.¹³ Security interests in general intangibles are perfected by filing with the Secretary of State.¹⁴ They are subject to a well-understood foreclosure and disposition regime.¹⁵ Contractual restrictions on assignment of interests in general intangibles are invalid.¹⁶ These features of Article 9, in addition to its general coherence and uniform treatment of other security interests, promise substantial improvements to this area of financing.

Part III goes on to consider and reject objections to this proposal. Five such objections are considered. Historical analysis shows that there was never a compelling reason for the exclusion, and policy analysis shows that exclusion is an inappropriate mechanism for protecting consumers or the insurance industry. Part IV concludes by taking stock of the problem and imagining the significance of this proposed solution for the broader financial market.

I. WHY PEOPLE BORROW AGAINST THEIR INSURANCE POLICIES, AND WHY IT SHOULD BE EASIER.

Judge Crippin in *St. John v. American Mutual Life Insurance Co.*, noted that “[W]ithout the right to assign, insurances on lives lose half their usefulness.”¹⁷ An insured’s right to assign an insurance policy to a third party is not seriously contested. The right was clearly recognized by the Supreme Court of the United States in 1911.¹⁸ But the law may make it difficult,¹⁹ and as a result compromise half the usefulness of an insurance policy.

Many different rationales might motivate an individual to borrow against her life insurance policy.²⁰ Most simply, an insured may desire to keep her insurance policy but be unable or unwilling to continue paying

¹² See *infra* note 94.

¹³ U.C.C. § 9-102(1)(42) (2000).

¹⁴ U.C.C. § 9-310 (2000).

¹⁵ U.C.C. § 9-610(a) (2000).

¹⁶ U.C.C. § 9-408 (2000).

¹⁷ *St. John v. Am. Mut. Life Ins. Co.*, 13 N.Y. 31, 39 (1855). In that case, perhaps not by coincidence, the surrender value of the policy was approximately half of the death benefit.

¹⁸ *Grigsby v. Russel*, 222 U.S. 149 (1911).

¹⁹ See *infra* Part II.

²⁰ Sachin Kohli, *Pricing Death: Analyzing the Secondary Market for Life Insurance Policies and its Regulatory Environment*, 54 BUFF. L. REV. 279, 293-95 (2006) (listing manifold reasons policy owner may wish to part with it).

premiums. Perhaps needs have changed, as would be the case if dependants have grown up or passed away. Perhaps her current policy is under-funded and she desires capital with which to invest in a better-suited life insurance product.²¹ Perhaps she needs an emergency fund to finance current expenses in the event of economic hardship.²² More than ever, our law respects such transactions and understands life insurance policies as instruments for planning for the aftermath of rapid declines in health other than death,²³ and as a financial asset more generally.

Recently, great attention has been directed towards so-called “life settlements” or “viatical settlements.”²⁴ In these transactions, insureds sell their policies to investors who then pay the premiums and stand to collect the death or “maturity” benefit. It is clear that some consumers benefit from this novel way of liquidating their insurance assets, but the irreparable quality of a sale increases the risk of fraudulent or unfair transactions.²⁵

²¹ Perhaps 40% of life insurance policy sales result in the purchase of a another financial product. Heather D. Mitchell, *The Producer's Role in a Life Settlement*, LIFE INS. SELLING, Feb. 1, 2004, (magazine), at 3 (statement of Scott Butterworth).

²² Andre P. Liebenberg, James M. Carson & Robert E. Hoyt, *The Demand for Life Insurance Policy Loans*, 77 J. RISK AND INSURANCE 651 (SEPT. 2010), available at SSRN: <http://ssrn.com/abstract=1653049>.

²³ Wayne M. Gazur, *Death and Taxes: The Taxation of Accelerated Death Benefits for the Terminally Ill*, 11 VA. TAX REV. 263, 266 (1991) (“Arguably, an income tax exclusion for accelerated death benefits . . . blur[s] the present distinction between the income taxation of life insurance, which traditionally emphasizes survivor protection, and the taxation of retirement, health, and long-term care requirements.”).

²⁴ See Ffiona M. Jones, Note, *The Viatical Settlement Industry: The Regulatory Scheme and Its Implications for the Future of the Industry*, 6 CONN. INS. L.J. 477, 480 (2000).

²⁵ According to one study, the price paid by third parties for life insurance policies tended to exceed surrender value, but amounted to only a small fraction of the present value of the policy's maturity payment. On average, insureds were paid 20% of the face value of the policy, but the policies purchased were worth 64% of the face value to the purchaser who holds them to maturity. More worryingly, it is not clear that insureds realize that this difference is so large since many industry estimates downplay relevant expenses the insured will bear in a policy sale. DELOITTE-UCONN ACTUARIAL CTR., DELOITTE CONSULTING & THE UNIVERSITY OF CONNECTICUT, *THE LIFE SETTLEMENTS MARKET: AN ACTUARIAL PERSPECTIVE ON CONSUMER ECONOMIC VALUE* 8 (2005); see also Joy D. Kosiewicz, Comment, *Death for Sale: A Call to Regulate the Viatical Settlement Industry*, 48 CASE W. RES. L. REV. 701 (1998) (describing potential abuses).

Another way for a cash strapped consumer to deal with premium payments is to borrow against the insurance policy for those same amounts. Loans secured by life insurance mark a palatable halfway point between the extremes of outright sale of the policy on the one hand and continued premium payment (which may no longer be possible for some insureds) on the other. Policy-secured loans allow an insured to monetize her valuable asset without permanently losing her residual interest in her policy. If she later regrets borrowing against her policy, she may be able to repay her creditor and again own the proceeds in full.²⁶ If the insured dies before having borrowed much of her line of credit, the surplus value above the debt belongs to her or her estate.²⁷

Today many consumers borrow from their life insurance companies. However, because the current legal regime discourages third-party creditors from making favorable bids, insureds must often borrow from their insurance company without being able to consider competing offers from other lenders.²⁸ The bargaining power of the insured and the lending insurance company is grossly unequal, and one may reasonably deduce that this inequality harms consumers and generally discourages consumers from borrowing against their insurance. Insurance statutes and market competition only partially mitigate these harms.

If we improve the law, with the result being a freer market, what is the benefit? This section addresses that question, explaining how the power to liberally sell or borrow against a policy will tend to benefit consumers by obtaining greater value for them than the transactions in which they currently engage. A liberal secondary market involving securitization of life insurance policies will also benefit investors, insurance companies, and the market as a whole.

²⁶ See 44 C.J.S. *Insurance* § 563 (2007).

²⁷ See 44 C.J.S. *Insurance* § 562 (2007).

²⁸ Insurance companies take steps to discourage insureds access to third-party financing. See Lori Widmer, *Life Settlement Regulation Makes It Harder to Avoid the Market*, AGENT SALES J., Feb. 2010 (“Many have gone so far as to ban the mere mention of life settlements to policyholders, and a number of insurers include contract stipulations that expressly prohibit agents from entering into such discussions.”). Some insurance companies have restricted agents from informing customers about third party assignability rights, while one insurance company has added a “right of first refusal.” James C. Magner, *What is Life Insurance? The Evolution of Financial Products*, 35 EST. PLAN 24, 30 (2008). Accumulator Universal Life III offered by Phoenix Home Life Variable Insurance Company, a Connecticut-domiciled affiliate of Phoenix Life Insurance. *Id.* at 30 n.55.0z.

A. HOW CONSUMERS BENEFIT FROM A LIBERAL AND EFFICIENT
ASSIGNMENT REGIME

Insurance companies provide loans pursuant to the terms of the particular insurance policy and applicable state laws. Insurance companies will often lend up to the surrender value of an insurance policy, which is the amount of cash the insurance company would pay to an insured who chooses to discontinue the policy. For a term-life policy, the surrender value is generally zero. For whole-life policies, which have an internal savings component, the surrender value, or the maximum borrowing amount, is generally no greater than the reserve set aside to fund the anticipated payment upon maturity.²⁹

It is, in any event, set by statute or by the contract at the time the policy is originated.³⁰ The surrender value at any given moment can be called the *ex ante* value of the policy, because it represents the current value as determined under a contract that does not account for intervening changes in facts.

If third party lenders were unimpeded by difficult and confusing laws, they would have incentives to provide better terms to some insureds than insurance companies. This is because they have an incentive to lend against the *ex post* value of the securing insurance policy, which accounts for subsequent changes in circumstances, while insurance companies do not have such an incentive.

²⁹ Doherty & Singer, *supra* note 1, at 451 (explaining that “[i]n the case of the lapse of a term-life policy, a policyholder who could no longer afford premium payments simply lost his insurance coverage and received nothing. In the case of a surrender of a universal, or whole-life policy, the predetermined schedule of surrender values offered by the insurance company—representing at most the reserve set aside to fund future insurance costs at standard rates—did not compensate a policyholder for the full actuarial value of the impaired policy.”).

³⁰ See ALASKA STAT. § 21.45.080(a) (2010); ARIZ. REV. STAT. ANN. § 20-1209(A) (2010); Del. Code Ann. tit. 18, § 2911(a) (2005); GA. CODE ANN. § 33-25-3(5) (2003); ME. REV. STAT. ANN. tit. 24-A, § 2510(1) (2000); MASS. GEN. LAWS ch. 175, § 132 (1998); MINN. STAT. ANN. § 61A.03(g) (West 2005); MONT. CODE ANN. § 33-20-131(1) (2009); NEV. REV. STAT. ANN. 688A.110(1) (LexisNexis 2009); N.J. STAT. ANN. § 17B:25-8 (West 2006); OR. REV. STAT. § 743.186(1) (2009); 40 PA. STAT. ANN. § 510(h)(2) (West 1999); S.C. CODE ANN. § 38-63-220(l) (2002); VT. STAT. ANN. tit. 8, § 3731(7)(A) (2009); WASH. REV. CODE ANN. § 48.23.080(1)(b) (West 2010); W. VA. CODE ANN. § 33-13-8(a) (LexisNexis 2006).

History may illuminate the present: insurance companies used to act as abusive monopolists when their customers wished to discontinue premium payments. Professor Gazur recounts a story of the early abuses of insurance company monopoly on the loan and surrender markets:

In London, [Elizur Wright] visited the insurance auctions at the Royal Exchange. There he saw old men standing on the life insurance auction block, their policies being offered to the highest bidder at a fraction of their actual worth. In one case a man had paid premiums for forty-four years and could meet the payments no longer. "This was done, I was told, because the companies made it a rule never to buy their own policies," wrote Mr. Wright.³¹

Although the worst abuses have been long curtailed, insurance companies still profit when their customers have fewer options in monetizing their policies. In particular, there is a direct relationship between lapse rate and profitability, and an inverse relationship between lapse rate and credit availability.

Insurance companies will ordinarily lend up to the surrender value of the policy, but no further. They may choose not to lend at all if the state statute does not require it.³² An insured that is unable to get a policy loan

³¹ Wayne M. Gazur, *Death and Taxes: The Taxation of Accelerated Death Benefits for the Terminally Ill*, 11 VA. TAX REV. 263, 273 (1991), citing ALBERT W. ATWOOD, *THE GREAT STEWARDSHIP* 75 (1945).

³² 5 PLITT ET AL., *COUCH ON INSURANCE* § 80:4 (3d. ed. 2005) (insureds right to loan may be conditioned on having paid premiums on time for a prescribed period of months or years); see also MASS. GEN. LAWS ch. 175, § 142(2) (1998) (stating that "[a]fter premiums have been paid for at least three full years on any policy of life insurance issued or delivered in the commonwealth by any life company, the holder thereof, upon written application therefore to the company at its home office and upon an assignment of the policy to the company, in a form satisfactory to it, shall be entitled to a loan from the company of a sum not exceeding its loan value, on the sole security of the policy."); N.Y. INSURANCE LAW § 3203(8)(A) (McKinney 2006); OHIO REV. CODE ANN. § 3915.05(G) (LexisNexis 2010); *Del Rio v. Prudential Ins. Co.*, 199 N.E. 32, 34 (1935) (insurer was compelled to comply with a statute requiring the making of a loan after three full years of premiums had been paid by insured); *Umstattd v. Metropolitan Life Ins. Co.*, 110 S.W.2d 342, 350 (1937); *Gray v. Aetna Life Ins. Co.*, 178 Tenn. 88, 156 S.W.2d 391, 393 (1941) (insured required to have paid a certain amount before being eligible for policy loan); 44 C.J.S. *Insurance* § 354 (2007).

sufficient to cover her premiums may surrender her policy or allow it to lapse.

Insurance companies build a rate of lapse into their business models.³³ They assume that some insureds will stop paying the premiums rather than wait to collect the full maturity sum, even when the maturity amount is substantially greater than the premiums probably required to service the policy. If insureds could borrow up to the true value of their policy at a competitive rate, they could pay their premiums on credit and avoid lapse, or borrow against their policies rather than use the surrender option.

Primary markets for insurance products are largely competitive,³⁴ so initial surrender prices should be actuarially fair at the time a consumer begins coverage. Even without laws forbidding the abusive practices Gazur reported, insurance companies have an incentive to offer *ex ante* reasonable surrender options because it is one feature consumers may compare as they decide which policy to select. Customers will pay less for an insurance policy if they think that it will be subject to unfair borrowing or surrender terms.

However insurers have no *ex post* incentive to update the surrender value to become actuarially fair.³⁵ The contract has been signed, and the competitive pressure is gone. In particular an insurance company is unlikely to improve the surrender or borrowing terms if an individual learns that her health prospects have worsened.

Poor health means that the insurance contract is likely to pay sooner than initially expected. Consequently, the insurance policy becomes more valuable. The insured, now having a shorter life span than was predicted by the insurer's initial models, will pay fewer premiums and wait a shorter time before her estate can collect. But this is true only if she holds the policy until maturity. No extra value is realized if she surrenders the policy or allows the policy to lapse.

If the surrender value represents the amount of money needed to pay the maturity sum in the future, and the maturity date has moved sooner, the surrender value should increase. But the insurance contract generally do

³³ DOMINIQUE LEBEL, TOWERS PERRIN TILLINGHAST, PRESENTATION AT SOCIETY OF ACTUARIES ANNUAL MEETING: PRICING LAPSE-SUPPORTED PRODUCTS/LAPSE-SENSITIVE PRODUCTS (Oct. 16, 2006) (A lapse-supported product is "a product where there would be a material decrease in profitability if, in the pricing calculation, the ultimate lapse rates were set to zero (assuming all other pricing parameters remain the same).").

³⁴ Doherty & Singer, *supra* note 1, at 468.

³⁵ *Id.* at 462.

not require such an increase, and insurance companies do not gratuitously do so. Surrender values are generally not updated for new health information, so they will remain low.

In the same way, if the insured wishes to borrow against the value of the policy, the insurance company will lend an amount, and at an interest rate, that reflects the initial contracting conditions. There will be no effort to compensate for the changed health conditions of the insured. Policy provisions³⁶ and state statutes³⁷ typically recognize no surrender value for term life insurance against which to borrow, even if the insured is likely to die within a year or two, and receive far more than the concomitant premiums could ever equal. Insurance companies exploit these individuals by offering loans with unnecessarily low credit limits and comparatively unattractive terms, and so encourage lapse.

Third parties may be willing to lend greater amounts and at lower rates, reflecting the updated longevity risk upon yield. In the short run, competition from third-party lenders will give better options to insureds. In the long run, competition will cause issuer insurance companies to issue policies that more closely track the updated longevity of consumers, granting greater and better *ex post* surrender values and borrowing terms to consumers.³⁸ In particular, consumers with the worst adverse health conditions and least ability to service their premiums will be most helped by increased competition in this market.

The outstanding value of life insurance policy loans in the US in 2009 exceeded \$121 billion.³⁹ The vast majority of these loans had no serious competition, and it is reasonable to believe that more competition among lenders would improve the secondary market. There are perhaps \$100 billion worth of impaired policies.⁴⁰ Almost \$12 billion of policy face values were sold to investors in 2008, a number which could easily grow to

³⁶ *Francis v. Universal Life Ins. Co.*, 223 So. 2d 188, 192 (La. Ct. App. 3d Cir. 1969), *application denied*, 254 La. 781, 226 So. 2d 771 (1969).

³⁷ See ALASKA STAT. § 21.45.080(b) (2010); ARIZ. REV. STAT. ANN. § 20-1209(B) (2010); DEL. CODE ANN. tit. 18, § 2911(c) (2005); GA. CODE ANN. § 33-25-3(12)(b) (2003); ME. REV. STAT. ANN. tit. 24-A, § 2510(2) (2000); MONT. CODE ANN. § 33-20-131(2) (2009); NEV. REV. STAT. ANN. § 688A.110(1) (LexisNexis 2009); N.J. STAT. ANN. § 17B:25-8 (West 2006); OR. REV. STAT. § 743.186(4) (2009); S.C. CODE ANN. § 38-63-220(l) (2002); VT. STAT. ANN. tit. 8, § 3731(7)(J) (2009); W. VA. CODE ANN. § 33-13-8(b) (LexisNexis 2006).

³⁸ Doherty & Singer, *supra* note 1, at 472.

³⁹ FED. RES., *supra* note 3, at 32.

⁴⁰ Doherty & Singer, *supra* note 1, at 452-53.

\$90-140 billion by 2016.⁴¹ Every one of these policies has a resale value larger than its surrender value and so is eligible for a larger policy loan or a lower rate than the insurance company would offer.⁴² The target market for life settlements, the sale of an insurance policy, is anticipated to grow at three times the total population in the coming decades.⁴³

There are clearly an enormous number of people who may be interested in, or well served by, loans secured by their life insurance policy. Competition from third party lenders will improve their prospects, as will a robust secondary market with securitized insurance-linked assets.

The insurance business has a set of terms and practices all its own, so it is fruitful to address some terminology. A *collateral assignment*⁴⁴ is an assignment of the policy as collateral. The creditor has no rights in the policy until the borrower defaults, at which time the creditor's interest in the pledged collateral may be used to satisfy the debt. A transfer of the entire interest in the insurance policy to a third party will be effected through an *absolute assignment*.⁴⁵ An absolute assignment of a life insurance policy is the irrevocable transfer of all of the owner's rights in the policy, typically made in order to give the policy away or to sell it.⁴⁶ An

⁴¹ Conning Research and Consulting, Inc., Life Settlements: A Buyers' Market for Now, Oct. 8, 2009.

⁴² For example, a policy with a face value of \$5 million may have a surrender value of \$1 million, reflecting the statutory or contractual conditions at the time the policy was signed. If the insured discovers that she has two years to live, she may find that the policy has a value on the secondary market of, say, \$3 million. Someone may be willing to pay her \$3 million for the right to collect \$5 million when she dies. That purchaser will pay the premiums until she dies, too. Similar math applies to borrowing. If the insured wishes to borrow, and absent new competition, the insurance company will lend to her as though she has \$1 million collateral – the surrender value of the policy. A third party will be willing to lend against \$3 million, recognizing a greater resale value upon which to foreclose in case of default. The third party may be willing to lend a larger amount, or at a more attractive rate for a loan which is recognized as oversecured.

⁴³ KAMATH & SLEDGE, *supra* note 8, at 1-2; *see also* Matthew Goldstein, *Why Death Bonds Look so Frail*, Bus. Wk., Feb. 25, 2008 (putting the market for life settlements at about \$15 billion).

⁴⁴ *See, e.g.*, Example Assignment of Life Policy to Secure and Future Debts, 10 AM. JUR. *Legal Forms* 2D § 149:183 (2010).

⁴⁵ *See, e.g.*, 9 CHRISTOPHER GADSEN, *Estate Planning*, in WEST'S PENNSYLVANIA FORMS § 14:7 (1995).

⁴⁶ MURIEL L. CRAWFORD & WILLIAM T. BEADLES, *LAW AND THE LIFE INSURANCE CONTRACT* 356 (6th ed. 1989).

absolute assignment can also be used to secure a loan.⁴⁷ A party may sign an absolute assignment in favor of a lender, but the lender does not presently gain the rights and privileges of ownership, nor will the lender simply come to own the policy upon default by the borrower. A court will treat the absolute assignment in form as a collateral assignment.

B. TOWARDS A THRIVING SECONDARY MARKET

Creditors will more readily lend against insurance policies if they are able to efficiently dispose of policies upon default.⁴⁸ If a dependable legal framework is provided, the secondary market for insurance policies should thrive and dramatically improve borrowing opportunities for insureds.⁴⁹ Arguments for robust secondary markets may seem naïve given the unfolding of the financial crisis,⁵⁰ nonetheless, it is generally accepted that secondary markets in assets tend to raise the value of those assets.

Generally, a vibrant secondary market increases demand for qualifying policies, conferring greater surplus to the seller or borrower consumers. This is for three reasons. First, secondary markets allow investors to sell their investments prior to maturity. Increased liquidity attracts a much greater pool of investors with shorter time horizons, or who anticipate that their portfolio needs may change. Without a liquid secondary market, fewer lenders will value insurance as collateral. Those who accept it will demand a proportionally higher return to compensate them for risks and opportunity costs associated with a long-term investment.

Second, a vibrant secondary market gives rise to greater specialization of actors. It takes specialized skills to evaluate the risks and return associated with a given policy. Where parties find it difficult to resell

⁴⁷ *Id.* at 360.

⁴⁸ Even those opposed to Article 9 inclusion seem to accept this statement. See Steven L. Harris & Charles W. Mooney, Jr., *How Successful Was the Revision of UCC Article 9?: Reflections of the Reporters*, 74 CHI.-KENT. L. REV. 1357, 1375 n.75 (1999). Consumer groups agreed with the Drafting Committee that non-Article 9 law had the practical effect of making credit secured by insurance policies much less available, but they did not see this as a good thing.

⁴⁹ See, e.g., Doherty & Singer, *supra* note 1, at 459; see also 35 Est. Plan. 24, 24 (“The most significant innovation the life insurance industry has experienced in recent memory has been the development of the so-called secondary market”).

⁵⁰ Doherty & Singer, *supra* note 1, at 459 (arguing that life insurance policy securitization and marketing will have a similarly beneficial effect in reducing risk as does mortgage securitization in its own market).

a policy, they must research policies for their own long-term holdings. But where resale is possible, a savvy investor may dedicate resources to evaluating policies. She may invest in far more policies than she would be comfortable holding to maturity because she anticipates selling them to investors lacking the specialized evaluating skills.⁵¹ More policies will be funded and better investment research skills will be developed in a specialized market with liquid secondary sales. Lenders may lend more on insurance than they otherwise would, knowing that they will not have to hold collateral to maturity.

Third, vibrant markets lead to price discovery, which allows non-speculators to be comfortable investing in a given asset class. Fourth, where policies are liberally sold and resold, they can be combined, bundled, and securitized in a way that reduces risk. The benefits of investing in pools, rather than in their individual underlying assets, are well known.⁵²

⁵¹ It is also true that some investors may dedicate less resources to evaluating assets when they know that they will be passed onto to less specialized secondary purchasers. That is one key cause of the present financial crisis. Too many investors or lenders allowed their internal controls to lapse because they knew that they would not bear the costs of their errors, and too many secondary purchasers trusted ratings agencies or bond insurers. However, the above point about the raise of specialized investment evaluation skills remains valid. If it costs \$10 to develop a method for determining whether investment X is \$1 more profitable than investment Y, or vice versa, then few companies will develop that method. But if a company can sell their interest in X or Y to a third party, and then use the proceeds to buy either X2 or Y2, that company can use the method again. The more iterations, the greater the return on the knowledge investment. Capital is better allocated when companies profitably invest in vetting and evaluation methods. Doubtless, many companies failed to adequately evaluate the viability of many subprime, exotic, or complex assets. But the few that did evaluate, and the many more that could have, did so because of technology that only made sense in a securitized market where primary investors didn't have to buy and hold.

⁵² See LIFE SETTLEMENTS TASK FORCE, STAFF REPORT TO THE UNITED STATES SECURITIES AND EXCHANGE COMMISSION 6 (2010) ("the majority of investors in today's life settlements market are large institutional investors looking to acquire pools of policies"). The benefits of pooled investments accrue only if the risks of individual assets are not highly positively correlated. Pooled life insurance policies will generally meet this condition. Mortality rates generally do not rise and fall in tandem for geographically spread policy holders. The possibility for pooling is one of the major enablers of an insurance industry. If one individual's death was strongly positively correlated with many other individuals, insurance companies would not be able to reduce risk by holding a large portfolio.

There is a growing interest in assets that have no correlation with market forces,⁵³ so secondary markets would serve a legitimate economic need of investors who seek to hedge. Investors seeking a strong yield without strong market exposure should find life insurance policies a potentially attractive asset class. Major institutional investors like UBS, Merrill Lynch, Citibank⁵⁴ and Berkshire Hathaway⁵⁵ have already entered this market. Investors have always been able to gain partial exposure to this asset by investing in insurance companies. But such investments are not ideal for hedging because the risk is affected by the management of, and investment portfolio held by, a particular insurance company. Moreover, since beneficiary payments under life insurance policies constitute a liability to insurance companies, the corresponding bet is actually to short the insurance company.

There are risks to these assets. Investors in insurance policies through intermediaries must trust that the company is truly investing their money in assignments of life insurance policies. Not all such companies are scrupulous agents for their investors. Some hide behind the opacity of their investment to squirrel away funds.⁵⁶ If investors are not to be disappointed here as they were with housing securities, these securities must be appropriately marketed and regulated. And securitized life insurance assets are not immune to whatever forces precipitated the current financial

⁵³ *Id.* (“Institutional investors reportedly view life settlements as an alternative asset class that is not correlated to traditional asset classes because returns principally are based on the death rates of the insured individuals rather than the performance of financial instruments or the overall economy. Diversification to uncorrelated assets is especially attractive to investors during periods of unfavorable economic conditions”); see also Matthew Goldstein, *Profiting from Mortality*, BUS. WK., July 30, 2007, at 44; Sam Rosenfeld, *Life Settlements: Signposts to a Principal Asset Class* (Wharton Fin. Inst. Ctr., Working Paper No. 09-20, 2009), available at <http://fic.wharton.upenn.edu/fic/papers/09/0920.pdf>.

⁵⁴ See Harold G. Ingraham, Jr. & Sergio S. Salani, *Life Settlements as a Viable Option*, J. FIN. SERV. PROFS. 72, 75 (2004). But see Matthew Goldstein, *Goldman Retreats from Life Settlements*, REUTERS.COM, Dec. 18, 2009 2:27 PM EST, <http://www.reuters.com/article/idUSN1823436220091218> (“life settlement derivatives appears [sic] to be a casualty of the worst financial crisis since the Great Depression”).

⁵⁵ John Hoogesteger, *Berkshire Unit Lends \$400M to Startup*, MINNEAPOLIS/ST. PAUL BUS. J. (Feb. 3, 2002, 11 PM CST), available at <http://twincities.bizjournals.com/twincities/stories/2002/02/04/story1.html>.

⁵⁶ *PCO, Inc. v. Christensen*, 58 Cal. Rptr. 3d 516, 516 (Cal. Ct. App. 2007) (PCO executives converted all \$89 million intended for viatical investment).

crisis.⁵⁷ But risks are no greater here than in any other area, and whichever financial reforms are attempted will succeed or fail for securitization here as elsewhere.⁵⁸ Moreover, some of the most potentially worrying products have been cancelled due to market forces.⁵⁹

It should be clear that secondary markets in insurance increase the demand for third-party creditors to lend to customer borrowers. It should also be clear that this increased demand is to the benefit of borrowers. What follows is an explanation of the current law of insurance-secured financing. It will be shown that the law is confused and antiquated, and the most logical reform proposal will virtuously liberalize the market for loans as well.

II. WHERE EXCLUSION LEAVES INSURANCE

Article 9 of the Uniform Commercial Code governs almost all security interests transactions in all US jurisdictions. Although it is preempted by any inconsistent state laws,⁶⁰ most states have redacted any prior inconsistent laws. The Code's merits are well-recited and have only grown as more states and more transactions have come under its scope. Article 9, in particular, rationalized and reformed a truly confusing area of the law.

As mentioned before, Article 9 excludes interests in and assignments of insurance policies from its scope.⁶¹ Nearly every state

⁵⁷ See, e.g., *Rep. Collin C. Peterson Holds a Hearing on the Over-the-Counter Derivatives Market: Hearing Before the H. Comm. on Agriculture*, 111th Cong. (2009) (Rep. Boswell asking, "does this securitization of life settlements not only add another element of possible risk to an industry that is already in need of more transparency and consumer safeguard, but is it something you -- we should even allow?").

⁵⁸ The author acknowledges the intuitive worry that derivatives in the insurance space have a worrying resonance to the fact that AIG's non-insurance activities threatened their core insurance business, and indeed, the entire economy. However, the analogy should be resisted, owing to the difference between securitization of insurance products, and securitization of non-insurance products by insurance companies.

⁵⁹ Goldstein, *supra* note 53 ("The Wall Street company once had big plans to sell derivatives pegged to the index [which tracks the life expectancy of a group of people who have sold their life insurance policies to an investment pool] to investors seeking exposure to the estimated \$15 billion life settlements market.").

⁶⁰ U.C.C. § 9-109(c)(1)-(3) (2011).

⁶¹ U.C.C. § 9-109(d)(8) (2011). *But see* CAL. COM. CODE § 9109 (Deering 2010); LA. REV. STAT. ANN. § 10:9-109(d)(8) (2011). Of course, there is an ad hoc

follows the UCC in excluding insurance policies from their secured transactions statute.⁶² Where a lien or assignment is not covered by the UCC, the court must decide which other body of law to apply.

It would be natural to look to whichever statute governed security interests before the UCC, but this is generally incorrect. Having adopted the Uniform Commercial Code, many states repealed the statutes governing chattel mortgages and pledges that had previously also governed interests in, and assignments of, insurance policies. This repeal leaves something of a statutory void for assignments of life insurance policies.⁶³

For example, pre-code chattel security in Illinois came in through six devices: the pledge, the chattel mortgage, the conditional sale, the trust receipt, accounts receivable financing, and the factor's lien in favor of wholesalers.⁶⁴ By 1962, all but one had been eliminated. The conditional sale was a creature of the Uniform Sales Act,⁶⁵ which was repealed following the adoption of the UCC.⁶⁶ The Uniform Trust Receipt Act was repealed following the adoption of the UCC,⁶⁷ as was the validating statute for accounts receivable financing,⁶⁸ chattel mortgages,⁶⁹ and the factor's lien in favor of wholesalers.⁷⁰ Only the common law pledge remained. Similar stories can be told of every other state.⁷¹

The little statutory law that remains is not particularly appropriate to insurance policy liens. For example, some states have reserved a

exception for health-care insurance receivables, *see id.*, but this hardly relevant. Moreover the code does not exclude the proceeds of insurance policies from its scope. *Id.* at §§ 10:9-109, -315, -322. But this inclusion is meant to allow secured parties whose collateral is destroyed to maintain their interest in the subsequent insurance money. *See* Coogan, *supra* note 6, at 515.

⁶² *See, e.g.*, FLA. STAT. ANN. § 679.1091(4)(g) (LexisNexis 2011).

⁶³ *See, e.g.*, ME. PUB. L. of 1963, c. 362 (1963).

⁶⁴ 2B Daniel R. Murray *et al.*, UNIFORM COMMERCIAL CODE WITH ILLINOIS CODE COMMENTS 9 (2010 ed., 2010).

⁶⁵ *Id.*

⁶⁶ 810 ILL. COMP. STAT. 5/10-102 (2011) (repealing ILL. REV. STAT. ch. 121 1/2, ¶ 1 *et seq.*).

⁶⁷ *Id.* (repealing ILL. REV. STAT. 121 1/2, ¶ 166 *et seq.*).

⁶⁸ *Id.* (repealing ILL. REV. STAT. 121 1/2, ¶ 220 *et seq.*).

⁶⁹ *Id.* (repealing ILL. REV. STAT. 95, ¶¶ 26-27).

⁷⁰ *Id.* (repealing ILL. REV. STAT. 82, ¶ 102 *et seq.*).

⁷¹ *See, e.g.*, 12A PA. STAT. ANN. § 10-102 (1953) (repealing Uniform Conditional Sales Act, 69 PA. STAT. ANN. § 361 *et seq.* (1931); Uniform Trust Receipts Act; 68 PA. STAT. ANN. § 551 *et seq.* (1953); a general chattel mortgage statute, 21 PA. STAT. ANN. § 940.1 *et seq.* (1953); and a factor's lien act, 6 PA. STAT. ANN. § 221 *et seq.* (1953)).

banker's lien that gives bank loans a general lien on all assets.⁷² There are cases in which this might accomplish the desired effect of allowing an individual to borrow against her insurance policy, but it is a cumbersome way to organize a loan. It may be better to say that there remains no statutory law that directly governs insurance liens and assignments. Thus, to a great degree, the governing pre-Code law is not just pre-Code statutory law, but pre-statutory common law.⁷³

Not only does this deny the insurance policy transactions the benefits afforded by the UCC, it also forces insurance-based lending to rely on law that has languished in isolation from growing case law and reforming trends. Article 9 explains itself with nearly syllogistic clarity.⁷⁴ Where clarification is required, the centralization of uniform law has encouraged a comprehensive scholarly treatment that explores, reconciles, and renews the law.⁷⁵ No such commentary fixes similar attention to niche subject of state-by-state case law on insurance-linked finance transactions.

The possibility of this problem was not lost on the Commenters for the 1972 Article 9. Professor Peter Coogan, Consultant to the Review Committee for Article 9, discussing the effect of the exclusion of bank deposit accounts from Article 9 explained how "[t]his illustrates one of the problems with respect to the exclusions generally, of section 9-104."⁷⁶ He

⁷² CAL. CIV. CODE § 3054 (Deering 2010); *DuBrutz v. Bank of Visalia*, 87 P. 467, 468 (Cal. Ct. App. 1906) (bank surrenders life insurance policy). Note, however, that California transactions do not need to resort to these sorts of statutes, since California's Article 9 does not exclude life insurance loans. This example is provided only illustratively.

⁷³ *Law Research Serv., Inc. v. Martin Lutz App. Printers, Inc.*, 498 F.2d 836, 840 (2d Cir. 1974).

⁷⁴ See Timothy R. Zinnecker, *Socrates, Syllogisms, and Sadistic Transactions: Challenges to Mastering U.C.C. Article 9 Through Deductive Reasoning*, 13 CHAP. L. REV. 97, 136 (2009).

⁷⁵ See, e.g., BENDER UCC REPORTER-DIGEST; THE ABCs OF THE UCC (American Bar Association); LARY LAWRENCE, ANDERSON ON THE UNIFORM COMMERCIAL CODE (WEST); HAWKLAND ET AL., HAWKLAND'S UNIFORM COMMERCIAL CODE SERIES (West); THOMAS M. QUINN, QUINN'S UNIFORM COMMERCIAL CODE COMMENTARY AND LAW DIGEST (West); BRADFORD STONE & KRISTEN DAVID ADAMS, UNIFORM COMMERCIAL CODE IN A NUTSHELL (West); JAMES J. WHITE & ROBERT S. SUMMERS, UNIFORM COMMERCIAL CODE (HORNBOOK SERIES) (West); UCC L.J.; Margit Livingston, *Survey of Cases Decided Under Revised Article 9: There's Not Much New Under the Sun.*, 2 DEPAUL BUS. & COMM. L.J. 47 (2003) (surveying case law developments).

⁷⁶ Program, *Impact of 1972 Revisions On Secured Financing Transactions Under UCC Article 9*, 33 BUS. LAW. 2491, 2532 (1978).

goes on to say “we have the awful problem that part of this was statutory and those statutes have all been repealed, like the chattel mortgage, the assignment of contracts, all that stuff, has been repealed, so that you go to the pre-pre-statutes, and sometimes you cannot find it.”⁷⁷

The insurance policy exception never enjoyed enthusiastic support from the drafters of the UCC. The written reflections of the Reporters indicate neither serious policy commitments to this exclusion, or even a concerted industry opposition to its inclusion. Relatively mild opposition from the insurance industry was persuasive in light of the Reporters’ sense that this exclusion simplified the drafting process. Even taking that conclusion for granted, the Reporters expressed reservations about extending the insurance exclusion to third party interests as well as issuer policy loans.

The problems with all exclusions are the same: the most recent statutes were repealed in conjunction with the adoption of a new uniform code. Article 9 does not apply to the excluded items, so they are orphans left in the care of truly ancient law.

Professor Coogan asked Bill Davenport, General Counsel for First Bank of Chicago, about the law applicable to bank deposit accounts, and Davenport’s reply centered on case law so old that Coogan interrupted, “We are now including a generation-some people may be of a generation that does not remember [the case]. Would you just explain it.”⁷⁸ An exclusion from Article 9 does not just freeze the applicable law as that of the early 1960’s. Exclusion kicks life insurance policies back a hundred years to the common law operative before any legislative reforms at all.⁷⁹

There was some hope among the drafters of Article 9 that the common law on insurance pledges would come to resemble the Article 9 law and thus “the exclusion would be more formal than real.”⁸⁰ Like so

⁷⁷ *Id.* at 2533.

⁷⁸ *Id.* at 2532 (discussing *Benedict v. Ratner*, 268 U.S. 353 (1925) and prior, related Illinois case law).

⁷⁹ Despite the obvious problems with reverting to the law of substantially different times, this is only one of many examples of the general phenomenon. *See, e.g.,* Teemu Ruskola, *Colonialism without Colonies: On the Extraterritorial Jurisprudence of the U.S. Court for China*, 71 LAW & CONTEMP. PROBS. 217, 223 (2008) (the U.S. Court for China, from 1906 to 1943, “was called on to ‘ascertain the common or unwritten law in force in the colonies prior to the Declaration of Independence and then to attempt to apply it to modern conditions in China’ . . .”) (quoting a Shanghai lawyer).

⁸⁰ 1 GRANT GILMORE, *SECURITY INTERESTS IN PERSONAL PROPERTY* 315 (photo. reprint 1999) (1965).

many theories of legal convergence, that hope has not materialized.⁸¹ As a result, the applicable common law remains splintered, inconsistent, irregular, and generally ill-suited to the demands of modern finance.⁸² It has failed to improve because all the other pledges and assignments were plucked away to develop case law under the UCC.

The distance between growing UCC law and languishing non-UCC laws leads to the distressing possibility that cross-jurisdiction transactions might implicate different security rules. The Reporters acknowledged this ambiguity under currently law:

It would be odd if a designation of applicable law by a debtor and secured party were to control some of these matters. Consider an example that may arise under current law. Former 9-318(4) makes ineffective terms in certain contracts that restrict assignments of the right to payment under the contracts. Under California's nonuniform version of Article 9, security interests in most insurance policies are within the scope of the article. Under New York's (and most states') version, security interests in insurance policies are excluded. If an insurance policy provides that it is governed by the law of New York, it would seem [sic] appropriate for New York's law to determine whether a term restricting assignment of the policy is effective. Since New York's Article 9 does not cover an assignment of the policy, New York's 9-318 would not appear to render ineffective the restriction on assignment. Now assume that the owner of the policy, a California resident, assigns it as security to a California bank, and the security agreement provides that it is governed by the law of California. Does California's 9-318(4) then render the restriction in the policy ineffective?

⁸¹ One of federalism's early indulgences was the notion that federal common law would come to influence and unify the various state common laws. *But see* *Erie R.R. Co. v. Tompkins*, 304 U.S. 64 (1938).

⁸² Karl Llewellyn, *Problems of Codifying Security Law*, 13 LAW & CONTEMP. PROBS. 687, 688 (1948) (the Chief Reporter for the Uniform Commercial Code noting the inefficiencies created by the hodgepodge of older commercial laws: "What is not minor is the price in complexity, inconvenience, and often in unfairness which must be paid when legal patterns of happenstance origin are taken in all their history-ridden detail as the basis for the doing of remodeling jobs which are themselves piece-work").

We are inclined to think it should not, but the answer is uncertain.⁸³

Unheard of in other areas, conflicting security rules from state to state are a reality for lawyers practicing law in this area. These issues would evaporate if all policies were governed by the UCC,⁸⁴ but because they are not, life insurance policies remain tangled in the interstate conflicts of law problems of a bygone era. The confusion and antiquation of that era gives rise to three problems, each of which serves to frustrate those third party lending, and secondary market trading, that would benefit consumers.

A. THE PERFECTION PROBLEM

The perfection problem refers to the difficulty in finding a rational, coherent, and clear perfection equivalent in non-UCC law.⁸⁵ Strictly speaking, it is impossible for any party to perfect an interest in a life insurance policy. This is because perfection is a concept introduced by the UCC, but the UCC excludes life insurance policies from coverage. One wishes that under the non-UCC regime, similar procedures could achieve perfection's goal: allowing parties to discover prior liens, and then establish their own priority in a durable and just manner. However, conflicts amongst assignees are common and messy under the non-Article 9 regimes. This is because the law governing priority is not as firmly established as might be inferred from industry practice. Subparts (1)-(3) show the places where industry consensus lacks doctrinal support.

Moreover, even if accepted that non-UCC law speaks coherently and with adequate approval of industry practice, industry practice remains unjust and inefficient. Subpart (4) explains the public policy problems with the status quo practice. The perfection problem thus indicates the gulf between non-UCC reality and the clear and efficient perfection parties have come to expect through Article 9. Under the UCC, notification would follow the method of any general intangible: attachment plus notification. With attachment plus notification, the problems of secret liens, private notification, and doctrinal uncertainty would be much reduced. The status

⁸³ UNIFORM COMMERCIAL CODE art. 9, pt. 4: RIGHTS OF THIRD PARTIES (Proposed Official Draft, Oct. 1996).

⁸⁴ U.C.C. § 9-301 (1999).

⁸⁵ Other commentators have noticed the perfection problem in the past, though none have used that title. *See, e.g.,* McLaughlin, *supra* note 11, at 959; Knippenberg, *supra* note 11.

quo exacerbates problems in a context of uncertainty by over-valuing notification to insurers and under-valuing public notification.

1. Notice to Insurance Company

Industry practice is to assume that priority of security goes to the assignee that first provides notice to the insurance company. Although there is some doctrinal support for this state of affairs,⁸⁶ the importance of insurer notification is not always dispositive at common law.

Requirements of notice are for the benefit of insurance companies.⁸⁷ Courts often emphasize that the notice requirement is part of the contract between the insured and the insurer, and cannot affect the rights of third parties, such as the assignee.⁸⁸ Thus, courts adjudicating between non-insurer assignees often ignore notice to insurance companies, deciding the case on other factors.⁸⁹

A substantial minority rule allows priority to the first assignee, regardless of notice to the insurer.⁹⁰ This minority rule was recently

⁸⁶ *Patten v. Mutual Ben. Life Ins. Co.*, 6 S.E.2d 26 (S.C. 1939); *Richards v. Griggs*, 16 Mo. 416 (1852); *Murdoch & Dickson v. Finney*, 21 Mo. 138 (1855); *Houser v. Richardson*, 90 Mo. App. 134 (1901); *Klebba v. Struempf*, 23 S.W.2d 205 (Mo. App. 1930).

⁸⁷ *See Equitable Life Ins. Co. of Iowa v. Mitchell*, 248 Ill. App. 401, 404 (Ill. App. Ct. 1927) (“It has been repeatedly held that provisions of a life insurance policy requiring notice of an assignment to be given to the company are for the benefit of the company and it alone may complain or object because of a failure to comply with the terms of the policy.”). Note that this demonstrates an important difference between UCC and non-UCC treatment of insurance companies. Notice under the UCC is for the benefit of all creditors and potential creditors, not for the benefit of one creditor or the notified party.

⁸⁸ *See, e.g., Allhusen v. Caristo Const. Corp.*, 103 N.E.2d 891, 892 (N.Y. 1952); *Herman v. Connecticut Mut. Life Ins. Co.*, 105 N.E. 450, 451 (Mass. 1914).

⁸⁹ *See Fidelity Mutual Life Ins. Co. v. City Nat’l. Bank*, 95 F. Supp. 276, 282 (N.D. W. Va. 1950) (first-in-time assignee has priority). *See also Fidelity & Deposit Co. v. Moore*, 14 S.E.2d 307, 310 (Va. Ct. App. 1941) (case determined on intent of the assignor).

⁹⁰ *Fidelity Mut. Life Ins. Co. v. City Nat’l Bank*, 95 F. Supp. 276, 282 (N.D. W. Va. 1950); *see also In re Leterman, Becher & Co.*, 260 F. 543, 547 (2d Cir. 1919); *Superior Brassiere Co. v. Zimetbaum*, 212 N.Y.S. 473, 475 (N.Y. App. Div. 1925) (“By the first assignment, the rights of the assignor pass to the assignee Notice of the assignment to the debtor adds nothing to the right or title transferred.”). The insurance company should correspond to the “debtor” in each of

affirmed by the Court of Appeals for the Second Circuit in *Rose v. AmSouth Bank of Florida*.⁹¹ There, the court overruled the district court's ruling that New York law required insurer notification in order for an assignment to be valid against a subsequent assignee. Thus, the newest and clearest ruling on priority gives the interest in an insurance policy to the earliest assignee, rather than earliest notifying assignee, in contradiction of industry practice.

2. Possession

The legal significance of possession of the original life insurance policy is treated inconsistently. As a matter of commercial practice, life insurance companies do not attribute legal significance to possession of a sole "original" policy.⁹² Additionally, the requirement of possession is not practical for interests in group life insurance policies.⁹³

Nevertheless, insurance policies are choses in action at common law,⁹⁴ and the common law pledge provides a mechanism for perfecting an interest in an insurance policy by possession.⁹⁵ Until the early nineteenth century, the only way to create a valid security interest in personal property

those cases. An assignee was due proceeds and assigned them twice, similar to an insured who assigned the policy twice.

⁹¹ *Rose v. AmSouth Bank*, 391 F.3d 63, 66 (2d Cir. 2004) (citing *Salem Trust Co. v. Manufacturers' Finance Co.*, 264 U.S. 182, 198 (1924)) (noting that the Salem court—which ruled on the basis of then-extant federal common law, and on which the district court relied—specifically commented that under New York Law the earlier assignee would have prevailed, notwithstanding its failure to take possession or provide notice).

⁹² Louisiana Official Revision Comments to R.S. – 2001, § 10:9-107.1(b), revised, 2004 (c) 2008.

⁹³ James Stuckey, *Louisiana's Non-Uniform Variations in U.C.C. Chapter 9*, 62 LA. L. REV. 793, 813 (2002).

⁹⁴ *Missouri State Life Ins. Co. v. Langreder*, 87 F.2d 586, 592 (7th Cir. 1937); *U.S. Life Ins. Co. v. Ludwig*, 103 Ill. 305, 312 (Ill. 1882); *Considine v. Considine*, 7 N.Y.S.2d 834 (1938); *Coleman v. Anderson*, 82 S.W. 1057 (Tex. Civ. App. 1904), *aff'd*, 86 S.W. 730 (Tex. 1905).

⁹⁵ RESTATEMENT (FIRST) OF SECURITY § 1 cmt. a (1941) ("Where a chose in action is represented by an indispensable instrument, whether negotiable or non-negotiable, the chose in action may be pledged."); RESTATEMENT (FIRST) OF SECURITY § 1 cmt. e (1941) ("Indispensable instruments include . . . insurance policies.").

was through physical possession by the pledgee.⁹⁶ Non-possessory security interests were presumptively fraudulent.⁹⁷ Non-possessory security interests found greater expression and acceptance in later years, but development was neither linear nor logical. Rather, the “the law of personal property security transactions [had come] to resemble the obscure wood in which Dante once discovered the gates of hell.”⁹⁸

There is substantial authority that assignments of insurance policies may be perfected by physical delivery of the policy.⁹⁹ In a case concerning unearned premiums on a life insurance policy, the bankruptcy court determined that Maine common law requires possession of the collateral as prerequisite to the enforceability against third parties of pledge of intangibles, and that “[A] pledge of insurance policies requires that the pledgee maintain physical possession of the policies.”¹⁰⁰ This result is by no means unique.¹⁰¹ Some decisions have even specified that no written assignment is necessary where the policy is delivered.¹⁰²

⁹⁶ Peter F. Coogan, *Article 9 – An Agenda for the Next Decade*, 87 YALE L.J. 1012 (1978). *See, e.g.*, *Silverman v. McGrath*, 10 Ill. App. 413 (1882) (possession essential to a valid pledge); *W.W. Kimball Co. v. Polakow*, 190 Ill. App. 174 (1914) (At common law, all pledges of personal property void unless title and possession went to pledgee.).

⁹⁷ *See Griffen v. Henry*, 99 Ill. App. 284 (1901) (At common law, transaction was fraudulent per se and incapable of explanation where pledgor retained possession.). *See also* Coogan, *supra* note 96, at 1012; JAMES ANGELL MACLACHLAN, *HANDBOOK OF THE LAW OF BANKRUPTCY* 255-70 (West Publishing 1956).

⁹⁸ GILMORE, *supra* note 80, at 27. *See generally id.* at 288-90.

⁹⁹ *See McLaughlin*, *supra* note 11, at 959.

¹⁰⁰ *See In re Maplewood Poultry Co.*, 2 B.R. 550, 554 & n. 5 (Bankr. Me. 1980) (internal citations omitted).

¹⁰¹ *In re Mile Hi Restaurants, Inc.*, 233 F. Supp. 936 (D. Colo. 1964); *Taylor v. S. Bank & Trust Co.*, 151 So. 357 (Ala. 1933) (life insurance policy); *Puckhaber v. Henry*, 93 P. 114 (Cal. 1907) (assignment and delivery of life policy); *Collins v. Dawley*, 4 Colo. 138 (1878) (life insurance policy); *Helms v. First Nat. Bank*, 28 So.2d 262 (Fla. 1946) (by implication; life insurance); *Equitable Life Ins. Co. v. Mitchell*, 248 Ill. App. 401 (1927) (life insurance policy); *Embry's Adm'r v. Harris*, 52 S.W. 958 (Ky. 1899) (life policy); *Arrowood v. Duff*, 152 S.W.2d 291 (Ky. 1941) (life insurance policy); *Lake v. New York Life Ins. Co.*, 45 So. 959 (La. 1908) (life insurance; dictum); *Foote v. Sun Life Assur. Co.*, 173 So. 477 (La. Ct. App. 1937) (dictum; life insurance policy); *Connecticut Mut. Life Ins. Co. v. Allen*, 235 Mass. 187 (1920) (life insurance policy); *Detroit Life Ins. Co. v. Linsenmier*, 217 N.W. 919 (Mich. 1928) (life policy); *Palmer v. Mut. Life Ins. Co.*, 130 N.W. 250 (Minn. 1911) (life policy); *Prudential Ins. Co. v. Sheehan*, 133

This raises the troublesome possibility that security interest in life insurance policies might be perfected by possession without notification.¹⁰³ The common law pledge existed in every state prior to the Uniform Commercial Code.¹⁰⁴ While Article 9 controls formerly-pledged transactions of other kinds, the life insurance carve-out puts these policies squarely within the case law that has always governed pledges. As a result, this case law has given great importance to physical possession of policies.

It should provide no comfort to note that not all jurisdictions follow this rule, with some vindicating the industry practice of disregarding physical possession.¹⁰⁵ Opportunities for confusion and conflict abound. Physical possession may matter in one state, but not in another, such that the perfection regime is ruefully diverse.

Not only do jurisdictions differ from one another, intra-jurisdictional variation is also substantial. It is often difficult to disentangle judicial decisions interpreting the common law of pledges rather than the statutory pledge act of a given state – only the latter being repealed in many of the states that have adopted the Uniform Commercial Code. The portions of those decisions that interpret the common law, and the cases so

S.W.2d 1060 (Mo. Ct. App. 1939) (life insurance policy; no formal or written assignment necessary); *Fidelity Union Trust Co. v. Phillips*, 68 A.2d 574, (N.J. Super. Ct. Ch. Div. 1949) (by implication; life policy); *MacQueen v. Dollar Sav. Bank Co.*, 15 N.E.2d 529 (Ohio 1938) (life insurance, pledged by deposit without written assignment); *Woofter v. Fourth Nat'l Bank*, 78 P.2d 683 (Okla. 1938) (insurance policy and benefit certificate); *Page v. Detroit Life Ins. Co.*, 11 Tenn. App. 417 (1929) (life insurance policy); *Sun Life Assur. Co. v. Weyen*, 136 F. Supp. 592 (D.C. Wash. 1955); *Massachusetts Mut. Life Ins. Co. v. Bank of California*, 60 P.2d 675 (Wa. 1936) (life policy). See 5 RUSS ET AL, *COUCH ON INSURANCE* § 37:47 (3d ed. 2008).

¹⁰² See *In re Bickford's Estate*, 38 N.Y.S.2d 785 (1942) (no written assignment necessary where policy is delivered); *Woofter v. Fourth Nat'l Bank*, 78 P.2d 683 (Okla. 1938) (pledge did not require written assignment).

¹⁰³ *Shanklin v. Madison County*, 21 Ohio St. 575 (1871) (A chose in action may be equitably assigned without any written transfer). See also *RESTATEMENT (FIRST) OF SECURITY* § 1, cmt. (e) (1941) (defining an insurance policy as an “indispensable instrument,” an interest in which may be secured by possession).

¹⁰⁴ See 1 GILMORE, *supra* note 80, § 14.1.

¹⁰⁵ See *Metro. Life Ins. Co. v. Haack*, 50 F. Supp. 55, 63-64 (W.D. La. 1943) (stating that an insurance policy cannot be pledged by possession); *Commercial Nat'l. Bank v. Chapman*, 206 F.2d 349, 349-51 (5th Cir. 1953) (holding that a statute authorizing pledge by delivery without assignment was ineffective, so creditor took no rights against beneficiaries of the policy).

distant in time as to predate those repealed statutes, make an uneven sample from which to rediscover the common law of choses.

3. Notification to Third Parties

Industry practice has it that insurers have no general duty of notification to any actual or potential creditor, and the common law agrees to some extent. As a result, important information may not be shared, to the frustration of many parties.

It is clear that subsequent assignees have no right to the information they need to determine whether their interest is subordinated.¹⁰⁶ The insurer has no general duty to notify assignees that the insured has discontinued premium payments.¹⁰⁷ Thus, an assignee may become an unsecured creditor when she finds that the insurance policy has lapsed for want of payment.

For this reason, it is generally incumbent upon assignees to diligently request information from policy issuers and, when necessary, pay premiums for the policies. But some statutes differ, reducing inter-jurisdictional uniformity and putting a burden on the issuing insurer.¹⁰⁸

Moreover, actions or representations by the insurer may give rise to estoppel,¹⁰⁹ and the insurer's knowledge of the terms of the assignment has given rise to liability.¹¹⁰ Thus, "[t]he outcome in the lapse cases is by no means a certitude either for the assignee or the insurer."¹¹¹ It becomes a

¹⁰⁶ See discussion *infra* Part A.4.

¹⁰⁷ See *Standard Fire Ins. Co. v. United States*, 407 F.2d 1295, 1300-01 (5th Cir. 1969); *Sorenson v. Nat'l. Life Ins. Co.*, 201 N.W.2d 510, 512 (Wis. 1972); *Lewis State Bank v. Travelers Ins. Co.*, 356 So. 2d 1344, 1346-48 (Fla. Dist. Ct. App. 1978); *Mut. Benefit Life Ins. Co. v. First Nat'l Bank*, 74 S.W. 1066, 1070 (Ky. 1903).

¹⁰⁸ See CAL. INS. CODE § 10173.2 (West 2005) (stating that notice is required); 215 ILL. COMP. STAT. ANN. 5/234 (West 2000) (stating that notice is required); N.Y. INS. LAW § 3211 (McKinney 2006) (stating that assignment may call for notice that premiums are due).

¹⁰⁹ *Missouri Cattle Loan Co. v. Great S. Life Ins. Co.*, 52 S.W.2d 1, 10-11 (Mo. 1932) (holding that assignee relied on insurer's promise to provide notice if premiums were due).

¹¹⁰ *Bank of Poplar Bluff v. Metro. Life Ins. Co.*, 723 S.W.2d 514, 517-23 (Mo. Ct. App. 1986) (the court looked to the contract of assignment and the policy assigned to determine whether the insurer was obliged to provide notice to assignee).

¹¹¹ Knippenberg, *supra* note 11, at 7.

complicated matter to determine which right of notice a secured party may expect.

4. Public Policy

As described above, in subsection 1, industry practice assumes priority is determined through a race-notification regime. Moreover, it is a race to notify the insurance company, not the Secretary of State, as it would be under the UCC. Even if this were as well-founded in law as it is in practice, it is doubtful that this expresses defensible policy.¹¹² Insurance company notification constitutes a non-public system of filing, and it is plagued by those problems endemic to non-public systems of security interests.

Where insurers have received a notice of assignment, there is no assurance that other creditors will be similarly notified. Insurance company records are proprietary, private records. Even where insurers are required to give notice to assignees of premium non-payment, insurers are under no obligation to notify subsequent assignees of prior policy assignments, nor even to respond to information requests by creditors.¹¹³

There is no reliable mechanism for creditors to determine whether their claims are likely to be subordinated. A creditor who wishes to learn about the encumbrances on a policy has no central public filing system to consult. Indeed, an investigation with the Secretary of State of the debtor may deceive some creditors into overestimating their security vis-à-vis a borrower.¹¹⁴ Interests in life insurance policies will not be recorded there.

This multiplies the possibilities for secret liens and mischief, as parties are induced to lend on terms implying higher degrees of security than they may eventually receive. This leads to litigation, into which even

¹¹² *Immel v. Travelers Ins. Co.*, 26 N.E.2d 114, 117 (Ill. 1940) (“It is essential to the prompt payment of losses that life insurance contracts be denied negotiability, and prompt payment of losses has come to be one of the most desirable of the attributes of such contracts. Life insurance is depended on for the payment of estate taxes, for the education of children, for all forms of immediate cash demands and for the very living of the family of the deceased policy-holder pending administration [T]he companies, in good faith, may safely pay promptly to those shown by their records to be entitled to payment.”).

¹¹³ *See, e.g., Wells v. John Hancock Mut. Life Ins. Co.*, 149 Cal. Rptr. 171, 174 (Cal. Ct. App. 1978).

¹¹⁴ McLaughlin, *supra* note 11, at 959.

the insurance company may be drawn.¹¹⁵ And it ends in a reduction in value offered to the insured. With secured lenders sliding into unsecured status, life insurance policy interests will be traded in a market for lemons.¹¹⁶ Increasingly, lenders will offer terms and interest rates consistent with unsecured loans, rather than the preferable rate befitting properly secured collateral.¹¹⁷

All of these problems multiply in the context of a securitized secondary market for policies. Securitization requires policies that can be combined without hindering the pool. Policies that carry litigation risks, or the details of which are unclear because of an uncooperative issuer, will not find an easy home. Rating agencies list legal risks and a dearth of acceptable policies as two of the major impediments to the ratings needed to create marketable securities out of life insurance policies.¹¹⁸ And the difficulty of investigating policies creates a cost that will be paid with each investigation – a cost that will be paid more often in a liquid secondary market.¹¹⁹

Finally, it is distasteful for a private record to be maintained on the terms of the most likely creditor. The issuer insurance company stands as a

¹¹⁵ See, e.g., *Aetna Life Ins. Co. v. Bunt*, 754 P.2d 993, 994-95 (Wash. 1988); *Am. W. Life Ins. Co. v. Hooker*, 622 P.2d 775, 776-77 (Utah 1980); *King v. Vineyard*, 477 P.2d 700, 701-03 (Okla. Civ. App. 1970); *Stanfill v. Defenbach*, 239 F.2d 685, 686 (9th Cir. 1957).

¹¹⁶ See generally George A. Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q.J. ECON. 488, 489-94 (1970).

¹¹⁷ See generally James J. White, *Efficiency Justifications for Personal Property Security*, 37 VAND. L. REV. 473, 480-81 (1984); Alan Schwartz, *The Continuing Puzzle of Secured Debt*, 37 VAND. L. REV. 1051, 1060-62 (1984); Homer Kripke, *Law and Economics: Measuring the Economic Efficiency of Commercial Law in a Vacuum of Fact*, 133 U. PA. L. REV. 929, 951-55 (1985).

¹¹⁸ See, e.g., WINSTON CHANG & GARY MARTUCCI, STANDARD & POOR'S, CREDIT FAQ: UNCOVERING THE CHALLENGES IN RATING LIFE SETTLEMENT SECURITIZATIONS, (2009); DBRS INC., METHODOLOGY – RATING U.S. LIFE SETTLEMENT SECURITIZATIONS, (2008), available at <http://www.dbrs.com/research/218570> (follow "Rating U.S. Life Settlement Securitizations" hyperlink under "Related Research"). See also LIFE SETTLEMENTS TASK FORCE, *supra* note 52, at 16-17 (stating that market participants agree that ratings will be required to make viable securities); 5 RUSS & SEGALLA, *supra* note 101, § 77:45.

¹¹⁹ LIFE SETTLEMENTS TASK FORCE, *supra* note 52, at 16 (stating that market participants agree that the cost of investigating and warranting policies in the pool against legal risks are impractical burdens).

potential lender under the policy as a matter of state law.¹²⁰ Further, the issuer stands to profit from the lapse of a policy when the insured is unable to obtain adequate financing. Insurance companies may face temptations to err in favor of their role as creditor and business, rather than in their role as a filing place for other lenders.

Even if insurance companies faithfully discharge all of their duties, there will be an appearance of impropriety to a creditor who finds that the private registration has not worked in his favor. Consider *Rose* again,¹²¹ where an assignee-plaintiff claimed to have sent written notification to the insurer, but the insurer claimed to have no record of it. The Court of Appeals found that plaintiff had notified the insurance company.¹²² And yet, the district court had ruled for the defendant, crediting an estoppel claim that plaintiff had not done enough to confirm that the insurance company recorded their assignment and informed subsequent assignees.¹²³ In another jurisdiction, the Court of Appeals could have affirmed the district court on the matters of law and the Roses would have lost their priority because of the insurance company's error.

Moreover, even as the case was resolved, the subsequent assignee may be legitimately aggrieved. They requested information from the insurer as to prior liens and were told that there were none.¹²⁴ They were deceived as to their priority by insurance company error. Either way, the insurance company's error determined the rights between rival claimants.

Disappointing as this error may be, it would be scandalous if one of the litigant creditors were the insurance company itself. As it stands, insurance companies profit from increased lapse, and lapse increases if creditors, aware of their precarious position with respect to non-public filing, are discouraged from providing alternative financing. It would be far better if the parties were to register their liens with the Secretary of State.¹²⁵

¹²⁰ 5 RUSS & SEGALLA, *supra* note 101, § 77:45.

¹²¹ *Rose v. AmSouth Bank*, 296 F. Supp. 2d 383 (E.D.N.Y. 2003), *rev'd*, *Rose v. AmSouth Bank of Florida*, 391 F.3d 63, 66-67 (2d Cir. 2004). Though reversed, the lower court is still instructive here because jurisdictions differ, and some follow the priority rules of the district court. In this instance, the Court of Appeals reversed as a matter of law because it applied New York Law.

¹²² *Rose*, 391 F.3d at 66-67.

¹²³ *Rose*, 296 F. Supp. 2d at 395.

¹²⁴ *Rose*, 296 F. Supp. 2d at 388.

¹²⁵ Another advantage of Article 9 is that it includes provisions for many types of errors arising from filing with the appropriate filing agency.

5. UCC Solution

As described above, industry practice has it that interests in insurance policies are perfected by notification to the insurance company, with physical possession of the policy having no legal effect. However, as also described above, the non-UCC law provides ample examples where the law contradicts insurance industry practice. Regardless of whether *Rose* can be distinguished in one jurisdiction or another,¹²⁶ the law here is a field of brambles, much underestimated in its propensity to entangle otherwise benign transactions. Professor Knippenberg summarizes the non-UCC law in this way:

The long and short of it is, there are risks and costs both to lenders seeking to secure a debt through an assignment of life insurance, and to insurers who are driven to interpleader actions or, not infrequently, forced to justify as defendants the payment of proceeds to one or another of multiple claimants. These risks and costs are of the sort that are predictably generated where, for lack of thorough statutory treatment, there is room left by uncertainty for argument.¹²⁷

He concludes that “the law governing assignment, then, is sufficiently flaccid, incomplete and non-uniform to suggest insurers and assignees alike would benefit from . . . Article 9.”¹²⁸ A fundamental policy of Article 9 of the Uniform Commercial Code is to discourage secret liens,¹²⁹ and it could be applied here to give parties greater comfort in their security.

The UCC should be amended to remove the life insurance exclusion and treat life insurance policy interests as general intangibles, while still acknowledging the realities of the insurer’s special role. Issuer loans against policies should be treated as purchase money security interests under § 9-107. Such loans should be automatically perfected for a period of time, and then achieve super priority if perfected through notice. Short term financing for an insured who is late in an insurance premium payment may never need to be filed. Nor would an insurance company be forced to file at a moment of great inconvenience, merely because of the

¹²⁶ *Rose v. AmSouth Bank of Florida*, 391 F.3d 63, 65 (2d Cir. 2004).

¹²⁷ Knippenberg, *supra* note 11, at 8.

¹²⁸ *Id.* at 9.

¹²⁹ *See In re Cushman Baking*, 526 F.2d 23, 28-29 (1st Cir. 1975).

time that the insured requires a loan. But in a timely manner, all liens on a policy must soon be disclosed. Setting a time limit for filing of liens will ensure that potential lenders know how long they must wait in order to discover all potential claimants.

Purchase Money Security Interest status is appropriate for two reasons. First, it is recognition that such loans often finance premiums that permit the continued life of the policy.¹³⁰ Second, such status acknowledges the insurers' other statutory responsibilities. Issuing insurance companies are required to offer policy loans by insurance statutes in most states.¹³¹ Without purchase money secured status, even a perfected security interest could take second priority on a loan whose value had long been promised as security to others. No party should be required by statute to lend, as a second lien, on an over-promised asset. Of course, the power of the insurance company to "jump the queue" with purchase money security interest priority will upset some other creditors. But they can be expected to protect themselves with indentures in the agreement with the borrower.

B. SURPLUS PROBLEM

The surplus problem refers to distribution of value of a defaulted security-policy above the value of the debt. When an insured defaults on

¹³⁰ See Knippenberg, *supra* note 11, at 232-33. See generally Kripke, *supra* note 117, at 951-57 (describing how PMSI creditors enable the insured to obtain new collateral, so they are not really disadvantaging prior creditors.); Lucian Arye Bebchuk & Jesse M. Fried, *The Uneasy Case for the Priority of Secured Claims in Bankruptcy*, 105 YALE L.J. 857, 880-902 (1996) (generally discussing efficiency and incentives for priority); Lynn M. LoPucki, *The Unsecured Creditor's Bargain*, 80 VA. L. REV. 1887, 1947-63 (1994) (discussing "three theories and one not so bad" in support of subordination).

¹³¹ See ALASKA STAT. § 21.45.080(a) (2010); ARIZ. REV. STAT. ANN. §§ 20-1208(A), 20-1209(A) (2010); DEL. CODE ANN. tit. 18 § 2911(a) (1999); GA. CODE ANN. § 33-25-3(5) (West 2003); ME. REV. STAT. ANN. tit. 24-A, § 2510(1) (2000); MASS. GEN. LAWS ANN. ch. 175, § 132 (West 1998); MINN. STAT. ANN. § 61A.03(g) (West 2005); MONT. CODE. ANN. § 33-20-131(1) (2009); NEB. REV. STAT. § 44-502(8) (2004); NEV. REV. STAT. ANN. 688A.110(1) (LexisNexis 2009); N.J. STAT. ANN. § 17B:25-8 (West 2006); N.Y. INSURANCE LAW § 3203(8)(A) (McKinney 2006); OHIO REV. CODE ANN. § 3915.05(G) (LexisNexis 2010); OR. REV. STAT. § 743.186(1) (2009); 40 PA. STAT. ANN. § 510(h) (West 1999); S.C. CODE ANN. § 38-63-220(l) (2000); S.D. CODIFIED LAWS § 58-15-15 (2004); VT. STAT. ANN. tit. 8, § 3731(7) (2009); WASH. REV. CODE ANN. § 48.23.080(1) (West 2010); W. VA. CODE § 33-13-8(a) (2006). See also *Metro. Life Ins. Co. v. Massachusetts Travelers Ins. Co.*, 471 U.S. 724, 729 (1985).

his debt obligations to a collateral assignee, a number of questions emerge: (1) may the creditor exercise the surrender option of the policy to satisfy the debt; (2) may the creditor wait until the policy matures and collect the proceeds; (3) may the creditor sell the policy to a third party, and under what conditions; and (3) may that third party surrender, wait to collect, or resell? At some stage, one of these options may produce cash in excess of the debt as of yet unsatisfied, provoking the most important question of all: who can keep this surplus of cash above the borrower's remaining debt?

There is a gulf between what the law permits and what is industry practice. Generally, lenders expect to keep the surplus from the policy, or else to sell the policy to a buyer who will someday get to keep the surplus. The borrower often loses more than the initial bargain contemplated, and the law generally regards surplus as the property of the borrower. Statutory treatment is desperately required to curtail the most abusive practices currently extant, as well as to clarify creditors' and third parties' rights to the benefits of their bargains.

As with the previous section considering the perfection problem, it makes sense to look at what third-party lenders believe and what they do. In many cases, lenders' actions are based on wrong assumptions, and increase their own risks needlessly. Lenders will generally lend an amount that falls somewhere between the policy's surrender value and the maturity proceeds. Lenders reason that if the insured defaults, they can surrender the policy with no risk and satisfy the remaining debt. Or, if they have the appetite and sufficient patience, they can pay the premiums until the policy matures and then collect the death benefit. Or they may sell the policy on the secondary market.

These various actions by lenders are based on their understandings (sometimes misunderstanding) of their rights. Creditors believe they have the right to surrender the insurance policy. Most lenders believe that they can foreclose on their security with minimal process or protection for the debtor and sell the policy to a third party, who takes the policy free and clear and may receive the full proceeds.

Some lenders believe that they may keep the full balance paid by the purchasing third party, or paid upon maturity by the insurance company, even if it exceeds the value of the defaulted debt, with no need to return the surplus to the debtor or beneficiaries.¹³² Other lenders believe it

¹³² This belief is perpetuated in part by the widespread practice of executing security assignments using absolute assignment forms. Thus, the paperwork already looks like the creditor has been given the whole policy, without regard to specific obligations.

is necessary for the debtor to consent to signing over his remaining rights in the policy, or designate the creditor as the beneficiary, and they make a practice of obtaining this consent from the insured in satisfaction of the debt.

Notwithstanding creditor optimism, there is substantial authority for all of the following contrary propositions: (a) the lender may not exercise the surrender option;¹³³ (b) the lender may not resell the policy to a third party;¹³⁴ (c) the lender may keep the amount of the debt owed, plus interest and premiums paid, but the borrower's estate or beneficiaries are due any surplus.¹³⁵ Each of these precedents implies potential litigation and impediments to insurance financing transactions.

Most crucially, (c) is well-supported and contrasts with widespread industry practice. Industry practice has galloped ahead of the law in this area.¹³⁶ There is little legal support for the widespread practice of creditor windfall, wherein a creditor is able to keep the surplus above the indebtedness amount, and it smacks of exploitation.

While curtailing exploitation, some provision must be made to allow creditors a reasonable return on their investment. The law should make creditors' rights clearer, and allow creditors to then charge a rate of interest that adequately compensates them for their risk, or else clarify that they intend to purchase the policy, surplus and all, rather than merely lend against it.

1. Windfall From Sale

Notwithstanding industry practice, numerous courts have adopted the view that a creditor who retains more than the amount of the indebtedness will have been unjustly enriched.¹³⁷ The clear majority

¹³³ See, e.g., *Brown v. New York Life Ins. Co.*, 22 F. Supp. 82, 88-89 (W.D.S.C. 1938).

¹³⁴ See, e.g., *Salvidge v. Mut. Life Ins. Co. of New York*, 191 N.W. 862, 863 (Iowa 1923); 5 RUSS & SEGALLA, *supra* note 101, § 37:68.

¹³⁵ See, e.g., *Luxton v. United States*, 340 F.3d 659, 653 (8th Cir. 2003); *Westchester Enters., Inc. v. Swartwout (In re Swartwout)*, 123 B.R. 794, 799-800 (Bankr. S.D. Ohio 1991); *Succession of Goudeau*, 480 So. 2d 806, 808 (La. Ct. App. 1985).

¹³⁶ Cf. Kenneth Kettering, *Securitization and Its Discontents*, 29 CARDOZO L. REV. 1553, 1632 (2008) (stating that securitization has grown immensely over the past twenty years despite shaky doctrinal foundations).

¹³⁷ *Albrent v. Spencer*, 88 N.W.2d 333, 335-36 (Wis. 1958) ("If the amount received is greater than the debt, there is an 'unjust enrichment' with liability for

position is that a creditor-assignee may only take the remaining indebtedness, plus expenses such as payments made to keep the policy alive.¹³⁸ Many states have statutes to this effect, patterned off of the Uniform Consumer Credit Code.¹³⁹ In the vast majority of cases, courts construe the assignment so as to reserve to the non-creditor beneficiaries any excess of proceeds over indebtedness.¹⁴⁰ The burden is on the creditor to establish what he is due under the indebtedness.¹⁴¹

Arguments in favor of a creditor's right of windfall are usually limited in their scope. For example, the assignee of a policy of insurance, assigned by way of security, is sometimes said to occupy the same status as the insured with respect to the rights and liabilities under that particular policy that the insured occupied.¹⁴² In allowing a creditor to foreclose upon and sell an insurance policy, the Florida Supreme Court's *Moon v. Williams* seems to advocate for this view:

The assignee of a policy of insurance, such as life insurance, assigned by way of security, in general, occupies the same status with respect to the rights and liabilities under the policy that the insured occupied, to the

the amount exceeding the amount of the debt plus interest.”); *Rattray v. Banks*, 121 S.E. 516 (Ga. Ct. App. 1924); *First Nat'l Bank v. Sec. Mut. Life Ins. Co.*, 222 S.W. 832 (Mo. 1920); *Minn. Mut. Life Ins. Co. v. Manthei*, 189 S.W.2d 144 (Mo. Ct. App. 1945).

¹³⁸ William H. Danne, Jr., Annotation, *Right of Creditor Beneficiary or Assignee of Insurance Policy on Life of Debtor to Excess Proceeds Over Amount Owed on Debt*, 6 A.L.R.6th 391 § 5 (2005).

¹³⁹ UNIF. CONSUMER CREDIT CODE (1974) § 4.105(2) (1974) (creditor must pay to the consumer or his or her estate all proceeds received by the creditor in excess of the amount to which the creditor is entitled within 10 days after receipt of the proceeds).

¹⁴⁰ Danne, *supra* note 138. See, e.g., *Luxton v. United States*, 340 F.3d 659, 662 (8th Cir. 2003). (“[A] collateral assignment transfers only those rights necessary to secure the assignor's debt and extinguishes the named beneficiary's interest only to the extent of the assignor's debt to the assignee.”).

¹⁴¹ See, e.g., *Floyd v. Victory Sav. Bank*, 189 S.E. 462, 467 (S.C. 1937).

¹⁴² 45 C.J.S. *Insurance* § 757 (2007) (note, however that this passage reads in full “The assignee of a policy of insurance, such as life insurance, assigned by way of security, in general, occupies the same status with respect to the rights and liabilities under the policy which the insured occupied, to the extent of the indebtedness for which the policy was assigned as collateral.”).

extent of the indebtedness for which the policy was assigned as collateral.¹⁴³

The court goes on to say that the assignee may sell the policy by order of court and that the purchaser

would stand in the position of the insured as to the right to exercise options under the policy, and therefore would thereby acquire the right to surrender the policy for its cash surrender value, or make such other settlement with the company in regard to the policy as could have been made by the insured, had the policy not been assigned.¹⁴⁴

Although *Moon* does authorize some creditor activity, the *Moon* court is careful to include the limiting phrase “to the extent of the indebtedness.”¹⁴⁵ The court does not explain what would happen if the court-ordered sale price exceeded the indebtedness, and it cites to *Metropolitan Life Insurance Co. v. O'Brien*, a case in which the creditor’s recovery is limited by the debtor’s indebtedness.¹⁴⁶

A similar argument emerges from the fact that most courts have held that a creditor, holding a policy as collateral, may surrender the policy to the insurance company upon the insured’s default.¹⁴⁷ An assignee-creditor has the power to terminate the contract for insurance and end any

¹⁴³ *Moon v. Williams*, 135 So. 555, 557 (Fla. 1931).

¹⁴⁴ *Id.*

¹⁴⁵ *Id.* at 556.

¹⁴⁶ 52 N.W. 1012, 1013-14 (Mich. 1892) (“Creditors, however, hold only what is necessary for their indemnity for the debt, and the representatives of the insured will be entitled to the balance.”).

¹⁴⁷ *Bush v. Block*, 187 S.W. 153, 156 (Mo. Ct. App. 1916) (Assignee of life policy taken as security loan, which then comes into default, may convert the policy into a paid-up policy upon notice to the insured); *Mut. Benefit Life Ins. Co. v. First Nat’l Bank*, 169 S.W. 1028, 1034 (Ky. 1914) (creditor to whom life policy assigned may surrender the policy); *Higgins v. Helmbold*, 48 App. D.C. 50 (1918); *Bank of Idana v. Ill. Life Ins. Co.*, 9 P.2d 629 (Kan. 1932); *McGimpsey v. Sec. Bldg. & Loan Ass’n*, 157 A. 441 (N.J. 1931); *Wilson v. Prudential Ins. Co.*, 187 A. 251 (Pa. Super. Ct. 1936); *See Gen. Am. Life Ins. Co. v. Fraventhal & Schwarz*, 101 S. W.2d 953, 954 (Ark. 1937).

future growth in the policy principal. Some creditors may reason *a fortiori* that power of surrender entails the existence of equal or lesser rights.¹⁴⁸

In *Citizens' Bank v. Pan-American Life Ins. Co.*, a bank purchased a life insurance policy sold in foreclosure by a collateral assignee.¹⁴⁹ The bank sought to have itself listed as a beneficiary under the policy.¹⁵⁰ The court ruled for the bank, analogizing the power of appointment to the right of surrender: "Rights with respect to loans and surrender clauses in a policy are rights of the same nature and character as the one to change beneficiary, and we can think of no reason why the purchaser of the policy in this case should not enjoy the same right"¹⁵¹

Similarly, if the power to destroy the policy is theirs, then any value in surplus of the surrender value persists due solely to their benign neglect of that power. And any premiums paid from that point forward goes to grow the principal and increase the chance that the principal will be realized rather than the surrender value.

There is a sense in which the surplus is created through the creditors' actions alone and so they are entitled to it. But it proves difficult to find a case where the surplus-taker did not acquire the policy after the appropriate judicial sale. No such case validates the right of the creditor to hold a maturity or resale balance in excess of the debt and costs. The most this reasoning proves is that if a party takes the policy after court-ordered sale, they may be able to keep whatever proceeds are later liberated – but it says nothing about the proceeds of the judicial sale itself, which surplus may be properly allocated to the insured.

Perhaps sensitive to unfavorable law, industry practice has it that a creditor who is owed less than the maturity payment will persuade a defaulted debtor to list the creditor as beneficiary on the policy and sign away his residual rights in the insurance in satisfaction of the debt. In this way, the creditor obtains an amount of money greater than the nominal value of the debt and the debtor retains no rights to any residual.

The transaction then acquires the character of a wager contract, with all the worrisome policy implications of the creditor hoping for the early demise of the insured.¹⁵² These surplus allocations are more

¹⁴⁸ *Accord*, FRANK HERBERT, DUNE 462 (2005) ("The power to destroy a thing is the absolute control over it").

¹⁴⁹ 141 So. 481 (La. Ct. App. 1932).

¹⁵⁰ *Id.*

¹⁵¹ *Id.* at 482.

¹⁵² See Anthony Alt, Note, *SPIN-Life Insurance Policies: A Dizzying Effect on Human Dignity and the Death of Life Insurance*, 7 AVE MARIA L. REV. 605 (2009). See also *infra* III.D.

distasteful than a simple policy purchase. This seems like an unjust windfall for the creditor who loaned money on security and now gets to keep the full value of the collateral. This could not have been part of the initial agreement since the insured has a right to decline such an assignment. Most likely, creditors are squeezing a debtor for an intangible asset during a time of difficulty.

In addition to being distasteful, these conclusions to the lending relationship are legally problematic. Industry practice is to structure the transaction so that it does involve consideration, perhaps by varying the terms of the agreement. But it remains true that if the insured has a right to satisfy the debt from sale of the security, the insured loses economic value for nothing in return when the insured signs away the security in total. Moreover, courts look to the relationship between the insured and the creditor-beneficiary in determining the controlling intention of the policy assignment.

Where courts allow the creditor to take an amount greater than the debt, they emphasize that the assignment was not as security for a loan,¹⁵³ that the creditor was a friend¹⁵⁴ or relative.¹⁵⁵ The only cases where creditors seem to be able to take the entirety of the proceeds are where the creditor procured the policy.¹⁵⁶

For all of the forgoing issues, authority can be found for nearly any position, few rules are clear, and jurisdictions tend to differ. Doubtless, some creditors may have found comfort in their ability to take surplus on a given set of facts, with a given contract, and under a certain reading of the case law. But even such a creditor will may have to anticipate ample litigation and difficulty in securitizing her acquired policies. As Professor Knippenberg put it, "These risks and costs are of the sort that are predictably generated where, for lack of statutory treatment, there is room left by uncertainty for argument."¹⁵⁷ Even if reform might limit creditors'

¹⁵³ *Am. Cas. Co. v. Rose*, 340 F.2d 469, 471 (10th Cir. 1964); *Zolintakis v. Orfanos*, 119 F.2d 571 574-75 (10th Cir. 1941) (probably a loan, but doubtful that that creditor-beneficiary could have collected the sums advanced).

¹⁵⁴ *Am. Cas. Co.*, 340 F.2d at 471 n.4; *Forster v. Franklin Life Ins. Co.*, 311 P.2d 700, 702 (Colo. 1957).

¹⁵⁵ *Wages v. Wages*, 42 S.E.2d 481, 482 (Ga. 1947).

¹⁵⁶ *Central Nat'l Bank v. Hume*, 128 U.S. 195 (1888); *Fitzgerald v. Rawlings Implement Co.*, 79 A. 915 (Md. 1911); *Haberfeld v. Mayer*, 100 A. 587 (Pa. 1917); *Watson v. Mass. Mut. Life Ins. Co.*, 140 F.2d 673 (D.C. Cir. 1943) *cert. denied* 322 U.S. 746 (1944); WILLIAM R. VANCE, *HANDBOOK ON THE LAW OF INSURANCE*, 739-40 (Buist M. Anderson ed., 3rd ed. 1951).

¹⁵⁷ Knippenberg, *supra* note 11, at 226-27.

ability to take the surplus from the insured, creditors will benefit from greater legal certainty and reduced litigation.

2. UCC Solution

The surplus problem involves confusion as to the treatment of surplus proceeds and facilitates predatory behavior by creditors. Inclusion in Article 9 is the appropriate remedy. It is not enough to simply clarify in statute that the creditor may not keep surplus unless clearly specified.¹⁵⁸ This clarification is appropriate, and a truthful depiction of the law as best as can be construed, but it creates bad incentives if adopted alone.

Imagine a creditor in possession of a policy with a maturity value of \$1,000,000, a surrender value of \$100,000 and a resale value, reflecting the expected value of the policy given premium and maturity date, of \$200,000. Imagine, further, that the creditor is owed \$100,000. Under current industry practice, the creditor is likely to resell the policy for \$200,000 to a purchaser willing to wait for maturity. The creditor will keep all \$200,000, representing \$100,000 of debt and a \$100,000 surplus. The better result is that the creditor keeps \$100,000 and returns \$100,000 to the debtor insured.

But if the law were amended to clarify that the \$100,000 belonged to the debtor, this better result will not obtain. Stripped of any potential surplus, the creditor would simply surrender the policy for \$100,000. Why? Surrender is always easier than more complex commercial transactions, which are risky in terms of their value, and which require the seller to pay the insurance premiums until disposition.

Surrender also reduces litigation risks. If the debtor has an interest in the surplus, the debtor may litigate if he feels the creditor made unwise choices in selling. He may claim that the creditor made a hasty sale, or a sale to a friend on unfair terms, resulting in a cognizable harm to the debtor's interest. There is no incentive for the creditor to bear those risks. As long as resale has risk but no benefit, and as long as surrender remains a legal option, value will be lost to the debtor-insured.

¹⁵⁸ There is nothing wrong, *per se*, in allowing an assignee to take the whole surplus. But such transaction is really a sale of the policy, in consideration for a loan, with the seller's right to repurchase for the loan principal plus interest. Presumably the loan offered is at a below market interest rate, as the lender expects to make their real gain on the surplus. But such a transaction should be clearly labeled as such, and not sprung upon a borrower.

Inclusion of interests in insurance policies within the UCC would subject the decision to resell or surrender to Article 9's standard foreclosure provisions. Upon default by the debtor, a secured creditor has a right to dispose of the collateral.¹⁵⁹ The creditor may come to own the collateral, should she wish, by purchasing it in a judicially administered sale.¹⁶⁰ But the disposition need not be judicially administered, nor need it even be a sale,¹⁶¹ so long as it is commercially reasonable.¹⁶² Dispositions in conformity with reasonable commercial practices are deemed to be commercially reasonable.¹⁶³

Creditors have hitherto had undue freedom with regard to liberal surrender. Surrender should properly be regarded as one of the many options potentially available to the foreclosing creditor. Sometimes surrender would be regarded as a commercially reasonable option, such as where the surrender amount is likely to equal the resale amount. But under the UCC, creditors would no longer be allowed a general safe harbor for surrenders where surplus-creating resales may be possible. So the creditor from the example above would be required to sell the policy for greater value, and share the surplus, less expenses, with the debtor.

Conversely, some creditors have failed to surrender to the detriment of the borrower. In one case, a pledgee held policies with a surrender value sufficient to satisfy its claims, but instead allowed the policies to decrease in value for years until they could no longer satisfy the claims. The court found for the pledgee, allowing it to recover the unsatisfied debt from the pledgor. The court reasoned that the Article 9 statutory obligation of "reasonable care in the custody and preservation of collateral" is inapplicable to interests in life insurance policies.¹⁶⁴ This is an appalling and inefficient result. Inclusion in Article 9 would mean that surrender would sometimes be required as part of the reasonable preservation and disposition of collateral. The legal duties imposed by Article 9 are crucial components to the correction of the surplus problem.

¹⁵⁹ U.C.C. § 9-610(a) (2000).

¹⁶⁰ *Id.* at § 9-610(f).

¹⁶¹ *Id.* at § 9-610(a) ("a secured party may sell, lease, license, or otherwise dispose of any or all of the collateral. . .").

¹⁶² *Id.* at § 9-610(b).

¹⁶³ *Id.* at § 9-627(b)(3). There is no recognized market for life insurance policies, though there may someday be a market for the securitized bundles of them. Thus the other methods of reasonable disposition will not work. § 9-627(b)(1)-(2).

¹⁶⁴ *Poultry Processing, Inc. v. Mendelson*, 584 A.2d 659, 662 (Me. 1991).

Where creditors lend a substantial proportion of the value, this change will not be burdensome. Only where creditors have loaned a small fraction of the value, and yet still expect the whole maturity payment, will this reform decrease the gain to creditors. These transactions are not sympathetic or efficient.

Eliminating the option to simply surrender the policy upon foreclosure will decrease some of the flexibility and security associated with lending on insurance policies. But there are two reasons to think that this change will not substantially harm the availability of credit to borrowers. First, insofar as creditors have expected to keep the windfall surplus, their practice has been to sell, not surrender, the most valuable policies. Under current lending practices, only the least valuable policies are rapidly surrendered – a practice which Article 9 would still respect as a commercial reasonable disposition.

Moreover, since Article 9 invalidates limits on assignment, parties will be free to draft complex hybrid credit/purchase agreements.¹⁶⁵ Consumers may be given an amount near the secondary market value of a policy in exchange for an absolute assignment, with some kind of right of redemption if the insured wishes to restore her interest at a later time. Such transactions would track the windfall benefit currently enjoyed by creditors, but it would make the transaction clear to consumers, as well as ensure them a fair price for losing their investment. It is also reasonable to assume that more transparency and fair prices would encourage consumers to borrow more, thus enlarging the market and opportunities for lenders.

C. THE RESERVATION PROBLEM

The “reservation problem” refers to a subtle problem emerging from drafting practices and non-UCC law, which disrupts the growth of a secondary market around foreclosed collateral assignments. The vast majority of collateral assignments have been executed in a manner that reserves to the assignor certain rights that the assignee needs for flexible resale.

Collateral assignments are performed using standard forms drafted by insurance companies. The considerable uniformity of forms was in part a deliberate effort of the insurance industry.¹⁶⁶ Insurance companies

¹⁶⁵ U.C.C. § 9-408 (2000).

¹⁶⁶ See John F. Handy, Assistant Counsel, *Why Uniformity in Collateral Assignment Blanks?*, 5 PROCEEDINGS OF THE ASSOCIATION OF LIFE INSURANCE

have for years standardized contracts for the benefit of the insured.¹⁶⁷ Collaboration between bankers and insurance companies resulted in a standardized assignment form in 1938.¹⁶⁸ These uniform forms were used almost universally in the following years.¹⁶⁹

By controlling the means of assignment, and limiting them to finite, boilerplate clauses, insurance companies can prevent creditors from taking advantage of their clients. On the other hand, those same standard contracts can also discourage creditors from accepting insurance policies as collateral for loans.¹⁷⁰

Standard assignment forms reserve to the assignor the right to designate or change beneficiaries, often called the power of appointment.¹⁷¹ That is, even once the insured individual gives her policy as collateral for a debt, she still has the sole right to decide who is to be paid when she dies. This reservation exists to prevent the beneficiary from limiting the insured's power to assign the policy.¹⁷² But this reservation casts a cloud over the salability of the policy. It is difficult for a creditor to effectively sell his interest in a policy missing this incident of ownership.

Parties cannot draft around this problem because assignments are only valid on the terms of the insurance policy,¹⁷³ which will invariably require the use of standard assignment forms. Many states have codified the requirement that policies are assignable or not assignable on the terms of the insurance contract.¹⁷⁴ Insurance companies will not be expected to

COUNSEL 307 (1932) (suggesting collaboration with the American Bankers Association).

¹⁶⁷ Comment, *The Assignment of Life Insurance as Collateral Security for Bank Loans*, 58 YALE L.J. 743, 754 (1949).

¹⁶⁸ See *id.* at 755.

¹⁶⁹ *Id.* at 756 nn.81-82.

¹⁷⁰ See, e.g., Neil A. Doherty and Hal J. Singer, *Regulating the Secondary Market for Life Insurance Policies*, 21 J. INS. REG. 63 (2003). See also *supra* note 30.

¹⁷¹ See 10 AM. JUR. LEGAL FORMS 2D § 149:184 (2010) ("The following specific rights, so long as the policy has not been surrendered, do not pass by virtue of this assignment: . . . (b) The right to designate and change the beneficiary.").

¹⁷² See *infra* II.C.1.

¹⁷³ See, e.g., *Immel v. Travelers Ins. Co.*, 26 N.E.2d 114, 116 (Ill. 1940) (citing 31 CORPUS JURIS, 430; 2 ROGER W. COOLEY, BRIEFS ON THE LAW OF INSURANCE 1829 (1905)).

¹⁷⁴ See ALA. CODE § 27-14-21(a) (2011); ALASKA STAT. ANN. § 21.42.270 (West 2011); ARIZ. REV. STAT. ANN. § 20-1122 (2011) (West); ARK. CODE ANN. § 23-79-124(a) (West 2011); CAL. INS. CODE § 10130 (West 2011); DEL. CODE ANN. tit. 18, § 2720 (West 2011); GA. CODE ANN. § 33-24-17 (West 2011); HAW. REV.

alleviate this problem, in part because they tend to benefit when third party interests are impaired.

1. Origin in the Vested Beneficiary Problem.

Beginning in the mid-nineteenth century, courts began to restrict the ability of insureds to assign their policies.¹⁷⁵ They did so on the theory that the beneficiary under the policy had a vested interest in the proceeds that could not be divested without his permission. It seemed unjust and problematic that a breadwinner could procure a policy to give peace of mind to her dependants and then secretly assign the policy to a bank. The beneficiary may have come to rely on the benefit. It was also argued that the insured had given the beneficiary a beneficial interest at the time of taking out the policy and was not at liberty to unilaterally divest the beneficiary.

The protection of the vested interest of a beneficiary became the law in all states but Wisconsin,¹⁷⁶ and life insurance policies became *de facto* unassignable. Such restrictions reduced the value of insurance policies to insureds, who were forced to accept whatever price the insurance company saw fit to offer for a policy loan or surrender.

Insurance contracts were soon drafted to reserve the insured's right to change beneficiaries.¹⁷⁷ This reservation clause limited the beneficiary's interest to a mere expectancy and freed the insured's hand to make assignments. A policy that was assigned absolutely would carry with it the

STAT. § 431:10-228(a) (West 2010); IDAHO CODE ANN. § 41-1826 (West 2011); KY. REV. STAT. ANN. § 304.14-250(1) (West 2011); ME. REV. STAT. ANN. tit. 24-A, § 2420(1) (2010); MONT. CODE ANN. § 33-15-414(1) (2010); N.D. CENT. CODE ANN. § 26.1-33-33 (West 2011); OKLA. STAT. ANN. tit. 36, § 3624 (West 2011); PA. CONS. STAT. ANN. § 512 (West 2011); S.D. CODIFIED LAWS § 58-10-6.1 (2011); VA. CODE ANN. § 38.2-3111 (West 2011); WASH. REV. CODE ANN. § 48.18.360 (West 2011).

¹⁷⁵ See Lewis D. Asper, *Ownership and Transfer of Interests in Life Insurance Policies*, 20 HASTINGS L.J. 1175, 1177. For more on the origin of this theory, see William Reynolds Vance, *The Beneficiary's Interest In A Life Insurance Policy*, 31 YALE L.J. 343, 347-48 (1922).

¹⁷⁶ See 4 GEORGE J. COUCH, CYCLOPEDIA OF INSURANCE LAW § 27:56 (2d ed. 1960). See also *Ellison v. Straw*, 92 N.W. 1094 (1902); *Clark v. Durand*, 12 Wis. 223 (1860).

¹⁷⁷ See e.g., Asper, *supra* note 175, at 1179; *Grimm v. Grimm*, 157 P.2d 841, 842 (Cal. 1945); *Morrison v. Mut. Life Ins. Co.*, 103 P.2d 963, 965 (Cal. 1940); *Davis v. Modern Indus. Bank*, 18 N.E.2d 639, 643 (N.Y. 1939).

power to select beneficiaries. Thus, be it assignor or assignee, someone always had the power to change beneficiaries, and so beneficiary rights would not vest. Thus, reservation clauses were originally drafted to empower insureds vis-à-vis their beneficiaries.

2. Reservation of Selection of Beneficiary Amounts to the
Reservation of a Substantial Incident of Ownership.

The power of appointment of beneficiaries is a significant incident of ownership and a crucially important one for the creditor who hopes to sell the policy to a third party purchaser. Incidents of ownership are the economic benefits of owning a policy¹⁷⁸ and are constituent elements of ownership. Regardless of what labels the parties may apply, a transaction that fails to give enough incidents of ownership to the assignee may be contested as less than a transfer of ownership. If an insured purports to assign a policy, but a court finds that the insured has retained for herself too much of the power associated with the policy, the insured will still be deemed the owner. Questions of whether the insured has “really” assigned the policy can become important if, for example, other creditors of the insured seek to foreclose on the policy.

Lists of the incidents of ownership of life policies are inconsistent and contradictory, shifting somewhat from court to court.¹⁷⁹ But it may be helpful to look to an area of the law that, though convoluted, at least speaks with one voice: federal taxation. If an assignee lacks all the incidents of ownership, a life insurance policy may remain in the gross estate of the assignor.¹⁸⁰ The federal estate tax sets rules to determine whether an insurance policy is includable in an individual’s gross estate. It lists the following incidents of ownership:

the power to change the beneficiary, to surrender or cancel
the policy, to assign the policy, to revoke an assignment, to

¹⁷⁸ 26 C.F.R. § 20.2042-1(c)(2) (2010).

¹⁷⁹ Asper, *supra* note 175, at 1183 (“This is due in part to the nature of the interests and in part to the fact that few transfers of interest in property are conducted at a higher level of ignorance and inattentiveness.”).

¹⁸⁰ 4 GEORGE J. COUCH, CYCLOPEDIA OF INSURANCE LAW § 63:41 (3d. ed. 2010) (“An insured’s reservation of the right to change beneficiaries under a life insurance policy is an ‘incident of ownership’ sufficient to cause inclusion of the policy proceeds in the insured/decedent’s gross estate....”).

pledge the policy for a loan, or to obtain from the insurer a loan against the surrender value of the policy, etc.¹⁸¹

Reservation of the power to change beneficiaries is by itself sufficient “incident of ownership” to cause inclusion of the policy proceeds in the insured’s gross estate.¹⁸² Conversely, an assignor who has exercised the surrender option of a policy can still have effectively removed the policy from his gross estate.¹⁸³

In a standard collateral assignment, an insured does not grant the insurer access to the power of appointment, or otherwise put that power at risk. It is difficult for a foreclosing creditor to persuade an insurance company to list him as the owner when such a large portion of the ownership has been reserved.

It is also difficult for a creditor to persuade a subsequent purchaser that he owns the policy if he is not listed as the owner. As a matter of industry practice, investors in life insurance policies expect to purchase policies with all the relevant rights attached. They designate themselves as beneficiary so that they can take the full proceeds, and they expect to be able to sell the policy on the secondary market, allowing the next purchaser to designate herself as the new beneficiary. Purchasers may wish to securitize policies for resale, requiring them to all be complete and possessing the full incidents of ownership.

Thus, the current drafting regime creates a difference between policies obtained by absolute assignment and collateral assignment. The former policies, assigned as consideration in sale, will come without strings attached. The latter, assigned as collateral, will lack important features that investors expect and desire.

¹⁸¹ 26. C.F.R. § 20.2042-1(c)(2) (2010).

¹⁸² See *Comm’r v. Estate of Noel*, 380 U.S. 678, 682 (1965) (flight insurance policy where insured possessed right to change beneficiary and right to assign policy). See also *Am. Nat’l Bank & Trust Co. v. United States*, 832 F.2d 1032 (7th Cir. 1987) (despite apparent assigning of policy to spouse); *Terriberry v. United States*, 517 F.2d 286, 289 (5th Cir. 1975); *Brown v. Comm’r*, 95 F.2d 184 (6th Cir. 1938) (as to policy assigned to decedent, who then reserved right to change beneficiary); COUCH, *supra* note 180.

¹⁸³ *Insurance Excluded Despite Withdrawal of Cash Value*, 52 Prac. Tax. Strategies 182, 182 (Mar. 1994) (citing *Estate of O’Daniel v. United States*, F.3d 321 (5th Cir. 1993)).

3. Harms of the Reservation Problem

As just discussed, investors in life insurance policies demand all the rights provided for in the policy. However, when life insurance is used as collateral, the only valid documentation of assignment will not assign all of the rights. This makes the policies less useful to the first investor, probably a foreclosing creditor, and unsuitable for securitization. The failure of law and practice to match the realities of a robust secondary market acts as a friction, or worse – a time bomb.

At the same time as the fact of these reserved rights could result in judgments against insurance policy creditors status as policy owner, they are footnotes and asterisks that impair securitization and resale. Legal uncertainty is particularly damning in the life insurance secondary market.

Unlike, say, real estate investors, life insurance investors take the ultimate value of the investment as known.¹⁸⁴ That is, investors demand certainty about the ultimate value of life insurance policies and will be unlikely to accept securitized assets which have risk litigation or difficulty in receiving maturity benefits. In the history of the United States, no insurance policy has ever failed to pay upon maturity. And there have been only three instances of the downgrading of an insurance company security.¹⁸⁵ Every online lecture listed by ILIAM lecture emphasizes certainty as one of the core distinguishing values of insurance linked assets.¹⁸⁶

A robust secondary market must come to rely on securitization, since institutional investors will not wish to purchase individual policies.¹⁸⁷ But securitized policies must be clean of legal nettles. Investors will pass over policies that may be subject to litigation, or are comprised of irregular bundles of incidents of ownership. The secondary market will be stunted if it carries only purchased, rather than foreclosed, insurance policies. And the market for loans on life insurance policies may segregate from the greater market for insurance policies, stunting the value proposition for investors in, and borrowers against, life insurance policies.

¹⁸⁴ Greg Schmitt, *Trends in Insurance Linked Assets – Part 1*, LIFE SOLUTIONS INT'L (Feb. 10, 2009), <http://www.lifesolutionsint.com/news-resources.aspx> (follow “Feb. 10 ILIAM – Trends in Insurance-Linked Assets – Part 1”).

¹⁸⁵ *Id.*

¹⁸⁶ See ILIAM, LIFE SOLUTIONS INT'L (2011) <http://www.lifesolutionsint.com/iliam.aspx>. ILIAM is the Insurance-Linked Investment Awareness Month, an annual lecture series and conference sponsored by Life Solutions International, one of the leading companies in this industry. *Id.*

¹⁸⁷ SEC STAFF REPORT, *supra* note 52, at 6.

4. Solving the Reservation Problem

Inclusion of life insurance policies under Article 9 will empower parties to solve the reservation problem. Consider first why the problem cannot be drafted away under the current legal regime. A beneficiary's interest does not vest if the insured always retains the power of appointment, and so collateral assignment invariably reserves that right to the insured.¹⁸⁸ But there are other ways to keep the beneficiaries' interest from vesting.

Absolute assignments keep the expectancy from vesting by granting to the assignee the power of appointment.¹⁸⁹ Similarly, the insured could grant the collateral assignee the right to select beneficiaries. This would keep the beneficiary's interest contingent while conveying to the creditor an important right he will want upon foreclosure. But the insured probably doesn't want a mere creditor to have the right to select the beneficiary, at least not until a default occurs. And even if a default occurs, the insured will want the excess of the proceeds to go to her own choice of beneficiaries, rather than granting a windfall to the creditor.

Where the parties intend for the creditor to have access to the full proceeds in the event of default, or to be able to resell with all the incidents of ownership, the vesting problem could be solved through drafting a springing appointment clause. The assignor could grant the assignee a contingent right of appointment that vests only in the event of default. But these clauses are unheard of. Insurance companies have not seen fit to add them to the set of available options, perhaps because of the ease with which securitization might then follow.¹⁹⁰

The industry practice discussed in Section III is for insureds and their assignees to give notice of assignment to the insurance company on forms issued by the insurance company. Insurance companies do not include springing beneficiary clauses in those forms, so springing beneficiary clauses are not used in collateral assignments and the power of appointing beneficiaries remains reserved in the insured. In this case, the

¹⁸⁸ *Janesville State Bank v. Aetna Life Ins. Co.*, 274 N.W. 232, 233 (1937).

¹⁸⁹ *See, e.g.*, 9 WEST'S PA FORMS § 14:7 (1995) ("I . . . assign . . . all incidents of ownership with respect to, life insurance policy number _____ issued on my life by [name of life insurance company]. The incidents of ownership hereby assigned include, but are not limited to, the right to designate the beneficiary or beneficiaries of the policy....").

¹⁹⁰ *See infra* Part III.E, explaining why some insurance companies have discouraged securitization.

standard form potentially endangers a secondary market because such a market is intolerant of archaic title disputes.

By contrast, Article 9 invalidates any clause that restricts the assignment of security interests in general intangibles.¹⁹¹ If life insurance policies were included in Article 9, parties would be enabled to draft springing appointment clauses rather than picking assignment forms from the insurance company's limited menu. Insurance contract provisions limiting assignment except where conducted through designated documentation would be invalid. This would render the reservation problem moot.

III. OBJECTIONS

A. CONSUMER PROTECTION

It may be argued that the exclusion of life insurance policies from UCC Article 9 is necessary to protect consumers from unwisely using their policies as collateral.¹⁹² Consumer protection is a worthy goal, and there are serious risks to consumers from insurance policy credit transactions. For example, an impaired life insurance policy could "cut off any interest of the debtor's beneficiaries under the policy if at the debtor's death an outstanding debt existed."¹⁹³ Moreover, insureds that lose their policy in default may find themselves unable to obtain a new policy, either because they are now too old or otherwise unattractive to insurers, or because insurers will not issue policies to individuals on whom an active policy exists, though now in the hands of the creditor.

Such arguments should not impede inclusion of life insurance. First, consumers tend to benefit when they can liberally monetize their assets.¹⁹⁴ Second, whatever risks are posed by policy lending, they are less than outright sales. An efficient borrowing and resale regime will give consumers another alternative to life settlements.

¹⁹¹ U.C.C. § 9-408(a) (2010).

¹⁹² *Ettinger v. Central Penn Nat'l Bank*, 2 B.R. 385 (E.D. Pa. 1979), *rev'd on other grounds*, 634 F.2d 120 (3d Cir. 1980) ("This was obviously done to prevent debtors from foolishly or capriciously utilizing their life insurance policies as collateral") (citing I.G. GILMORE, *SECURITY INTERESTS IN PERSONAL PROPERTY* 315 (1965); Ray D. Henson, *Insurance Proceeds as "Proceeds" Under Article 9*, 18 CATH. U. L. REV. 453, 456 (1969)).

¹⁹³ *Id.*

¹⁹⁴ *See infra* Part I.

Third, UCC exclusion amounts to the least efficient point of regulation for consumer protection. The law currently allows consumers to borrow against their policies, wisely or not, from anyone they please. True, UCC inclusion would likely increase insurance policy borrowing; non-UCC law has the side effect of discouraging would-be creditors from becoming competitors to the presumptive monopoly of the insurer. But it is rare that the best way to help consumer is to frustrate and raise costs on an otherwise legal transaction. If third-party lending posed a threat to consumers, regulations can be promulgated to address those threats directly, rather than by increasing legal uncertainty and cost. Insureds and creditors should not have their rights frustrated in transactions that have long been allowed.

More interesting consumer protections arguments address compromises in medical privacy.¹⁹⁵ Some life insurance financing agreements require the insured to open her health files to the creditor, or submit to periodic medical examinations. Creditors and investors are interested in the longevity risk associated with their interest in the policy. When financial commitments and health become intermingled, policy tradeoffs must be made between consumer privacy, transparency, and other values.

For example, without deciding the issue, a Florida Court questioned whether a right to medical privacy exists where a medical condition has become an essential condition of a commercial transaction.¹⁹⁶ Such arguments bear consideration. They should be evaluated against the benefits accrued to consumers from ready alienability of their policies. Statutes like HIPAA still apply¹⁹⁷ and will no doubt require more careful attention in the coming years. But the best consumer protections will be targeted to help insureds both keep their privacy and avoid exploitation. The worst solution is to protect consumers by using outdated, unclear law to discourage fair competition between creditors.

A similar response is appropriate to the problem of frauds against consumers, and other exploitative practices. It can be difficult for an individual to procure a new life insurance policy after selling hers or losing it through foreclosure. Individuals may be persuaded to part with an asset

¹⁹⁵ See Andrew Spurrier, Note, *The Death of Death Futures?: The Effects of the Health Insurance Portability and Accountability Act of 1996 on the Insurance and Viatical Settlement Industries*, 4 CONN. INS. L.J. 807, 836 (1998).

¹⁹⁶ *State v. Viatical Servs., Inc.*, 741 So. 2d 560, 564 (Fla. Dist. Ct. App. 1999). See also *Life Partners v. Morrison*, 484 F.3d 284, 295-96 (4th Cir. 2007).

¹⁹⁷ Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 201 *et seq.*

that they would prefer to keep, or may later regret giving up.¹⁹⁸ And the tax implications of such a transfer can sometimes be surprising.¹⁹⁹ These legitimate concerns may require disclosure and regulatory oversight.²⁰⁰ Yet our approval of assignments indicates a confidence that these problems can be addressed. It is of independent value that the law be orderly and that consumers get the best possible price for their policies.

B. STATUS QUO AND THE ORIGIN OF THE CODE

This section treats the general conservative objection that the Drafters of the Code knew what they were doing, and we should not amend their work without knowing why they set things up the way they did. Indeed, since most of the problems explained in the preceding sections are not new, it would be strange, if not hubristic, to amend the Code without wondering what the drafters thought of these problems.²⁰¹

It will be shown in this section that this general objection is not persuasive here. The origin of the exclusion lies not in the drafters' thoughtful understanding of subtle economic and legal realities so much as bowing to the pressure of an industry that feared change. As ambitious as Article 9 may have been, the drafters made compromises in order to ease its passage.²⁰²

¹⁹⁸ J. Alan Jensen and Stephan R. Leimberg, *Stranger-Owned Life Insurance: A Point/Counterpoint Discussion*, 33 ACTEC J. 110, 113 (2009) ("therefore, it will reduce the ability of the insured to buy additional coverage throughout his life. . .").

¹⁹⁹ Rev. Rul. 2009-13, 2009-21 I.R.B. 1029 (explaining that individuals who sell their insurance policies may owe taxes on the amount received, less premiums paid. Thus, settlement income does not receive the same tax advantage for the insured as maturity proceeds. Note, however, that tax implications of a policy loan are unlikely to be as surprising and adverse.).

²⁰⁰ See generally Miriam R. Albert, *The Howey Test Turns 64: Are the Courts Grading this Test on A Curve?* 2 WM. & MARY BUS. L. REV. 39-50 (2011) (statutes and regulations regulating viatical settlements).

²⁰¹ Notwithstanding the growing importance of secondary markets. See *infra* Part I.B.

²⁰² Homer Kripke, *The Principles Underlying the Drafting of the Uniform Commercial Code*, 1962 U. ILL. L. R. 321, 327 (1962) ("The draftsmen and the members of the sponsor organizations knew that to draft a dead-letter bill would accomplish nothing. The Code had to be enacted.").

1. Early Exclusion in Article 9

The first draft of the Uniform Commercial Code, promulgated in 1952, did not exclude insurance policies from the scope of Article 9,²⁰³ Article 9 was first adopted in Pennsylvania without any exclusion,²⁰⁴ but the integrity of the Code was soon threatened by a seeming drafting error.

The confusion arose from an apparent conflict between the text of the Code and its comments. Comment 4 to Section 9-105 of the 1952 UCC stated:

‘Instrument’ (subsection (1)(g)): the term as defined includes not only negotiable instruments and investment securities but also other intangibles which are evidenced by writings which are in ordinary course of business transferred by delivery, for example, insurance policies.²⁰⁵

This Comment clearly indicates the desire of the drafters to classify insurance policies as instruments.

However, the statutory text of the definition does not mention insurance as an instrument, and indeed, implies the contrary: “‘Instrument’ means . . . [a writing] which evidences a right to payment of money and is of a type which is the ordinary course of business transferred by delivery.”²⁰⁶ To be an instrument, insurance policies must have been transferred by delivery in the ordinary course of business, but the extant commercial practice required more than mere delivery to transfer insurance policies.²⁰⁷ Life insurance policies were ordinarily transferred by delivery *and* by a written agreement of transfer, not mere delivery. If not an instrument, life insurance policies would seem to have been left out of the Code notwithstanding the drafters’ intentions.

There were a number of ways to potentially square the drafters’ intentions with the text, but none proved satisfactory. For example, if the commercial practice of delivery was a necessary condition, but not sufficient, then life insurance policies might still fit the definition as

²⁰³ See U.C.C. § 9-104 (1952).

²⁰⁴ PA. STAT. ANN. tit. 12A, § 1-101 *et seq.* (Purdon Supp. 1953).

²⁰⁵ U.C.C. § 9-105, Comment 4 (1952).

²⁰⁶ *Id.* § 9-105.

²⁰⁷ Carl W. Funk, *Problems of Classification Under Article 9 of the Uniform Commercial Code*, 102 U. PA. L. REV. 703, 709 (1954).

instruments. But many lawyers were unwilling to make this interpretive leap without guidance.²⁰⁸

An alternative interpretation might have fitted insurance policies into another category of collateral. It could have been argued that insurance policies qualified as chattel paper, the definition of which read “of a type which is in ordinary course of business transferred by delivery with appropriate endorsement or assignment.”²⁰⁹ But a consensus did not form around this interpretation either. The Comments clearly placed insurance in the mutually exclusive “instruments” group. It was impossible to square the text of the statute with the commercial reality of insurance policy transfer, regardless of what the Comments did to keep policies out of other categories. It became necessary to draft an amendment.

In resolving this confusion, the Drafting Committee bowed to industry pressure, and simply excluded life insurance policies. Even the revered Drafting Committee had to consider the political realities of getting legislatures to accept their proposal, as drafter Fairfax Leary explains:

All along there were other indirect pressures on the draftsmen from special interests. These pressures were felt through various and sundry people who got the information from their contacts and passed it on. There was great pressure to produce an adoptable Code, and, therefore, certain interests who might oppose the Code had to be pacified [One] was the insurance industry and sure enough you'll find their exemption in 9-104.²¹⁰

Other drafters have made similar remarks and calls for reform.²¹¹

²⁰⁸ *Id.* at 709-10.

²⁰⁹ U.C.C. § 9-105(b) (1954).

²¹⁰ Fairfax Leary, *Reflections of a Drafter: Fairfax Leary*, 43 OHIO ST. L.J. 557, 558 (1982). See also Kathleen Patchel, *Interest Group Politics, Federalism, and the Uniform Laws Process: Some Lessons from the Uniform Commercial Code*, 78 MINN. L. REV. 83, 101 (1993) (“[C]ar-trusts and insurance were exempted from Article 9 coverage to pacify, respectively, the railroad interests and the insurance industry.”); Soia Mentschikoff, *The Uniform Commercial Code: An Experiment in Democracy in Drafting*, 36 A.B.A. J. 419 (1950) (describing extensive interaction with interest groups); WILLIAM TWINNING, KARL LLEWELLYN AND THE REALIST MOVEMENT 330 (1973) (describing Llewellyn’s commitment to a draft which would be adopted, even if it meant excluding areas that should logically be included, like insurance).

²¹¹ Coogan, *supra* note 96, at 1054.

At first, the insurance industry suggested several solutions, including simply expanding the definition of instruments to more clearly cover life insurance policies.²¹² Later insurance industry lawyers demanded exclusion from the Code rather than disambiguation.²¹³

Resistance came from resistance to relatively small concessions. For example, there was a difference in commercial practice between insurance companies and third party creditors, and insurers did not wish for a Code that would require them to change their practice. Third party creditors were in the habit of taking possession of collaterally assigned policies, while insurance companies tended not to take possession of the collaterally assigned policy. Insurance companies were afraid that they might have had to change their lending practices slightly to be on par with third party lenders.²¹⁴ Although this would have increased uniformity and certainty, insurance companies preferred to maintain the status quo. They would have found a policy possession requirement an “inconvenience.”²¹⁵

According to one account, insurance companies had no opposition to Article 9 more substantial than that the status quo was adequate enough, and so change should be resisted simply because it constituted change. This is the opinion of Professor Grant Gilmore, Co-Reporter for Article 9: “If [my] personal recollection may be relied on, the attitude of counsel [for the insurance companies] was not that any provision of the Article was incorrect, harmful, or disadvantageous to their client, but was rather that they were disinclined to flee the evils that they knew not of.”²¹⁶ Professor Coognan, Dean of Commenters on the 1972 revision of Article 9, shared Gilmore’s perspective:

²¹² Funk, *supra* note 207, at 711 (citing Willis H. Satterthwaite, Assignments of Life Insurance Policies Under the Uniform Commercial Code (May 2, 1953) (unpublished manuscript) (suggesting that Section 9-105(g) be amended to read: “(g) ‘Instrument’ means ... or any other writing ... which evidences a right to the payment of money and is of a type which is in ordinary course of business transferred by delivery or by delivery with appropriate indorsement [sic] or assignment”)).

²¹³ Robert Dechert, *The Uniform Commercial Code and its Impact Upon the Life Insurance Business*, in 47 PROCEEDINGS OF THE LEGAL SECTION OF THE AMERICAN LIFE CONVENTION 48, 60 (1954).

²¹⁴ J.C. Vance, Annotation, *Right of Life Insurance Beneficiary Against Estate of Insured Who Used Policy as Collateral*, 91 A.L.R. 2d 496 (1963); Funk, *supra* note 207, at 710-11.

²¹⁵ Dechert, *supra* note 213, at 60.

²¹⁶ 2 GRANT GILMORE, SECURITY INTERESTS IN PERSONAL PROPERTY § 10.7, at 315 (1965).

Then there are other exemptions or exclusions which were based solely upon the fact that some group had a big club, and would say that if you were going to leave those in, then we will have to learn a new set of laws and we are just not going to do it. We do not know whether it is good or bad, but we do not want to take the time to learn. The insurance people were one group who got such a consideration.²¹⁷

As Article 9 has proved reliable and stable, other groups that had lobbied for exclusion, like the railroads, voluntarily gave up them up.²¹⁸ The insurance industry has grown to enjoy its exclusion and has not expressed any desire to give it up.

The Pennsylvania legislature thus added an insurance exclusion only three months after adopting Article 9.²¹⁹ The Drafters of the Code added the exclusion as well. Their decision to resolve the ambiguity in this way was a direct result of insurance company pressure.²²⁰

2. Exclusion in Revised Article 9

The exclusion was almost eliminated in Revised Article 9.²²¹ California has a non-uniform version of the Code with respect to interests in insurance, and the Committee was interested in California's choice to remain non-uniform.²²² California first adopted a uniform version of Article

²¹⁷ Comm. On. Unif. Commercial Code, Program, *Impact of 1972 Revisions on Secured Financing Transactions Under UCC Article 9*, 33 BUS. LAW. 2491, 2533 (1978).

²¹⁸ *Id.* ("When we asked the railroads, in 1972, whether they really wanted to continue to exclude the equipment trusts from the operation of Article 9, nobody could remember why they did it. So the exclusion of equipment trusts from Article 9 has now been eliminated. Thank God.").

²¹⁹ PA. STAT. ANN. tit. 12A, § 9-104(g) (Purdon Supp. 1954); *see also* Funk, *supra* note 207, at 711.

²²⁰ Gilmore, *supra* note 80, at 315. ("This exclusion, like that of railroad equipment trust under subsection (e), was politically inspired.").

²²¹ *See, e.g.*, NAT'L CONFERENCE OF COMM'RS ON UNIF. STATE LAWS. AM. LAW INST. DRAFT UNIFORM COMMERCIAL CODE, REVISED ARTICLE 9. SECURED TRANSACTIONS; SALES OF ACCOUNTS AND CHATTEL PAPER (1995).

²²² Louisiana also chose to exclude policies of insurance from their U.C.C., but it is not clear that the Committee took account of their practices. Article 9 of the Uniform Commercial Code first took effect in Louisiana on January 1, 1990, 9 years before The American Law Institute's promulgation of Revised Article 9. For

9 with respect to insurance, and later narrowed the exclusion of life insurance policies. The revision treated insurance policy loans differently from other loans largely because of insurance company lobbying.²²³ California also accepted that loans from an issuing insurance company “essentially involve a set-off,” and are not really loans.²²⁴ Thus, California’s Section 9 now excludes “[a]ny loan made by an insurance company pursuant to the provisions of a policy or contract issued by it and upon the sole security of the policy or contract.”²²⁵ Loans by third parties are not excluded from the UCC.

The drafters preferred the California approach. Professor Homer Kripke, Associate Reporter for the Review Committee, concurred with Gilmore’s reflection that the exclusion existed less for good public policy reasons than because of the insurance industry’s sense that it was perfectly happy with the status quo:

We have thus had a clear-cut issue as to the approach of this Committee. The California position seems (at least to the writer) to be more sound theoretically than the existing Code. On the other hand, we seem not to have had any real

a discussion of Louisiana’s non-uniform treatment of Article 9, see James A. Stuckley, *Louisiana’s Non-Uniform Variations in U.C.C. Chapter 9*, 62 LA. L. REV. 793 (2002). There is only one glaring problem with the Louisiana approach for the present purposes. Chapter 9 of the Louisiana Code does not adequately protect the rights of those with interests in insurance policies to assign them. By excluding insurance policies from the definition of “general intangible,” Louisiana was able to conveniently draft separate provisions specific to insurance, such as the perfection by control provision. *Id.* at 842. But life insurance policies were thereby removed from the scope of U.C.C. § 9-408 which rendered ineffective restrictions on alienability of general intangibles. With no clause protecting the alienability of life insurance policies, the reservation problem still plagues Louisiana.

²²³ See, e.g., Further Comments on Chapter 9: Comments on Memoranda of Subcommittees of State Bar Committee and California Bankers Committee, Further Comments of State Bar. (“Therefore, we think that the amendment proposed by the California Bankers Committee is a sound modification of the rule of the Official Draft and will avoid unnecessary opposition from life insurance companies. . . .”).

²²⁴ *The Uniform Commercial Code, A Special Report by the California State Bar Committee on the Commercial Code*, 37 J. ST. B. CAL. 119, 200 (1962). But see *infra*.

²²⁵ CAL. COM. CODE § 9109(d)(8) (West 2009).

trouble with the existing Code and a change would certainly create some opposition.²²⁶

The superiority of the California approach was thus weighed against resistance from industry groups.

The Drafting Committee met with insurance industry representatives to vet their opposition to ending the life insurance exclusion. Nearly all of their expressed concerns focused on the difficulties incumbent on the obligor of an account that is subject to transfer. The Drafting Committee deemed some of these concerns unwarranted.²²⁷ Others, if warranted, could be solved through some kind of in-Code accommodation.²²⁸ At the end of a June 1996 meeting, the Drafting Committee voted, three to five, in favor of ending the exclusion.

Notwithstanding the arguments and votes against the exclusion, the Drafting Committee ultimately retained it.²²⁹ They opted for the low-hanging fruit of eliminating the exclusion of health-care-insurance receivables. To the degree that the insurance exclusion is supported by simple incumbency, it should be clear that the status quo was not the result desired by those most thoughtfully involved in the drafting. The exclusion has serious negative effects for consumers and makes life insurance products less attractive, very likely harming the insurance industry in general. Acquiescence to change-averse industry lobbyists can no longer justify the life insurance exclusion.

²²⁶ UNIFORM COMMERCIAL CODE: CONFIDENTIAL DRAFTS, *supra* note 10, at 4-5.

²²⁷ Harris & Mooney, *supra* note 48, at 1374-75 (“e.g., the concern that an insurer would need to consult the UCC filings before deciding whom to pay”). This concern is not warranted because the code allows such an obligor to pay the presumed obligee unless notice has been given of assignment.

²²⁸ *Id.* at 1375 (“e.g., the concern that the insurer would be obligated to pay the secured party upon receipt of a notification of assignment”).

²²⁹ NAT’L CONFERENCE OF COMM’R ON UNIF. STATE LAWS, REVISION OF UNIFORM COMMERCIAL CODE ARTICLE 9 (1997) (“The Drafting Committee recognizes that insurance policies can be important items of collateral in many other business contexts and that the “cash” or “loan” value of life insurance policies also can be a useful source of collateral for borrowing by individuals. Nevertheless, it decided that other law should continue to govern security interests in insurance policies.”).

C. "SPECIAL" TRANSFERS OF INTEREST

Although an insurance exception was created in light of political pressures, the avowed purpose of the exclusion was given in the Official Comments. "Such transactions are often quite special, do not fit easily under a general commercial statute and are adequately covered by existing law."²³⁰

In what ways these transactions are special, and why they do not fit, is not explained by the Commenters.²³¹ Subsequent treatises have accepted the Comment without elaboration.²³² Although every transaction is no doubt quite special, in the same sense as every child is above average,²³³ there is no good reason to credit this comment.

Some resistance to creating parity between insurance-backed loans and other loans is based on the once popular theory that issuer-policy loans from the insurer were not loans at all, merely advances on the proceeds.²³⁴ This view holds that a policy loan carries no obligation on the part of the insured to repay the amount borrowed, but the insurer can cancel the policy if the loan value ever exceeds the cash value of the policy.²³⁵

Two textual considerations show why this idea of "advances against life insurance policy proceeds" cannot justify the policy exclusion. First, party-specific explications cannot defend a transaction-specific exclusion. As the Comments make clear, "transfer[s] of interests in . . . a

²³⁰ UNIFORM COMMERCIAL CODE: 1962 OFFICIAL TEXT WITH COMMENTS, *reprinted in* XXIII UNIFORM COMMERCIAL CODE DRAFTS 401 (Elizabeth Slusser Kelly ed., 1984). The Comments to the current draft of the U.C.C. do not explain the life insurance policy exclusion.

²³¹ Indeed, it is clear they had no idea either. *See infra* Part II.B..

²³² *See, e.g.*, 11 Lary Lawrence, Lawrence's Anderson on the Uniform Commercial Code § 9-109:29 (3d. ed. 2010).

²³³ *See* GARRISON KEILLOR, LAKE WOBEGON DAYS (1985).

²³⁴ *See, e.g.*, *Ford v. Mut. Life Ins. Co.*, 13 So.2d 45 (Miss. 1943); COUCH, *supra* note 32, § 80:1; VANCE, *supra* note 156, at 645.

²³⁵ VANCE, *supra* note 156, at 652. Yet this view warrants skepticism. It would imply that insurers violate no lending statutes when offering misleading terms and usurious interest rates, or loan money in a racially discriminating manner. Second, if a policy loan creates no obligation in the insured, then loan repayments constitute payments without obligation. As a result, the insurance company ought to pay taxes on income that did not constitute obligated loan repayments. Third, if policy loans constituted an advance on proceeds, the loan principal ought to be out of the reach of ordinary creditors, receiving the same immunity as the proceeds would. But insureds cannot draw down their insurance policies to live at a high standard while remaining judgment proof.

policy of insurance” are excluded because “such transactions” are special, not because the transactions’ participants are quite special. Nor does the exclusion mention or emphasize the relationship between the transferor and the transferee.

Neither the text of the UCC nor the Comments intimate that the specialness is any greater or lesser when the creditor is the policy issuer. No explanation that defends the exclusion in terms of the relationship between the insured and the insurer, as opposed to a third party, can make sense of the text or its application in decades of transactions. Even if it could, it would only justify an exclusion of transfers from insured to insurer, partially validating the reform proposal advocated in this article.²³⁶

Second, the question of whether a loan from an issuer is really a loan, as opposed to some other transaction, takes away focus from the real problem – bad, non-uniform law – and cannot justify keeping the exclusion as it currently exists. The Article 9 exclusion does not distinguish between loans and “advances” or “setoffs.” Instead, it applies to any “transfer of an interest in” of a policy of insurance. A given transfer may be a setoff and not a loan, but simply being a setoff does not make the transaction “special” and unable to fit within the general security statute. Article 9 makes adequate provisions for setoffs in deposit accounts.²³⁷

If insurance companies deserve special treatment by virtue their identity or the nature of the transaction, there is room to acknowledge these differences in the Code without exclusion. Consider the creditor-bank that doubles as the holder of a deposit account. Like an insurance company, it is in a privileged position to monitor the customer. Also like the insurance company, it has a dual role as creditor and debtor, mirroring the insurance company’s role as policy loan-creditor and “debtor” of the ultimate proceeds.

The Code allows the bank to perfect interests in the deposit accounts by control.²³⁸ Banks are afforded special treatment in virtue of their special role, but they still join the general structure of the Code. The

²³⁶ Even if the insurer’s relationship is different enough to warrant an alternative perfection and assignment scheme, third parties would still deserve an efficient system vis-à-vis one another. The Code is so wholly superior to existing law that third parties must be allowed to avail themselves even if the text were somehow construed to allow a coherent account of insurance companies’ specialness.

²³⁷ U.C.C. §§ 9-109(d)(10)(A), 9-340 (2000) (including set-off rights in scope of Article 9).

²³⁸ *Id.* at § 9-314. See generally Willa E. Gibson, *Banks Reign Supreme Under Revised Article 9 Deposit Account Rules*, 30 DEL J. CORP. L. 819 (2005).

Code acknowledges the dual role of the creditor-bank well enough without an exclusion, and it could do the same for insurance policies.

California has enshrined insurer's privilege, but done so within the ambit of the UCC.²³⁹ There are flaws with the California approach that are severe enough to make the California approach inferior to full inclusion. California excludes only issuer loans, and third party interests in loans perfect only upon written notification to the insurer. Notwithstanding such problems, both California's approach and the UCC's treatment of deposit accounts show that UCC-inclusion can be accomplished a number of ways, not all of which should seem a radical departure. Either would be a marked improvement upon the status quo since either solution would eliminate the uncertainty about how security interests are granted and perfected.

D. STOLI

It may be mistakenly thought that this proposal will facilitate stranger-originated life insurance (STOLI, as it is often called). In a typical STOLI transaction, a speculator persuades a consumer to obtain a policy of insurance. The speculator will typically offer to pay the premiums for a period of time. In some STOLI transactions, the premium payments constitute a loan that will be secured by the policy, and the speculator becomes the owner of the policy after a period of time.²⁴⁰ The consumer will either be promised some payment for their participation, or else be enticed by the offer of "free insurance," enjoyed in the years prior to transferring the policy to the speculator.

STOLI transactions are thought to be worrisome for a variety of reasons.²⁴¹ First, by enabling speculators to treat insurance as a mere investment, STOLI transactions misuse public subsidy of insurance. Incentives to hold insurance are intended to promote the core survivor-protection function of insurance, because society benefits when insurance

²³⁹ CAL. COM. CODE § 9312(b)(4) (West 2009) ("[S]ecurity interest in, or claim in or under, any policy of insurance, including unearned premiums, may be perfected only by giving written notice of the security interest or claim to the insurer."); *id.* 9310(b)(11).

²⁴⁰ Absent other concerns, the period will usually be the contestability period. After that period, the insurance company must generally honor the policy.

²⁴¹ Eryn Mathews, Note, *STOLI on the Rocks: Why States Should Eliminate the Abusive Practice of Stranger-Owned Life Insurance*, 14 CONN. INS. L.J. 521 (2008). See also Anita Huslin, *Wealthy Engage in Controversial Re-Selling of Life Insurance Policies*, WASH. POST, Nov. 27, 2007, at D1. (Larry King victimized in a STOLI arrangement).

products replace lost incomes and relieve the government of burdens.²⁴² STOLI speculators enjoy these subsidies without any party contemplating income replacement.

Second, STOLI transactions are often marketed without adequate disclosure of their downsides to insureds, including taxes, fees, reduced eligibility for Medicaid and other programs, and difficulty obtaining new insurance policies after the transaction.²⁴³ Third, they are intended to circumvent insurable interest law.²⁴⁴ The law has found it worrisome what strangers might do with a financial interest in the insured's passing; even family members murder one another enough for insurance proceeds.²⁴⁵ Perhaps more important was the general distastefulness of gambling on another person's life.²⁴⁶ As a result, many legislatures passed statutes recognizing the common law requirement that only those with appropriate interests in the insured living could own insurance against her dying.²⁴⁷

²⁴² *Tax Treatment of Single-Premium Life Ins. Before the Subcomm. on Tax'n and Debt Mgmt. of the Senate Comm. on Fin.*, 100th Cong. 118 (1988) (statement of Dennis E. Ross, Deputy Assistant Secretary (Tax Policy), Department of the Treasury) ("In certain cases, life insurance may enable the surviving spouse and minor children to avoid becoming dependent on governmental assistance, thereby relieving the government of an obligation it otherwise would have to assume.").

²⁴³ Bob Lotane, *STOLI – It's Not Dead Yet*, FLORIDA UNDERWRITERS MAGAZINE, Feb. 2010.

²⁴⁴ *See generally*, 28 JOHN ALAN APPLEMAN, APPLEMAN ON INSURANCE § 174.02 (2d ed. 2009) ("The requirement that a person purchasing a life policy must have some interest, pecuniary or otherwise, in the continued life of the insured. . . .").

²⁴⁵ *Prudential Ins. Co. of America v. Athmer*, 178 F.3d 473 (7th Cir. 1999) (wife murders husband).

²⁴⁶ GEORGE J. COUCH, CYCLOPEDIA OF INSURANCE LAW § 24:117 (2d ed. 1984) ("The reason given for such rule is that a contract made [devoid of an insurable interest] is against public policy on the theory that the beneficiary would be more interested in the early death of the insured than in the prolongation of his life. The purpose . . . is to prevent wagering contracts on the life of another by one having no insurable interest therein"); *see also* *Grigsby v. Russell*, 222 U.S. 149, 156 (1911) ("[T]he ground of the objection to life insurance without interest in the earlier English cases was not the temptation to murder but the fact that such wagers came to be regarded as a mischievous kind of gaming.").

²⁴⁷ *See, e.g.*, ARK. CODE ANN. § 23-79-103(c)(1) to (2) (West 2009) ("In the case of individuals related closely by blood or by law, a substantial interest engendered by love and affection [and i]n the case of other persons, . . . a lawful and substantial economic interest in having the life . . . of the individual insured continue . . .").

STOLI policies contemplate circumventing these statutes to whatever degree possible.

This article should not be taken to endorse or ease the creation of STOLI transactions. Article 9's freedom of assignment will not invalidate efforts to prevent STOLI transactions. True, Article 9 will not abide policy provisions limiting transfers of the policy to third parties.²⁴⁸ However, insurance policies may be rescinded for fraud, and almost all policy applications ask questions about intentions to transfer the policy to a third party. Insurers will be free to rescind policies that appear to have been fraudulently obtained, particularly during the contestability period.²⁴⁹ And Article 9 is explicit that its assignment facilitation clause²⁵⁰ will control only for the creation of security interests.²⁵¹ STOLI transactions involve absolute assignments of the entire policy; hence other statutes²⁵² and contract provisions can constrain these transfers. It is possible to distinguish STOLI from reform of life insurance securitization.²⁵³ Many states have already taken action to bar STOLI²⁵⁴ without taking a stand

²⁴⁸ Franklin L. Best, Jr., *Securitization Of Life Insurance Policies*, 44 TORT TRIAL & INS. PRAC. L.J. 911, 929-30 (2009) (discussing drafting of policies to allow rescission).

²⁴⁹ See 29 APPLEMAN, *supra* note 244, at § 178.03 (insurance statutes set a period of years after which insurance companies may generally not contest a policy's validity for reasons of fraud in acquisition).

²⁵⁰ U.C.C. § 9-408 (2010).

²⁵¹ *Id.* comment 3.

²⁵² Section 9 of the NAIC Viatical Settlements Model Act provides that "[p]rior to the initiation of a plan, transaction or series of transactions, a viatical settlement broker or viatical settlement provider shall fully disclose to an insurer a plan, transaction or series of transactions, to which the viatical settlement broker or viatical settlement provider is a party, to originate, renew, continue or finance a life insurance policy with the insurer for the purpose of engaging in the business of viatical settlements at any time prior to, or during the first five (5) years after, issuance of the policy." NAIC VIATICAL SETTLEMENTS MODEL ACT § 9.

²⁵³ SEC STAFF REPORT, *supra* note 52, at 12. See also *Life Settlements and the Need for Regulatory Transparency Before the S. Special Comm. On Aging*, 111th Cong. 1 (2009) (statement of Mary Beth Senkewicz, Deputy Ins. Comm'r, Florida Office of Ins. Reg.); Cory Chmelka, *Premium Financing: The Time Is Now*, CPA J. (Sept. 2009); Christina Pellett, *Life Settlements Poised for 'Natural Growth,' But Producers Still Lacking in Education*, AGENT'S SALES J. (Feb. 2010) ("While the two are often tied together in media coverage, life settlements are not the same as STOLI - though some STOLI arrangements do involve life settlements.").

²⁵⁴ Best, *supra* note 248, at 917-27.

against life insurance related financial products, and even the life settlement industry generally opposes STOLI.²⁵⁵

E. INSURANCE INDUSTRY VITALITY

Any reform proposal must take into account the vitality of the insurance industry as a whole. As described above, increasing credit to insureds will reduce lapse.²⁵⁶ The reduction in lapse will tend to be among the impaired policies, resulting in adverse selection (from the insurance company's perspective).²⁵⁷ One may speculate that a general reduction in lapses by policyholders could lead to more payouts to insurance beneficiaries, and consequently increased costs for insurance companies. Insurance companies might pass on costs to other consumers,²⁵⁸ or face a risk of insolvency.²⁵⁹ Such results would decrease the utility of a competitive credit regime.

²⁵⁵ *Life Settlement Industry Opposes Stranger-Originated Annuities*, MARKETWIRE (May 5, 2010), <http://www.marketwire.com/press-release/Life-Settlement-Industry-Opposes-Stranger-Originated-Annuities-1160433.htm>.

²⁵⁶ See LeBel & Tillinghast, *supra* note 33. See also Jim Connolly, *New Persistency Study Shows Lapse Rates Have Generally Declined*, NAT'L UNDERWRITER LIFE & HEALTH (May 4, 2008).

²⁵⁷ Best, *supra* note 245, at 915.

²⁵⁸ Hanming Fang & Edward Kung, *How Does Life Settlement Affect the Primary Life Insurance Market?* 2 (Nat'l Bureau of Econ. Research, Working Paper No. 15761, 2010), available at <http://econ-www.mit.edu/files/5329> (“[L]ife insurance companies, as represented by the Deloitte Report (2005), claim that the life settlement market, by denying them the return on lapsing or surrendered policies, increases the costs of providing policies in the primary market. They allege that these costs will have to be passed on to consumers, which would ultimately make the consumers worse off.”).

²⁵⁹ Perhaps this is why most life insurance companies oppose securitization of policies. Press Release, Am. Council of Life Insurers, *Statement of the ACLI Regarding Securitization of Life Settlements* (Feb. 3, 2010), available at <http://www.secondaryinsurancemarketblog.com/files/aclipolicy.pdf>. Statement of the ACLI Regarding Securitization of Life Settlements (Feb. 3, 2010) (“ACLI Statement”), available at http://www.acli.com/NR/rdonlyres/972B2B38-89F0-4683-B236-A01360544A9F/23344/STOLI_SecuritizationPolicyFinal_020310.pdf (The American Council of Life Insurers are a trade group for life insurance companies. They mainly oppose securitization out of fear that it will increase demand for fraudulent STOLI policies); *But see* Press Release, Institutional Life Markets Ass'n, ACLI Mixes “Apples and Oranges” to Mislead Customers (Feb. 4, 2010), available at <http://www.lifemarketsassociation.org/documents/PR->

However, the SEC Life Settlements Task Force was not persuaded that lapse-reduction threatens the industry.²⁶⁰ The Task Force noted that prudent pricing models involve conservative lapse rate assumptions.²⁶¹ At worst, certain insurance companies will suffer, but the industry as a whole will remain healthy.²⁶²

Moreover, reforms to the law of assignment are likely to be to the benefit of the insurance industry, for at least four reasons. First, these proposals are efficiency increasing, and insurance companies should be able to obtain some compensating share of the surplus. For example, legal reform will reduce costly litigation and confusion that currently is a cost for insurers too.²⁶³

Second, whatever wealth is transferred from insurance companies to creditors and investors is likely to find its way back to insurance companies anyway. Insurance companies are the ones with the best actuarial information and they are, theoretically and actually, the most likely third-party creditors against other insurance company's policies.

%20ACLI%20misleads.pdf; Press Release, Life Insurance Settlement Association, *Life Insurance Settlement Association Responds to Misleading ACLI Position on Life Settlements*, MARKETWIRE (Feb. 5, 2010), available at <http://www.marketwire.com/press-release/Life-Insurance-Settlement-Association-Responds-Misleading-ACLI-Position-on-Life-Settlements-1113175.htm>.

²⁶⁰ SEC STAFF REPORT, *supra* note 52, at 20 (“the Task Force was told that the extent of this impact is likely to be small.”) (citing Telephone Interview with Scott Hawkins, Conning Research & Consulting (Mar. 30, 2010); Michael Shumrak, *Life Settlements—A Window Of Opportunity For The Life Insurance Industry?*, REINS. NEWS, Feb. 2010, at 14 (only about 1% of life policies have been settled)).

²⁶¹ SEC, STAFF REPORT, *supra* note 52, at 20 (citing Christian Kendrick, *Special Report: Return of Premium Products*, TRANSAMERICA REINS. (Jul. 13, 2007), available at http://www.transamericareinsurance.com/Media/media_associateArticle.aspx?id=295); see also DELOITTE CONSULTING LLP & THE UNIV. OF CONN., *THE LIFE SETTLEMENT MARKET: AN ACTUARIAL PERSPECTIVE ON CONSUMER ECONOMIC VALUE* 12 (2005), available at http://www.quatloos.com/uconn_deloitte_life_settlements.pdf (a life settlements transaction “generally has minimal or no impact on the anticipated profitability of a life insurance contract because the persistency of an unhealthy policyholder is precisely what is assumed at the time of original pricing.”).

²⁶² SEC STAFF REPORT, *supra* note 52, at 20.

²⁶³ See Knippenberg, *supra* note 11, at 226 (“The long and the short of it is, there are risk and costs. . . to insurers who are driven to interpleader actions or, not infrequently, forced to justify as defendants the payment of proceeds to one or another of multiple claimants.”) (citing *Lincoln Nat'l Life Ins. Co. v. Brown Schools*, 757 S.W.2d. 411, 414 (Tex. Ct. App. 1988)).

Much of what insurers lose in lapse-reduction will really represent a transfer from one insurance company to another, with the consumer as the incidental beneficiary.

Third, insurers may sometimes be pleased that their customers turn to third parties for credit. Policy loans disrupt insurer cash flow, and so their dynamics are of vital interest to insurers.²⁶⁴ Since insurers may be required by law to offer policy loans²⁶⁵ and may be limited by law in their ability to charge market interest rates, there may be times where insurers would prefer not to serve their customers' financing needs.

This result may be exacerbated by the inverse relationship between an insurer's ability to lend to their customers, and their customers' need for loans: policy borrowing is largely driven by emergencies,²⁶⁶ so catastrophic events both induce borrowing and also accelerate maturity payments. Insureds resort to policy loans more often when other forms of credit are difficult to obtain, regardless of the market interest rate.²⁶⁷ Rendering alternative financing more accessible may induce some insureds to borrow elsewhere. This will reduce unanticipated draws on the insurance company's balance sheet, even when statutory interest rate compares favorably with the market interest rate.

Fourth, a liberal secondary market allows insurance companies new ways to hedge risk. Actuarial technology gives insurers great power to

²⁶⁴ Andre P. Liebenberg, James M. Carson, & Robert E. Hoyt, *The Demand for Life Insurance Policy Loans*, 77 J. RISK & INS. 651, 651 (2010).

²⁶⁵ See ALASKA STAT. ANN. § 21.45.080(a) (West 2011); ARIZ. REV. STAT. ANN. § 20-1208(A) (2011); ARIZ. REV. STAT. ANN. § 20-1209(A) (2011); DEL. CODE ANN. tit. 18 § 2911(a) (West 2011); GA. CODE ANN. § 33-25-3(5) (West 2011); ME. REV. STAT. ANN. tit. 24-A, § 2510(1.) (2010); MASS. GEN. LAWS ANN. ch. 175, § 132(7) (West 2011); MINN. STAT. ANN. § 61A.03(g) (West 2011); MONT. CODE. ANN. § 33-20-131(1) (2010); NEB. REV. STAT. ANN. § 44-502(8) (2010); NEV. REV. STAT. ANN. 688A.110(1) (West 2011); N.J. STAT. ANN. § 17B:25-8 (West 2011); N.Y. INS. LAW § 3203(8)(A) (McKinney 2011); OHIO REV. CODE ANN. § 3915.05(G) (West 2011); OR. REV. STAT. ANN. § 743.186(1) (West 2011); 40 PA. CONS. STAT. ANN. § 510(h) (West 2011); S.C. CODE ANN. § 38-63-220(k)(1) (2010); S.D. CODIFIED LAWS § 58-15-15 (2011); VT. STAT. ANN. tit. 8, § 3731(7) (West 2010); WASH. REV. CODE. ANN. § 48.23.080(1) (West 2011); W. VA. CODE ANN. § 33-13-8(a) (West 2011). See also *Metro. Life Ins. Co. v. Mass. Travelers Ins. Co.*, 471 U.S. 724, 728, (1985).

²⁶⁶ Liebenberg, Carson & Hoyt *supra* note 264.

²⁶⁷ A. Edward Day & Patric H. Hendershott, *Household Demand for Policy*, 44 J. RISK & INS. 441 (1977). But see J. David Cummins, *An Econometric Model of the Life Insurance Sector of the U.S. Economy*, 40 J. RISK & INS. 533 (1973) (arguing for both market interest rate and alternative funds hypotheses).

predict the time and extent of their liabilities, but insurers currently can do nothing to meet expected and liabilities except altering their asset mix. An insurance company that recruited heavily in the past may be able to predict substantial liabilities in a decade or so. But it faces the possibility that its cash-out date will be a depressed period for the investment market; an insurance company with significant fixed liabilities maturing in 2008 may have had more difficulty paying than one paying the same liabilities in 1998.

As it stands, an insurance company can respond to such risks by shifting from risky, illiquid assets (that may earn higher returns) into comparatively safer, liquid assets (that may earn less attractive returns). This is a method of mitigating risk, but it is a crude method and it sacrifices returns.

Insurance companies would do better if they could periodically update their inter-temporal diversification.²⁶⁸ With a robust secondary market, an insurance company could buy policies due to mature at the same time as those they have issued. Then they would be due payments at the same time their own liabilities matured. Put simply, insurers could make sure that cash was flowing in to match the cash that was flowing out. The more robust the secondary market, and the easier to pool insurance-linked assets, the easier and cheaper for insurance companies to rebalance their portfolios. It is perhaps no wonder that the largest insurance policy securitization to date, and the only rated securitization, was internal to an insurance company.²⁶⁹

IV. CONCLUSION

The advantages of having a single commercial law govern secured transactions in every state were known to the drafters of the Code and have since been demonstrated to practitioners who may have been initially skeptical. Life insurance policies were excluded from the scope of Article 9 because of industry resistance, but that resistance rested on skepticism about the merits of Article 9.

²⁶⁸ See IAN AYRES & BARY NALEBUFF, *LIFECYCLE INVESTING* (2010) (describing the Samuelson Share, and methods for investors to achieve intertemporal diversification).

²⁶⁹ Meg Green, *AIG Files First Rated Life Settlement Securitization*, BESTWEEK, Apr. 16, 2009 (\$8.4 billion transaction internal to an AIG subsidiary); see also SEC STAFF REPORT, *supra* note 52, at 15-16 (discussing securitizations).

The time for skepticism is over. Importantly, the legal morass of the common law has become more of a problem since the time when the code was contemplated. Removing almost all other secured transactions to the Code has left insurance alone to develop the case law, leaving industry practices to exist in uncertain tension with the throwback common law.

The law governing perfection and surplus allocation is unclear and at odds with creditors' expectations. The reservation problem, too, stands as an impediment on securitization and resale, and a source of potential litigation.

All these problems would be solved by bringing interests in life insurance policies into the scope of the UCC. The nature of the inclusion can be debated. The simplest, clearest solution is for life insurance policies to be treated as general intangibles, but even if they are given their own rules within the UCC, as they are in California and Louisiana, the system will be much improved.

The path leading away from exclusion has ramifications for reform projects generally. In reform projects, compromises may sometimes be struck. But the transactions left unchanged because they are "good enough," do not remain good enough as the market grows in response to the reform.

Perhaps if Article 9 had not created a unified security regime, the disparate types of security agreements would have grown together organically, jurisdiction to jurisdiction, with life insurance policies lending among them. But the growth of non-UCC securitization has been isolated and localized life insurance policy collateral, stunting the growth and rationalization of the law of insurance-backed-lending.

Moreover, the success of Article 9 security agreements in other areas has led to a rise in successful securitizations. The market expects that assets can be used in sophisticated financing agreements and securitizations. Article 9 has created an expectation of, and appetite for, a high standard of efficiency and predictability in financing transaction. As it stands, life insurance policies cannot satisfy that appetite. Every reform compromise carries with it the possibility of regression, making the unreformed law even worse than before. For the life insurance policy exclusion, and other opportunities for reform, fuller reform is the better policy.

LIABILITY INSURANCE COVERAGE FOR CLERGY SEXUAL ABUSE CLAIMS

Peter Nash Swisher *
Richard C. Mason **

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* Professor of Law, University of Richmond Law School. B.A., Amherst College; M.A., Stanford University; J.D., University of California, Hastings College of Law.

** Cozen O’Connor law firm, Philadelphia, Pa. B.A., Loyola University at Baltimore; J.D., University of Maryland School of Law.

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I. INTRODUCTION

Sexual offenders constitute a grave social problem in contemporary American society.¹ For a quarter century, sexual abuse claims have been brought against an increasing number of Roman Catholic dioceses and priests,² and against members of other religious denominations as well.³

¹ See, e.g., *MySpace Pulls 90,000 Sex Offenders From Site*, RICH. TIMES-DISPATCH, Feb. 4, 2009, at A3 (noting that this figure was nearly double what MySpace officials had originally reported the previous year).

² See, e.g., Scott Glover & Jack Leonard, *Cardinal Mahony Under Federal Fraud Probe Over Abusive Priests, Sources Say*, L.A. TIMES, Jan. 29, 2009 (reporting that Cardinal Mahony “was accused of transferring priests who molested children to other parishes rather than removing them from the priesthood and alerting authorities.”); see also David L. Gregory, *Some Reflections on Labor and Employment Ramifications of Diocesan Bankruptcy Filings*, 47 J. CATH. LEGAL STUD. 97 (2008) (discussing the significance of Roman Catholic dioceses filing for bankruptcy in the wake of clergy sexual abuse scandals, and making significant mention of liability insurers proactively filing declaratory judgment actions to avoid coverage in clergy sexual abuse claims). Clergy sexual abuse claims have not been limited to the United States, and high profile clergy sexual abuse claims also have been reported in a number of other countries as well, including Australia, Brazil, Britain, Ireland, France, Italy, Germany, and Belgium. See, e.g., Henry

Sexual predators who abuse minor children should be prosecuted to the fullest extent of the law, and face serious criminal and civil liability for their detestable acts. But should these sexual abuse claims, including clergy sexual abuse, be covered under liability insurance policies, which commonly exclude acts that are “expected or intended from the viewpoint of the insured”? The courts have been far from uniform in addressing this and other related issues arising under liability insurance policies.⁴

Beginning with the earliest claims for insurance for sexual abuse, liability insurers typically have denied coverage for such claims under standard liability insurance policies. Insurers long have contended that the

Chu, *Cardinal Asked Victim to Keep Silent*, L.A. TIMES, Aug. 31, 2010 (“The former head of Belgium’s Roman Catholic Church acknowledged Monday that he was wrong to have urged a sexual abuse victim to stay quiet until after the bishop who repeatedly molested him over a span of 13 years could retire.”).

³ See, e.g., Carolyn Peirce, *Jewish Coalition Want Abuse Victims to Speak Out*, WASH. EXAMINER, Jan. 25, 2009, available at <http://washingtonexaminer.com/local/jewish-coalition-want-abuse-victims-speak-out> (reporting on an Orthodox Jewish cantor who had previously participated in an international child pornography ring. “It’s like the Catholic Church all over, but not as large,” one coalition member stated.); see also Charles Toutant, *Mormon Church Sued on Charges of Sexual Abuse by Youth Leader*, 185 N.J. L.J. 475 (2006) (reporting that a Mormon bishop from Provo, Utah notified the child abuser’s new ward, or congregation, about his previous criminal sexual offenses in Utah and Wisconsin, but the ward still put him in positions working with children in Dallas, Texas, and later working with children in Ledgewood, New Jersey).

⁴ See, e.g., STEVEN PLITT, DANIEL MALDONADO & JOSHUA D. ROGERS, COUCH ON INSURANCE 3D §§ 127:24-127:28 (2008 rev. ed.) [hereinafter COUCH ON INSURANCE]; JERRET E. SALE & LINDA M. BOLDUAN, *Insurance Coverage for Sexual Molestation*, in 3 Rowland H. Long, *The Law Of Liability Insurance* Ch. 11C (Matthew Bender ed. 2010) [hereinafter LONG ON LIABILITY INSURANCE]; see also Jesse J. Cooke, Book Note, *Beyond an Unfortunate “Occurrence”: Insurance Coverage and the Equitable Redress of Victims of Sexual Predator Priests*, 36 ARIZ. ST. L.J. 1039 (2004); Barron L. Weinstein, *Sexual Misconduct Claims: A Policyholder’s Perspective of Key Coverage Issues*, 38 THE BRIEF 49 (2009); James L. Rigelhaupt, Jr., Annotation, *Construction and Application of Provisions of Liability Insurance Policy Expressly Excluding Injuries Intended or Expected by Insured*, 31 A.L.R. 4th 957 (1984); Joseph Conder, Annotation, *Liability of Church or Religious Society for Sexual Misconduct of Clergy*, 5 A.L.R. 5th 530 (1992), superseded in part by Marjorie A. Shields, Annotation, *Liability of Church or Religious Organization for Negligent Hiring, Retention, or Supervision of Priest, Minister, or Other Clergy Based on Sexual Misconduct*, 101 A.L.R. 5th 1 (2002).

standard general liability policy was not intended to cover intentional acts, including sexual abuse.⁵

At the same time, the insurance industry has made available a special “sexual abuse” coverage endorsement to add coverage specifically for sexual abuse. When the sexual abuse endorsement is purchased, liability coverage for sexual abuse is expressly afforded.⁶ However, most insureds have not purchased this add-on coverage.

Because insurance generally exists only to provide indemnity for fortuitous, unexpected, and accidental loss, and because insurance generally does *not* provide coverage for intentional acts, liability insurers usually except from coverage intentional acts, or “expected or intended” injury.⁷ Indeed, the underlying public policy rationale against insurance indemnification for intended loss is so strong that the courts will in some circumstances forbid payment of insurance benefits, even if the insurance policy is silent on this particular point. However, the states differ markedly on the type of intentional conduct that is sufficiently volitional in nature to bar coverage.⁸

Over the last decade, a number of policyholders facing sexual abuse claims, including clergy sexual abuse, have taken the position that even if a sexual offender’s acts arguably *were* “expected or intended,” and therefore excluded from coverage under a liability insurance policy’s “expected or intended” provision, the sexual offender’s employer, supervisor, or religious order might still come within policy coverage under the legal doctrine of negligent supervision, negligent hiring, negligent

⁵ See, e.g., *Grange Mut. Cas. Co. v. Thomas*, 301 So. 2d 158, 158-59 (Fla. Dist. Ct. App. 1974); *Altena v. United Fire & Cas. Co.*, 422 N.W.2d 485, 490 (Iowa 1988); *Rodriguez ex rel. Brennan v. Williams*, 713 P.2d 135, 137-38 (Wash. Ct. App. 1986) (“The average person purchasing homeowner’s insurance would cringe at the very suggestion” that the person was paying for coverage for sexual abuse, “[a]nd certainly [the person] would not want to share that type of risk with other homeowner’s policy holders.”).

⁶ See, e.g., *Jane D. v. Ordinary Mut.*, 38 Cal. Rptr. 2d 131 (Cal. Ct. App. 1995); *Dobbs v. State Farm Fire & Cas. Co.*, 773 N.E.2d 1251 (Ill. App. Ct. 2002).

⁷ See generally ROBERT H. JERRY II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW § 63C (4th ed. 2007); JEFFREY R. STEMPEL, STEMPEL ON INSURANCE CONTRACTS §§ 1.06[B], 1.08[2] (3d ed., rev. vol. 2010).

⁸ See generally EMERIC FISCHER, PETER N. SWISHER & JEFFREY W. STEMPEL, PRINCIPLES OF INSURANCE LAW 58-68 (3d rev. ed. 2006).

retention, or under similar doctrines based upon *negligence* principles rather than based on *intentional acts* by the insured.⁹

This article addresses issues that arise when a policyholder under a standard general liability insurance policy, not containing an express sexual abuse coverage endorsement (or an express sexual abuse exclusion), seeks insurance coverage for sexual abuse claims. Such cases continue to increase in frequency as the legacy of sexual abuse and molestation generates an unrelenting deluge of insurance coverage claims.

The purpose of this article is to explore and analyze the case law and various legal theories supporting and rejecting liability insurance coverage claims involving institutional sexual abuse allegations. This article concludes by recommending a better-reasoned objective concurrent causation legal doctrine that would bring a realistic, and more uniform, judicial approach to the liability insurance interpretive conundrum involving clergy sexual abuse coverage disputes. The article also synthesizes the law concerning other prominent coverage issues in the rapidly developing area of sexual abuse insurance claims.

A. CIVIL ACTIONS TO RECOVER FOR SEXUAL ABUSE.

Until the 1980s, civil actions for sexual abuse were uncommon, although examples dating back more than fifty years can be found.¹⁰ Certainly, in the United States there were far fewer reports of clergy sexual abuse in earlier years, and almost certainly fewer instances of sexual abuse

⁹ See, e.g., *Evangelical Lutheran Church in Am. v. Atl. Mut. Ins. Co.*, 169 F.3d 947 (5th Cir. 1999) (applying Illinois law) (holding that the negligent training and supervision of a minister was covered, even though the minister's sexual assault was not covered); *Mfrs. & Merchs. Mut. Ins. Co. v. Harvey*, 498 S.E.2d 222 (S.C. Ct. App. 1998) (holding that a claim of negligent entrustment was covered, although sexual molestation of minors by the insured was not covered). *But see* *Diocese of Winona v. Interstate Fire & Cas. Co.*, 89 F.3d 1386 (10th Cir. 1996) (applying Minnesota law) (holding that negligent and reckless supervision claims involving a priest child molester were *not* covered since the Archdiocese knew or should have known that personal injury from child sexual abuse was highly likely to occur); *Am. Commerce Ins. Co. v. Porto*, 811 A.2d 1185 (R.I. 2002) (holding that a separate negligent supervision claim was *not* covered since it causally resulted in the sexual molestation of a child).

¹⁰ See, e.g., *McLeod v. Grant Cnty. Sch. Dist. No. 128*, 255 P.2d 360 (Wash. 1953) (student who allegedly was raped at school claimed school was negligent in leaving students unsupervised and allowing access to darkened area).

in general.¹¹ However, by the late 1970s, reports of sexual abuse of children had sharply increased,¹² and claims seeking financial compensation for sexual molestation increased rapidly.

In recent decades, assorted youth organizations have been sued for sexual molestation, although in many cases the courts have held such sexual abuse was not foreseeable.¹³ In some of these cases, plaintiffs have alleged prior knowledge on the part of a responsible parent or supervisor. However, allegations concerning pervasive knowledge and deliberate tolerance of sexual abuse – and even conspiracies to allow it or to conceal it – are rarely pled in suits against lay organizations, although they have become a staple of clergy sexual abuse lawsuits during the last two decades, as discussed below.

Adults sued for sexual abuse occurring within their own home also have been held subject to liability under principles set forth in *Restatement (Second) of Torts* § 316 (Duty of Parent to Control Conduct of Child).¹⁴ *Restatement (Second) of Torts* § 316 provides that parents are obligated to prevent their children from creating a risk of bodily harm to others if the parent “(a) knows or has reason to know that he has the ability to control his child, and (b) knows or should know of the necessity and opportunity for exercising such control.”¹⁵

Similarly, one may be subject to liability for sexual offenses committed by one’s spouse. “[W]hen a spouse has actual knowledge or special reason to know of the likelihood of his or her spouse engaging in sexually abusive behavior against a particular person or persons, a spouse has a duty of care to take reasonable steps to prevent or warn of the harm . .

¹¹ See THE NAT’L REVIEW BD. FOR THE PROT. OF CHILDREN AND YOUNG PEOPLE, A REPORT ON THE CRISIS IN THE CATHOLIC CHURCH IN THE UNITED STATES 22-25 (2004).

¹² *Id.* at 23.

¹³ See, e.g., *Doe v. Goff*, 716 N.E.2d 323 (Ill. App. Ct. 1999) (holding that the Boy Scouts of America could not be held liable for failure to prevent the sexual assault of a Boy Scout because it was unforeseeable); H.B. *ex rel.* *Clark v. Whittemore*, 552 N.W.2d 705 (Minn. 1996) (holding that a trailer park manager did not have a duty to warn or protect children whom she knew were being sexually abused by a resident); *Montgomery v. YMCA of Cincinnati*, 531 N.E.2d 731 (Ohio Ct. App. 1996).

¹⁴ See, e.g., *Gritzner v. Michael R.*, 611 N.W.2d 906 (Wis. 2000).

¹⁵ *Id.* Likewise, there is a duty to control the conduct of a third person as to prevent him from causing physical harm to another if a “special relationship” exists between the actor and the other person that gives to the other a right of protection. See, e.g., *RESTATEMENT (SECOND) OF TORTS* § 315(a)–(b) (2010).

. [and] breach of such a duty constitutes a proximate cause of the resultant injury, the sexual abuse of the victim.”¹⁶ For example, a wife who invited children to visit her house, when she knew her husband had molested women and children in the past, was subject to liability in negligence.¹⁷ Even a grandmother was held subject to liability for failing to protect her granddaughter from a known risk of sexual abuse by the grandfather.¹⁸

Such actions, however, rarely compare to clergy sexual abuse litigation in terms of the alleged degree of institutional knowledge and culture of tolerance of sexual abuse. It is largely these features that generate profound questions whether general liability policies afford coverage in regard to clergy sexual abuse actions.

B. CHARACTERISTICS OF CIVIL ACTIONS AGAINST RELIGIOUS ORGANIZATIONS AND ORDERS

Public knowledge of sexual abuse by Roman Catholic clergy became widespread in 1984 with the well-publicized revelations concerning Father Gilbert Gauthe in Lafayette, Louisiana. Prior to 1984, the Catholic Church, like many organizations that minister to minors, long had been troubled by pedophilia and similar abuse by its employees and agents.¹⁹ In 1957, a Church expert in treating offenders reportedly had advised one or more archbishops that: “Experience has taught us these men are too dangerous to the children of the parish and the neighborhood” to

¹⁶ J.S. *ex rel.* C.S. v. B.J.H., 714 A.2d 924, 935 (N.J. 2000).

¹⁷ Pamela L. v. Farmer, 169 Cal. Rptr. 282 (Cal. Ct. App. 1980). *See also* Big Brother/Big Sister of Metro Atlanta, Inc. v. Terrell, 359 S.E.2d 241 (Ga. Ct. App. 1987) (social service organization); Enumclaw v. Wilcox, 843 P.2d 154 (Idaho 1982) (wife’s “acts or failure to act . . . may have created or contributed to the environment which permitted her ex-husband’s [molestation],” but did not constitute an occurrence under insurance policy because it was not the conduct that caused the injury); Metro. Prop. & Cas Ins. Co. v. Miller, 589 N.W.2d 297, 300 (Minn. 1999) (suing wife for her “alleged failure to warn of or prevent the abuse” where husband molested minor child).

¹⁸ Doe v. Franklin, 930 S.W.2d 921 (Tex. App. 1996). *But see, e.g.,* T.A. *ex rel.* Kramer v. Allen, 669 A.2d 360 (Pa. Super. Ct. 1995) (holding that step-grandparent did not owe any special duty to step-grandchildren to control her husband’s conduct, and was thus not liable for her husband’s abuse under negligence theory).

¹⁹ *See generally* Rev. Thomas Doyle, *A Very Short History of Clergy Sexual Abuse in the Catholic Church*, CRUSADE AGAINST CLERGY ABUSE, <http://www.crusadeagainstclergysbuse.com/htm/AShortHistory.htm> (last visited Feb. 22, 2011).

continue in their current ministries.²⁰ By 1971, there allegedly were discussions at the bishopric level concerning clergy sexual abuse.²¹

The perceived institutional character of the sexual abuse problem (particularly pedophilia) in religious organizations helps explain why civil complaints frequently allege facts indicating such organizations possessed a high degree of knowledge that minor laity were in jeopardy of abuse by priests. For example, complaints not uncommonly allege the failure of the religious organization to report prior known instances of child abuse.²² Allegations of prior knowledge are alleged with distinct conviction. A representative complaint alleges:

Although [defendant order of friars] knew Father Posey was unsuitable for his position, they failed to review and monitor his performance, to confront him, and to sanction him about “known irregularities in his employment,” e.g., taking young children on trips and to his home.²³

Civil conspiracy claims also frequently accompany claims of clergy sexual assault or abuse.²⁴ A typical complaint alleges that school administrators:

agreed or otherwise conspired to cover up incidents of sexual abuse of minors by Salesian priests and/or educators and to prevent disclosure, prosecution and civil litigation including, but not limited to: failure to report incidents of abuse to law enforcement or child protection agencies; denial of abuse [they] had substantiated; aiding criminal child molesters in evading detection, arrest and prosecution; allowing criminal child molesters to cross state and international borders for purposes of gaining access to uninformed parents whose innocent children could be sexually abused; failure to warn; and failure to

²⁰ *Id.*

²¹ *Id.*

²² See, e.g., *Nunnery v. Salesian Missions, Inc.*, No. 07-2091, 2008 WL 1743436, at *6 (D.N.J. Apr. 15, 2008).

²³ *John Doe CS v. Capuchin Franciscan Friars*, 520 F. Supp. 2d 1124, 1130 (E.D. Mo. 2007).

²⁴ See *Nunnery*, 2008 WL 1743436.

seek out and redress the injuries its priests and / or educators had caused.²⁵

In litigation against Capuchin Franciscan Friars, it was alleged:

Defendants knowingly failed to disclose Father Posey's sexual misconduct. ... Defendant[s] and the Roman Catholic Archdiocese of St. Louis and the Archbishop of the Archdiocese of St. Louis, in concert with one another, and with the intent to conceal and defraud, conspired and came to a meeting of the minds whereby they would misrepresent, conceal, or fail to disclose information relating to the sexual misconduct of Defendant[s]' agents. By so concealing, Defendant[s] committed at least one act in furtherance of the conspiracy.²⁶

Such allegations, it has been held, are premised on factual assertions and thus "cannot be characterized as . . . 'bald assertions' and 'legal conclusions draped in the guise of factual allegations ... 'allegations.'"²⁷

In sum, complaints against clergy and religious institutions are often distinguished by (1) allegations of specific facts constituting prior knowledge, and (2) allegations of conspiracy, fraud, and other similar schemes. These alleged fact patterns form the predicate for an expanding body of law concerning insurance coverage for clergy sexual abuse.²⁸

Liability insurance policyholders who would be barred from coverage for acts of sexual misconduct that are expected or intended from

²⁵ *Id.* at *7.

²⁶ *Capuchin Friars*, 520 F. Supp. 2d at 1129.

²⁷ *Nunnery*, 2008 WL 1743436 at *7.

²⁸ Moreover, since a number of sexual abuse "occurrences" have taken place over a period of many decades, and since some states have suspended otherwise applicable statutes of limitation, and now allow plaintiffs in sexual abuse cases to bring previously barred claims, the possibility of multiple liability insurers and "lost policies" over many years may constitute another real problem. *See, e.g., City of Sharonville v. Am. Emp'rs Ins. Co.*, 846 N.E.2d 833 (Ohio 2006) (holding that when a liability insurance policy has been lost or destroyed, the existence of coverage may be proved by secondary evidence other than the policy itself, including circumstantial evidence of payment records, renewal letters, miscellaneous correspondence, or prior claim files, unless the record contains evidence that the policy was lost or destroyed in bad faith).

the viewpoint of the sexual molester,²⁹ are increasingly bringing coverage claims they assert are predicated upon *negligence*-based claims against the sexual molester's employer, supervisor, religious organization, or another co-insured. These underlying claims typically are based upon claims of negligent supervision, negligent employment, negligent retention, and other negligence principles involving vicarious liability. The courts have been far from uniform in how they treat such claims.³⁰

Although many courts have not recognized vicarious sexual abuse liability claims based upon agency principles³¹ or based upon the doctrine of *respondeat superior*,³² nevertheless the courts are deeply divided on the

²⁹ See generally *infra* Part II (discussing and analyzing the Intentional Acts Exclusion).

³⁰ See generally COUCH ON INSURANCE, *supra* note 4, § 127:27; LONG ON LIABILITY INSURANCE, *supra* note 4, ch. 11C.02[8]; Cooke, *supra* note 4; Weinstein, *supra* note 4; Conder, *supra* note 4; Shields, *supra* note 4.

³¹ See, e.g., *Capuchin Friars*, 520 F. Supp. 2d at 1137 (holding that sexual misconduct by a Roman Catholic priest toward his student did not fall within the scope of the priest's employment under Missouri law, and therefore a religious order could not be held liable for the priest's actions under an agency theory); *Gray v. Ward*, 950 S.W.2d 232 (Mo. 1997) (en banc) (similar holding); *Eckler v. Gen. Council of Assemblies of God*, 784 S.W.2d 935 (Tex. App. 1990) (summary judgment granted to defendant church based on an agency theory alleged by the plaintiff).

³² See, e.g., *Tichenor v. Roman Catholic Church*, 869 F. Supp. 429 (E.D. La. 1993), *aff'd*, 32 F.3d 953 (5th Cir. 1994) (holding that the Roman Catholic church was not liable under the doctrine of *respondeat superior* for the alleged illicit sexual acts of a Roman Catholic priest, where such acts were not in furtherance of the priest's duties and did not advance church doctrine, and where there was no evidence that the church authorized the priest's illicit sexual acts in advance, or ratified them afterwards); *Mark K. v. Roman Catholic Archbishop of Los Angeles*, 79 Cal. Rptr. 2d 73 (Cal. Ct. App. 1998) (holding that the doctrine of *respondeat superior* was not available to impose liability on a religious institution based upon allegations of childhood sexual abuse by a priest, since this sexual abuse was outside the scope of the cleric's employment); *Doe v. Norwich Roman Catholic Diocese*, 909 A.2d 983 (Conn. Super. Ct. 2006) (holding that a bishop, monsignor, and the church were not vicariously liable under the doctrine of *respondeat superior* for sexual assaults committed by a priest on a minor since it was contrary to the teachings of the church, and the priest's sexual assaults on the minor were repugnant to his employer's business and in contravention to the employer's aims and rules); *Elders v. United Methodist Church*, 793 So.2d 1038 (Fla. Dist. Ct. App. 2001) (holding that the local church, the church conference, and church district superintendents were not liable to a member of the congregation for alleged sexual misconduct by a pastor under the doctrine of *respondeat superior*, since the sexual

issue of whether a church or other religious organization should be held liable for the negligent hiring, the negligent retention, or the negligent supervision of a priest, minister, or other clergy member based upon allegations of sexual misconduct.

A number of courts have recognized such claims based upon vicarious liability principles of negligent hiring, negligent retention, or negligent supervision of a priest or other clergy member.³³ Other courts,

misconduct of the pastor was for personal motives, and not to further the interests of the church); *Olinger v. Corp. of the President of the Church of Jesus Christ of Latter-Day Saints*, 521 F. Supp. 2d 577 (E.D. Ky. 2007) (holding that the church could not be vicariously liable under Kentucky law for a missionary's alleged sexual molestation of a minor child, since there was no evidence that the missionary or anyone else believed that he was acting to further the interest of the church at the time of the alleged sexual misconduct, and such sexual molestation was clearly outside the scope of the missionary's employment). *But see Doe v. Hartz*, 52 F. Supp. 2d 1027 (N.D. Iowa 1999) (plaintiff's *respondeat superior* claim survived motion to dismiss on basis that church knew or should have known about past misconduct and mental disease or defect made misconduct a realistic threat, but noting that this was a "remarkably tenuous" basis for imposing *respondeat superior* liability); *Parks v. Kownacki*, 711 N.E.2d 1208 (Ill. App. Ct. 1999) (holding that questions of material fact as to whether a parish priest was a child abuser or not, and whether the church or diocese which appointed the priest knew, or should have known, of his tendencies precluded the dismissal of a lawsuit against the church and the diocese based on the doctrine of *respondeat superior*), *rev'd*, 737 N.E.2d 287 (Ill. 2000).

³³ *See, e.g., Nutt v. Norwich Roman Catholic Diocese*, 56 F. Supp. 2d 195 (D. Conn. 1999) (applying Conn. law) (holding that the Roman Catholic Marianist Society had actual or constructive knowledge of the priest's grossly inappropriate sexual misconduct toward the plaintiffs); *Hartz*, 52 F. Supp. 2d at 1077-78 (applying Iowa law) (holding that a parishioner's allegation that the church, diocese, and bishop knew of a priest's "mental disease or defect" and the threat posed to parishioners was sufficient to state a claim for negligent supervision arising out of the priest's sexual assault of the parishioner); *Mark K.*, 79 Cal. Rptr. 2d at 78 (holding that in an action for negligent supervision and retention of a priest who sexually molested a child, the archdiocese had failed to warn the victim of the priest's known propensity for engaging in sexual misconduct with boys); *Fortin v. The Roman Catholic Bishop of Portland*, 871 A.2d 1208 (Maine 2005) (stating there were sufficient facts to hold the diocese liable for negligent supervision of a priest who sexually abused a parochial school student and altar boy); *Hutchison ex rel. Hutchinson v. Luddy*, 742 A.2d 1052 (Pa. 1999) (finding that the Roman Catholic Church, bishop, and diocese negligently hired, supervised, and retained a priest, despite knowledge of his pedophilic disposition, when the priest later molested a minor in a motel room).

however, have *not* recognized these vicarious liability claims sounding in negligence.³⁴ Still other courts have split in holding that the First Amendment of the United States Constitution may—or may not—bar a legal action against a church or other religious organization for the negligent retention or supervision of a clergy member who engaged in sexual misconduct.³⁵

³⁴ See, e.g., *Wilson v. Diocese of N.Y. of the Episcopal Church*, No. 96 Civ. 2400, 1998 WL 82921 (S.D.N.Y. Feb. 26, 1998) (applying N.Y. law) (holding that an Episcopal diocese and individual church were not liable for the negligent supervision or training of a priest who allegedly sexually assaulted the plaintiff, where there was no evidence that the diocese knew, or should have known, of any alleged propensity on the priest's part to commit sexual assault); *Beach v. Jean*, 746 A.2d 228 (Conn. Super. Ct. 1999) (holding that defendant Roman Catholic diocese and church could not foresee the specific sexual harm alleged by the plaintiff, and did not know or suspect that the pastor posed a risk to minors); *Iglesia Cristiana La Casa Del Señor, Inc. v. L.M.*, 783 So. 2d 353 (Fla. Dist. Ct. App. 2001) (holding that the church did not have actual or constructive notice of the pastor's sexual misconduct); *Pachulski v. Roman Catholic Diocese of Grand Rapids*, No. 205293, 1999 WL 33441139 (Mich. Ct. App. June 18, 1999) (holding that the diocese and the diocese's bishop had no actual knowledge of the priest's sexual misconduct with a minor); *C.B. ex rel. L.B. v. Evangelical Lutheran Church in Am.*, 726 N.W.2d 127 (Minn. Ct. App. 2007) (holding that church entities were not liable for the minister's sexual abuse of a minor under the theory of negligent supervision, since there was no evidence that the church was put on notice of the minister's sexual abuse); *N.H. v. Presbyterian Church*, 998 P.2d 592 (Okla. 1999) (holding that the critical element for recovery under a negligent hiring, retention, or supervision theory is the employer's prior knowledge of an employee's propensity to commit the harm, and the national organization had no notice of any previous act or incident that would have alerted it to the fact that the minister was a pedophile, and was sexually abusing children); *Eckler*, 784 S.W.2d at 941 (holding that in order for an act of negligence to be a proximate cause of the injury, it must be a cause in fact of the injury, and the injury must be reasonably foreseeable. The court noted that the general church council had not been notified of any complaints against the local church or a youth minister who had allegedly sexually abused children, and therefore it had no duty to supervise or investigate the local church and its ministers); *Doe v. Archdiocese of Milwaukee*, 700 N.W.2d 180 (Wis. 2005) (holding the archdiocese was not liable under a negligent supervision claim, since there was no evidence that the archdiocese knew or should have known of the priest's abusive tendencies at or before the time the minor was sexually abused).

³⁵ See, e.g., *Ehrens v. Lutheran Church—Missouri Synod*, 269 F. Supp. 2d 328 (S.D.N.Y. 2003); *Schmidt v. Bishop*, 779 F. Supp. 321 (S.D.N.Y. 1991) (purportedly applying New York law); *Gray*, 950 S.W.2d 232; *Mars v. Diocese of Rochester*, 763 N.Y.S.2d 885 (N.Y. Sup. Ct. 2003); *L.L.N. v. Clauder*, 563

When the religious organization is subject to liability, the organization almost invariably looks to its insurer to defend it and to pay claims. We now analyze and discuss the developing law concerning insurance coverage for sexual abuse claims.

II. THE DEVELOPING LAW OF LIABILITY INSURANCE COVERAGE FOR SEXUAL ABUSE CLAIMS

A. OVERVIEW OF INSURANCE COVERAGE ISSUES

Modern standard general liability policies condition insurance coverage on whether there has been an “occurrence.” These policies typically define “occurrence” as:

An accident, including continuous or repeated exposure to general conditions, resulting in bodily injury or property damages neither expected nor intended from the standpoint of the insured.

Also, standard general liability policies often include the following exclusion:

- We will not provide insurance:
2. For personal injury or property damage:
 - a. which is either expected or intended by you;

This is known as the “intentional act exclusion.”

In light of the afore-cited and similar provisions, many sexual abuse coverage disputes have turned upon: (1) whether sexual molestation falls within the policy’s intentional act exclusion, or (2) whether sexual molestation meets the “occurrence” definition in the policy. The decisions usually analyze whether bodily injury was “expected” or “intended” by the insured. In addition, some courts ask a threshold question: whether sexual abuse itself can be an “accident.”

N.W.2d 434 (Wis. 1997). *But see* Bivin v. Wright, 656 N.E.2d 1121 (Ill. App. Ct. 1995); *Fortin*, 871 A.2d 1208; Olson v. First Church of the Nazarene, 661 N.W.2d 254 (Minn. Ct. App. 2003); Kenneth R. v. Roman Catholic Diocese of Brooklyn, 654 N.Y.S.2d 791 (App. Div. 1997); Christopher B. v. Schoeneck, No. 99-0450, 1999 WL 1102901 (Wis. Ct. App. Dec. 7, 1999), *review denied*, 2000 Wisc. LEXIS 305 (Feb. 22, 2000).

The “expected or intended” question must be addressed even when the policy does not contain an “intentional act” exclusion. This is because the “occurrence” definition, contained in the vast majority of standard general liability policies, affords coverage only for bodily injury that is “neither expected nor intended from the standpoint of the insured.” It has been held that this “neither expected nor intended” clause in the “occurrence” definition is the equivalent of the intentional act exclusion.³⁶ Accordingly, decisions applying the intentional act exclusion, as discussed *infra* § IIB, frequently provide guidance regarding the “occurrence” question.

B. THE “EXPECTED” OR “INTENDED” ISSUE UNDER GENERAL LIABILITY POLICIES

An “occurrence” in homeowners and commercial general liability insurance generally is limited to unexpected, unintended, and accidental loss.³⁷ Also, many liability insurance policies contain an “intentional act exclusion” providing that coverage is excluded for “bodily injury or property damage that is expected or intended by the insured.”³⁸ The underlying public policy rationale of this “intentional act exclusion” in liability insurance is that it would defeat the purpose of insurance and encourage “moral hazard” if a policyholder could be compensated for losses he intentionally brings about, knowing that the insurer would be liable for any resulting damages or personal injury.³⁹

But how have the courts decided which acts are “expected or intended by the insured”? There are currently three major judicial

³⁶ W. Va. Fire & Cas. Co. v. Stanley, 602 S.E.2d 483, 492 (W. Va. 2004) (citing Patrons-Oxford Mut. Ins. Co. v. Dodge, 426 A.2d 888, 891 (Me. 1981)).

³⁷ See generally STEMPEL, *supra* note 7, at § 1.06[B][1].

³⁸ See 1 SUSAN J. MILLER & PHILLIP LEFEBVRE, MILLER’S STANDARD INSURANCE POLICIES ANNOTATED 214, 409, 414 (4th ed. 1995) (citing to the Insurance Services Office, Inc. (ISO) Forms HO 00 03 04 91 (Homeowners Insurance) and CG 00 01 10 93 (Commercial General Liability Insurance)); see, e.g., Transamerica Ins. Grp. v. Meere, 694 P.2d 181, 186 (Ariz. 1984) (en banc) (holding that there is a strong underlying public policy that forbids insurers from indemnifying persons against loss resulting from their own willful wrongdoing. The intentional act exclusion therefore “is designed to prevent an insured from acting wrongfully with the security of knowing that his insurance company will ‘pay the piper’ for the damages”).

³⁹ See, e.g., W. Nat’l Assurance Co. v. Hecker, 719 P.2d 954, 959-60 (Wash. Ct. App. 1986).

approaches for interpreting the “expected” or “intended” question under liability insurance policies involving sexual abuse claims: (1) the “objective” or “classic tort” standard for determining acts that are intended or expected from the viewpoint of the insured; (2) the “subjective” or “particular insured” standard for determining acts that are intended or expected from the viewpoint of the insured; and (3) the “inferred intent” standard as applied to child sexual abuse cases.⁴⁰

1. The “Objective” or “Classic Tort” Standard for Determining Intentional Acts in Liability Insurance Coverage Disputes

Under an “objective” or “classic tort” standard, a court will look at the natural and probable consequences of the insured’s deliberate act in order to determine the insured’s intent.⁴¹ If an intentional act by the insured results in injuries that are, in an objective sense, the natural, foreseeable, and probable result of the insured’s intentional act, such loss is excluded from coverage under the liability insurance intentional acts exclusion.⁴² Commentators have differed, however, on whether this

⁴⁰ See, e.g., Peter C. Haley, *Paradigms of Proximate Cause*, 36 TORT & INS. L.J. 147, 149 (2000) (“Proximate cause is a factor in all three types of civil actions seeking damages: common law torts, common law contract, and statutory. However, tort actions have been the subject of most of the judicial and scholarly attention devoted to proximate cause.”).

⁴¹ See, e.g., CNA Ins. Co. v. McGinnis, 666 S.W.2d 689, 691 (Ark. 1984) (sexual assault of a minor); see also Truck Ins. Exch. v. Pickering, 642 S.W.2d 113, 116 (Mo. Ct. App. 1982) (involving an intentional wrongful death action and holding that “one is presumed to intend the natural and probable consequences of his acts and conduct.”); Mutual Serv. Cas. Co. v. McGehee, 711 P.2d 826, 827-28 (Mont. 1985) (action for battery); Fuisz v. Selective Ins. Co. of America, 61 F.3d 238 (4th Cir. 1995) (applying Va. law) (defamation action). But see also Rodriguez v. Williams, 729 P.2d 627, 629-30 (Wash. 1986) (en banc) (criticizing this “objective” or “classic tort” standard in an insurance law context). See also *infra* note 43 (citing additional authority).

⁴² See, e.g., COUCH ON INSURANCE, *supra* note 4, at § 127:2d (“A majority of courts utilize an objective standard to determine whether the injury was intentional. Accordingly, sexual abuse is considered an intentional act when the injury is the natural and probable consequence of the insured’s conduct.”) (citing to a number of cases arguably supporting this proposition, including B.B. v. Cont’l Ins. Co., 8 F.3d 1288, 2195 (8th Cir. 1993) (applying Mo. law); Horace Mann Ins. Co. v. Fore, 785 F. Supp. 947, 956 (M.D. Ala. 1992); Troy v. Allstate Ins. Co., 789 F.

traditional “objective” or “classic tort” standard applied to cases of rape, sexual assault, and sexual molestation is the majority view,⁴³ or a minority view.⁴⁴

2. The “Subjective” or “Particular Insured” Standard for Determining Intentional Acts in Liability Insurance Coverage Disputes

Under a “subjective” or “particular insured” standard, the court must find not only that the insured intended a specific act, but *also* that the insured intended a specific harm.⁴⁵ The “subjective” standard—that the insured must have intended *both* the conduct in question, *and* the insured must have intended some type of injury,⁴⁶ or a particular type of injury,⁴⁷ is the majority approach today⁴⁸ involving most intentional acts committed by

Supp. 1134, 1136 (D. Kan. 1992); *Fernandez v. Strand*, 63 F. Supp. 2d 949, 956 (E.D. Wis. 1999)).

⁴² See, e.g., *JERRY & RICHMOND*, *supra* note 7, at 439-69 (commenting that the “classic tort” or “objective” standard is a minority approach); *LONG ON LIABILITY*, *supra* note 4, at § 11C.02[1][c][i] (same).

⁴³ See, e.g., *MacKinnon v. Hanover Ins. Co.*, 471 A.2d 1166, 1167 (N.H. 1984) (concerning battery and negligent infliction of emotional distress claims arising out of the alleged sexual abuse of a minor); *N. Sec. Ins. Co. v. Stanhope*, No. 09-078, 2010 WL 3934335, at *5 (Vt. 2010).

⁴⁴ See, e.g., *JERRY & RICHMOND*, *supra* note 7, at 439-69 (commenting that the “classic tort” or “objective” standard is a minority approach); *LONG ON LIABILITY*, *supra* note 4, at § 11C.02[1][c][i] (same).

⁴⁵ See, e.g., *MacKinnon v. Hanover Ins. Co.*, 471 A.2d 1166, 1167 (N.H. 1984) (concerning battery and negligent infliction of emotional distress claims arising out of the alleged sexual abuse of a minor); *N. Sec. Ins. Co. v. Stanhope*, No. 09-078, 2010 WL 3934335, at *5 (Vt. 2010);

⁴⁶ See, e.g., *Am. Family Mut. Ins. Co. v. Johnson*, 816 P.2d 952 (Colo. 1991) (assault and battery claims); *Amco Ins. Co. v. Haht*, 490 N.W.2d 843 (Iowa 1992) (alleged battery and wrongful death claim caused by a thrown baseball); *Tenn. Farmers Mut. Ins. Co. v. Evans*, 814 S.W.2d 49 (Tenn. 1991) (alleged arson of property).

⁴⁷ See, e.g., *Providence Mut. Ins. Co. v. Scanlon*, 638 A.2d 1246 (N.H. 1994) (personal injury from a BB gun); *Columbia Cas. Co. v. Westfield Ins. Co.*, 617 S.E.2d 797 (W.Va. 2005) (suicide deaths of inmates). *But see also* *FISCHER, SWISHER & STEMPEL*, *supra* note 8, at 62 (“The specific intent view errs too greatly in favor of the policyholder by insulating him or her from the financial consequences of antisocial conduct.”).

⁴⁸ *But see supra* note 43 and accompanying text.

an insured in liability insurance coverage disputes *other* than child sexual abuse cases.⁴⁹

A growing number of courts have questioned whether this majority “subjective” standard approach is appropriate in liability insurance claims involving child sexual abuse allegations. Although an insured seeking coverage for injuries arising out of sexual misconduct and sexual abuse may argue that he or she had no subjective intent to “harm” the minor child,⁵⁰ most courts have characterized these subjective assertions made by adult sexual molesters that they did not subjectively intend to harm their child sexual abuse victims as “absurd” and “irrational.”⁵¹ For example, the California Supreme Court in the case of *J.C. Penney Casualty Insurance Co. v. M.K.*,⁵² observed that the insurer contended coverage was excluded:

[T]he [sexual] molestations were intentional. Defendants respond that even an intentional and wrongful act is not excluded from coverage unless the insured acted with a “preconceived design to inflict injury.” They contend psychiatric testimony shows that molesters . . . often intend no harm despite the depravity of their acts, and that the

⁴⁹ See generally FISCHER, SWISHER & STEMPEL, *supra* note 8, at 58-65; JERRY & RICHMOND, *supra* note 7, at 463-67.

⁵⁰ See, e.g., *Atl. Emp’rs Ins. Co. v. Tots & Toddlers Pre-Sch. Day Care Ctr., Inc.*, 571 A.2d 300, 303 (N.J. Super. 1990) (“While socially unacceptable, [the insured sexual molester] argue[s] a pedophile or other sexual deviant may not necessarily [subjectively] intend to cause his or her victims any injury, even though that behavior may constitute criminal activity.”); see also *Northland Ins. Cos. v. Coconut Island Corp.*, 961 F. Supp. 20, 22 (D. Maine, 1997); *Fire Ins. Exch. v. Abbott*, 251 Cal. Rptr. 620, 629 (Cal. Ct. App. 1988) (similar subjective arguments made by sexual abusers).

⁵¹ See, e.g., *Landis v. Allstate Ins. Co.*, 546 So. 2d 1051, 1053 (Fla. 1989) (holding that the sexual molester’s subjective argument “defied logic”); *Mut. of Enumclaw v. Merrill*, 794 P.2d 818, 820 (Ore. Ct. App. 1990) (holding that the sexual molester’s subjective argument was “little short of absurd”); see also *CNA Ins. Co. v. McGinnis*, 666 S.W.2d 689, 691 (Ark. 1984) (“We agree with the view expressed by the dissent in the Court of Appeals in this case, that for a stepfather in such a situation ‘to claim that he did not expect or intend to cause injury, flies in the face of all reason, common sense and experience.’”) (quoting *CNA Ins. Co. v. McGinnis*, 663 S.W.2d 182, 185 (Ark. Ct. App. 1984) (Corbin, J., dissenting)).

⁵² *J.C. Penney Cas. Ins. Co. v. M.K.*, 804 P.2d 689 (Cal.), *cert. denied sub nom.*, 502 U.S. 902 (1991).

molestation is often a misguided attempt to display love and affection for the child.⁵³

The court concluded:

We conclude there is no coverage as a matter of law. No rational person can reasonably believe that sexual fondling, penetration, and oral copulation of a five-year-old child are nothing more than acts of tender mercy . . . The courts of many other states also have considered the issue and, almost without exception, have held there is no coverage.⁵⁴

Because the subjective intent test is capable of reaching a conclusion – that the molester intended no harm – that is anathema to prevailing logic and public policy sensibilities regarding child abuse and molestation, it has fallen into extreme disfavor over the last decade. Accordingly, the “inferred intent” standard has emerged as the majority view today.

3. The “Inferred Intent” Standard as Applied to Child Sexual Abuse Cases

A substantial majority of courts have applied an “inferred intent” standard to bar coverage in sexual molestation cases involving an adult sexual predator and a sexually abused child, even when the insured sexual molester asserts the absence of any subjective intent to harm the child.⁵⁵

⁵³ *Id.* at 693.

⁵⁴ *Id.*

⁵⁵ *See, e.g.,* State Farm Fire & Cas. Co. v. Abraio, 874 F.2d 619, 623 (9th Cir. 1989) (applying Cal. law) (holding that there is an irrebuttable presumption of intent to harm as a matter of law in child molestation cases); *J.C. Penney*, 804 P.2d at 695 (“There is no such thing as negligent or even reckless sexual molestation. The very essence of child molestation is the gratification of sexual desire. The act is the harm. There cannot be one without the other. Thus, the intent to molest is, by itself, the same as the intent to harm.”), *cert. denied sub nom, Kelley v. J.C. Penney Cas. Ins. Co.*, 502 U.S. 902 (1991); *Allstate Ins. Co. v. Mugavero*, 589 N.E.2d 365, 369 (N.Y. 1992) (“[I]n the exceptional case of an act of child molestation, cause and effect cannot be separated; that to do the act is necessarily to do the harm which is its consequence; and that since unquestionably the act is intended, so also is the harm.”). *See generally* Wiley v. State Farm Fire & Cas.

The underlying public policy rationale for this “inferred intent” standard when applied to child sexual abuse claims is premised on a state’s criminal prohibition of sexual contact between an adult and a child,⁵⁶ as well as the reasonable expectations of the parties to coverage.⁵⁷

Although a majority of courts have adopted and applied this “inferred intent” standard in cases where the insured asserts a subjective intent not to harm the minor victim, a more subtle issue is raised when the insured asserts an incapacity to form *any* requisite intent. Some courts have reasoned that if the nature and character of the act are such that an intent to harm may be inferred, such as in cases involving the insured’s acts of child sexual abuse, then any question of an inability to form this intent to harm, whether it arises out of alleged mental disease or incapacity, or whether it arises out of voluntary intoxication, is immaterial in resolving the insurer’s obligation to coverage, and the insured’s intent to harm in

Co., 995 F.2d 457, 461-62 nn.5-6 (3d Cir. 1993) (applying Pa. law) (stating that this majority “inferred intent” standard applied as a matter of law to child sexual abuse claims has been adopted in Alabama, Alaska, Arkansas, Arizona, California, Colorado, Delaware, Florida, Georgia, Iowa, Kansas, Illinois, Indiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Washington, West Virginia, and Wisconsin); *see also* Allstate Ins. Co. v. Roelfs, 698 F. Supp. 815 (D. Alaska 1987); State Farm Fire & Cas. Co. v. Davis, 612 So.2d 458, 463-64 (Ala. 1993) (also collecting cases from other jurisdictions); Allstate Ins. Co. v. Troelstrup, 789 P.2d 415, 418-19 (Colo. 1990), *rev’g*, 768 P.2d 731 (Colo. Ct. App. 1988); Allstate Ins. Co. v. Mugavero, 589 N.E.2d 365, 368 (N.Y. 1992), *rev’g*, 561 N.Y.S.2d 35 (N.Y. App. Div. 1990) (also collecting cases from other jurisdictions).

⁵⁶ *See, e.g.*, State Farm Fire & Cas. Co. v. Smith, 907 F.2d 900, 902 (9th Cir. 1990) (predicting Nev. law); Landis v. Allstate Ins. Co., 546 So. 2d 1051, 1053 (Fla. 1989); Allstate Ins. Co. v. Mugavero, 589 N.E.2d 365, 369 (N.Y. 1992); Nationwide Ins. Co. v. Abernethy, 445 S.E.2d 618, 620 (N.C. Ct. App. 1994); Rodriguez v. Williams, 729 P.2d 627, 630 (Wash. 1986).

⁵⁷ *See, e.g.*, Wiley v. State Farm Fire & Cas. Co., 995 F.2d 457, 464 (3d Cir. 1993) (applying Pa. law) (“[T]he average person purchasing homeowner’s insurance would cringe at the very suggestion that he was paying for [coverage for liability arising out of his sexual abuse of a child]. And certainly he would not want to share that type of risk with other homeowner’s policy holders.”) (quoting Rodriguez *ex rel.* Brennan v. Williams, 713 P.2d 135, 137-38 (Wash. Ct. App.), *aff’d*, 729 P.2d 627 (Wash. 1986)); *see also* Allstate Ins. Co. v. Mugavero, 589 N.E.2d 365, 370 (N.Y. 1992); Horace Mann Ins. Co. v. Leebert, 376 S.E.2d 581, 586 (W. Va. 1988) (similar holdings).

such a context therefore is irrelevant.⁵⁸ Other courts hold that, as a matter of law, an insured may never assert a lack of capacity to form intent caused by voluntary intoxication as a defense to the application of an intentional act exclusion, regardless of the act committed.⁵⁹ A minority of other courts have held, however, that where an incapacity to form intent to harm is alleged, that incapacity may render unintentional any harm caused by the insured, so that such an incapacity must be considered by the finder of fact when resolving the issue of any existence of intent to harm.⁶⁰

In conclusion, under either the “objective” or “classic tort” standard,⁶¹ or under an “inferred intent” standard,⁶² the overwhelming majority of American courts have persuasively-- and correctly-- held that an adult sexual molester of an abused child will *not* be entitled to coverage under a liability insurance policy based upon its intentional acts exclusion.⁶³

⁵⁸ See, e.g., *State Farm Fire & Cas. Co. v. Estate of Jenner*, 874 F.2d 604, 605, 607 (9th Cir. 1989) (applying Cal. Law); *Landis v. Allstate Ins. Co.*, 546 So.2d 1051, 1053 (Fla. 1989); *Pub. Emps. Mut. Ins. Co. v. Rash*, 740 P.2d 370, 373 (Wash. Ct. App. 1987).

⁵⁹ See, e.g., *Allstate Ins. Co. v. Hampton*, 433 N.W.2d 334, 336 (Mich. Ct. App. 1988); *Hanover Ins. Co. v. Newcomer*, 585 S.W.2d 285, 289 (Mo. Ct. App. 1979).

⁶⁰ This is the minority “Arizona rule.” See, e.g., *Globe Am. Cas. Co. v. Lyons*, 641 P.2d 251, 254 (Ariz. Ct. App. 1981) (“derangement of . . . intellect”); *Parkinson v. Farmers Ins. Co.*, 594 P.2d 1039, 1041 (Ariz. Ct. App. 1979) (voluntary intoxication); see also *Hanover Ins. Co. v. Talhouni*, 604 N.E.2d 689, 691-93 (Mass. 1992) (further explaining *Worcester Ins. Co. v. Fells Acres Day Sch., Inc.*, 558 N.E.2d 958, 965 (Mass. 1990)). See *Wiley v. State Farm Fire & Cas. Ins. Co.*, 995 F.2d 457, 465-67 (3d Cir. 1993), for the application of Pennsylvania law to and a general discussion of these three judicial approaches to the “inferred intent” rule when the insured asserts his or her incapacity for an intent to harm.

⁶¹ See *supra* notes 41-44 and accompanying text.

⁶² See *supra* notes 54-59 and accompanying text.

⁶³ See generally COUCH ON INSURANCE, *supra* note 4, at § 127:26; FISCHER, SWISHER & STEMPEL, *supra* note 8, at 64-66; LONG ON LIABILITY, *supra* note 4, at § 11C:02[1]. Although the underlying rationale for applying an “inferred intent” standard when the sexual abuse victim is a minor may not always apply when the victim is an adult, a majority of courts nevertheless still apply this “inferred intent” standard to adult sexual abuse victims, as well as to child sexual abuse victims. See, e.g., *W. Am. Ins. Co. v. Vago*, 553 N.E.2d 1181, 1185 (Ill. Ct. App. 1990); *Rulli v. State Farm Fire & Cas. Co.*, 479 N.W.2d 87, 89 (Minn. Ct. App. 1992); see also *W. Nat’l Assur. Co. v. Heckler*, 719 P.2d 954, 960 (Wash. Ct. App. 1986).

C. THE “EXPECTED OR INTENDED” STANDARD APPLIED TO
INSURANCE CLAIMS BY EMPLOYERS AND SUPERVISORS OF
THE ABUSER

Most current insurance coverage claims involve the sexual molester’s employer, supervisor, or religious organization who is allegedly responsible under a legal doctrine of negligent supervision, negligent hiring, negligent retention, or under a similar vicarious liability doctrine based upon *negligence* principles, rather than based upon the *intentional acts* of a sexual molester that were “expected or intended” by the insured.

1. The “Accident” Requirement

Most contemporary homeowners and general liability insurance policies provide coverage only for *accidental* “occurrences.” For example, a typical homeowner’s policy provides coverage for “bodily injury” or “property damage” caused by an “occurrence.” Occurrence typically is defined to mean “an *accident*, including continuous or repeated exposure to substantially the same general harmful conditions.”⁶⁴ General liability insurance policies likewise cover “bodily injury” or “property damage” caused by an “occurrence,” where an “occurrence” generally is defined as “an *accident*, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured.”⁶⁵

An “occurrence” under liability insurance coverage must be an *accidental* event. It has been said that an “accident” is an unintended and unanticipated event, and that it occurs without design, coordination, or expectation.⁶⁶ In other words, bodily injury or property damage that is the

(“[T]he nature of the act, its forcible and nonconsensual character, and the harm that certainly results makes the inference of intent no less strong [than in a child sexual abuse case]”).

⁶⁴ See, e.g., Insurance Services Office Inc. [ISO] Form HO 00 03 04 91 [Homeowners Insurance].

⁶⁵ See, e.g., Insurance Services Office Inc. [ISO] Form GL 00 00 01 73 [General Liability Insurance] (emphasis in original). See *generally* LONG ON LIABILITY, *supra* note 4, at § 11C.02[1][a].

⁶⁶ See, e.g., *Allstate Ins. Co. v. Steele*, 74 F.3d 878, 880 (8th Cir. 1996) (applying Minn. law) (“[An accident is] an unexpected happening without intention or design.”); *High Country Assocs. v. N. H. Ins. Co.*, 648 A.2d 474, 478 (N.H. 1994) (“[W]e interpret ‘accident’ in the definition of ‘occurrence’ to mean

probable, intended, or expected result of the insured's actions is *not* injury or damage that was caused by an *accidental* occurrence.⁶⁷ Whether an accidental event occurred for the purpose of liability insurance coverage usually is considered from the viewpoint of the tortfeasor-insured.⁶⁸

Decisions outside the realm of sexual abuse claims sometimes have turned on the “neither expected nor intended” wording in the “occurrence” clause in determining whether particular forms of misconduct qualified as an “occurrence.” These decisions assume that if the resulting injury was not expected or intended by the insured, coverage exists even if the underlying tort, such as gradual pollution or long-term asbestos exposure arguably was not what ordinary people would refer to as an “accident.”⁶⁹

Such decisions do not treat “accident” as an independent requirement for an “occurrence” to exist.⁷⁰ Rather, they implicitly conclude that the “expected or intended” clause does not narrow the meaning of “accident,” but instead subsumes the term “accident.” A

circumstances . . . that were unexpected and unintended from the viewpoint of the insured.”); *St. Paul Fire & Marine Ins. Co. v. McCormick & Baxter Creosoting Co.*, 923 P.2d 1200, 1203 (Ore. 1996) ([T]he word ‘accident’ denotes an incident or occurrence that happened by chance, without design, and contrary to intention and expectation.”) (quoting *Finley v. Prudential Ins. Co.*, 388 P.2d 21, 26 (Or. 1963)).

⁶⁷ See, e.g., *Fed. Ins. Co. v. Gen. Mach. Corp.*, 699 F. Supp. 490, 494 (E.D. Pa. 1988) (“An ‘accident’ is an event which takes place without having been foreseen, expected, or anticipated by anyone If an occurrence is the ordinary and expected result of the performance of an operation, then it cannot be termed an accident.”); *Green Const. Co. v. Nat’l Union Fire Ins. Co.*, 771 F. Supp. 1000, 1002 (W.D. Mo. 1991) (“An ‘accident,’ as that term is used in standard CGL policies ‘means that which happens by chance or fortuitously, without intention or design, and which is unexpected, unusual, and unforeseen.’”), *vacated on other grounds*, 975 F. Supp. 1365 (W.D. Mo. 1996); *Gassaway v. Travelers Ins. Co.*, 439 S.W.2d 605, 608 (Tenn. 1969) (“[D]efined accident as used in liability insurance policies as an event not reasonably to be foreseen, unexpected and fortuitous.”).

⁶⁸ See, e.g., *Capitol Indem. Corp. v. Blazer*, 51 F. Supp. 2d 1080, 1085 (D. Nev. 1999); *Agoado Realty Corp. v. United Int’l Ins. Co.*, 733 N.E.2d 213, 216 (N.Y. 2000).

⁶⁹ E.g., *Mass. Bonding & Ins. Co. v. Orkin Exterminating Co.*, 416 S.W.2d at 396, 400-01 (Tex. 1967) (holding that the negligent application of a pesticide that had a cumulative toxic effect was an “accident”); see also *King v. Dallas Fire Ins. Co.*, 27 S.W.3d 117, 123 (Tex. Ct. App. 2000).

⁷⁰ See *Sheets v. Brethren Mut. Ins. Co.*, 679 A.2d 540, 548 (Md. 1996) (negligence is deemed “accidental” so long as it causes damage that is unforeseen or unexpected by the insured).

number of decisions have followed this analysis in sexual abuse cases, concluding that damage was not “expected or intended,” without considering further whether what occurred would be regarded by anyone as an “accident.”⁷¹

These decisions, however, do not confront the issue of whether the term “accident” in the definition of “occurrence” possesses a meaning that is independent of the “neither expected nor intended” clause. On the other hand, a significant number of other courts – particularly when addressing sexual abuse and molestation claims on public policy grounds – have concluded that the term “accident” *does* have independent meaning. These decisions, involving sexual abuse allegations, generally hold that, in determining whether the sexual misconduct has resulted in an “occurrence,” the threshold question is whether the alleged misconduct can aptly be regarded as an “accident.” If it cannot, there is no further inquiry.

For example, as the Colorado Court of Appeals, in *Mountain States Mutual Casualty Co. v. Hauser*, recently observed, even if the insured’s negligence in hiring the perpetrator is alleged as a cause of the victim’s injuries, “it was not a risk covered by the policy since it was not an ‘accident.’”⁷² Citing decisions from California and New York, the court held: “Negligent hiring/supervision [of a sexual molester] is not an ‘accident.’”⁷³ The court explained further:

[The insured] cites no case where an intentional act of sexual assault constituted an “accident” or “occurrence” within the meaning of a comprehensive general liability policy. Rather than resort to “head-spinning judicial efforts at definition,” we conclude that the common understanding of an “accident” does not include the [sexual] assault that occur here.⁷⁴

⁷¹ See *Safeco Ins. Co. of Am. v. White*, 913 N.E. 2d 426, 431-32 (Ohio 2009) (citing cases in other jurisdictions).

⁷² *Mountain States Mut. Cas. Co. v. Hauser*, 221 P.3d 56, 60 (Colo. Ct. App. 2009) (citing *Am. Empire Surplus Lines Ins. Co. v. Bay Area Cab Lease*, 756 F. Supp. 1287, 1290 (N.D. Cal. 1991) (cab company employee sexually molested a passenger)).

⁷³ *Id.* at 60 (citing *Bay Area Cab Lease*, 756 F. Supp. at 1289).

⁷⁴ *Id.* The *Hauser* court indicated that absent an “accident” the “standpoint of the insured-employer” was irrelevant. However, because the insured-employer allegedly expected injury, the court did not need to decide whether a non-expectation of injury has any relevance where the underlying event was not an “accident.” *Id.* at 62.

An accident is never present when a deliberate act is performed unless some additional, unexpected, independent and unforeseen happening occurs which produces the damage, the court added.⁷⁵ This analysis assumes particular importance in “negligent hiring” and “negligent supervision” cases (as in *Hauser*) where the policyholder usually asserts the injuries were neither “expected nor intended” from *its standpoint* (as distinguished from the molester’s standpoint). The “accident” requirement also can limit coverage for abuse claims based on alleged “misrepresentations” by a school or church that children would be safe from abuse.⁷⁶

It is difficult to predict how influential the *Hauser* approach will be. Certainly, the alternate approach – which focuses exclusively on the “expected or intended” clause – may be unwelcome in those jurisdictions that claim to place particular emphasis on reading insurance contract provisions as a whole, so that each provision is afforded meaning.⁷⁷ But

⁷⁵ *Id.*

⁷⁶ *John Doe 1 v. Archdiocese of Milwaukee*, No. 2009AP2266, 2010 WL 4723728, at *4 (Wis. Ct. App. Nov. 23, 2010) (“The cause of the plaintiffs’ injuries, the misrepresentation by the Archdiocese, cannot be characterized as accidental. The affirmative representations of safety by the Archdiocese did not occur by chance, nor was it unforeseen or unintended. . . .”).

⁷⁷ *See, e.g., Ohio Cas. Ins. Co. v. Union Pac. R.R. Co.*, 469 F.3d 1158, 1163 (8th Cir. 2006) (applying Ark. law) (“Different clauses of an insurance contract are read together to harmonize all parts because it is error to give effect to one clause over another when the two clauses are reconcilable.”); *Liberty Mut. Ins. Co. v. Treedale, Inc.*, 418 F.3d 330, 336 (3d Cir. 2005) (applying Penn. law) (“[Insured] focuses on phrases that it believes are favorable to its interpretation and ignores all of the other language that runs counter to its interpretation.”); *Premcor USA, Inc. v. Am. Home Assur. Co.*, 400 F.3d 523, 529 (7th Cir. 2005), *as amended on reh’g*, (Apr. 21, 2005) (applying Ill. law) (“Our task is to determine whether this provision remains ambiguous when viewed in the context of the entire . . . policy.”); *Herman Miller, Inc. v. Travelers Indem. Co.*, 162 F.3d 454, 455 (6th Cir. 1998) (applying Mich. law) (“Viewed alone, we could not say that the terms ‘piracy,’ ‘idea misappropriation,’ or ‘unfair competition’ could never constitute patent infringement. However, to draw such an inference when considering these terms within the policy as a whole construes them too broadly.”); *Silverball Amusement, Inc. v. Utah Home Fire Ins. Co.*, 842 F. Supp. 1151, 1159 (W.D. Ark. 1994), *aff’d*, 33 F.3d 1476 (8th Cir. 1994); *Am. Guarantee and Liab. Ins. Co. v. Shel-Ray Underwriters, Inc.*, 844 F. Supp. 325, 331 (S.D. Tex. 1993); *Allstate Ins. Co. v. Hardnett*, 763 So. 2d 963, 965 (Ala. 2000) (“The provisions of the policy cannot be read in isolation, but, instead, each provision must be read in context with all other provisions.”); *Van Ness v. Blue Cross of Cal.*, 104 Cal. Rptr. 2d 511,

those court decisions that conflate “injury neither expected nor intended” with “accident” seem to read the policy as if it defined “occurrence” as:

An accident, meaning an event, including continuous or repeated exposure to conditions, causing property damage or bodily injury that is neither expected nor intended from the standpoint of the insured.

However, this questionable interpretation differs from how the clause *actually* reads, which is:

An accident, including continuous or repeated exposure to conditions, resulting in property damage or bodily injury that is neither expected nor intended from the standpoint of the insured.

Thus, in the “occurrence” definition, as it *actually* reads, the clause beginning “resulting in” modifies, and narrows, the definition of “accident.” By analogy, the words “that is” within this clause have an effect much like they would in a sentence reading: “I am looking to buy a

516 (Cal. Ct. App. 2001); O'Brien v. Progressive N. Ins. Co., 785 A.2d 281, 287 (Del. 2001) (“[A] court’s interpretation of an insurance contract [sic] must rely on a reading of all of the pertinent provisions of the policy as a whole, and not on any single passage in isolation.”); Playtex FP, Inc. v. Columbia Cas. Co., 622 A.2d 1074, 1076 (Del. Super. Ct. 1992) (“[T]he meaning which arises from a particular portion of an agreement cannot control the meaning of the entire agreement where such inference runs counter to the agreement’s overall scheme or plan.”) (citations omitted); Clarendon Am. Ins. Co. v. 69 W. Wash. Mgmt. LLC, 870 N.E.2d 978, 983 (Ill. App. Ct. 2007); Emp’rs Mut. Liab. Ins. Co. of Wis. v. Mich. Mut. Auto Ins. Co., 300 N.W.2d 682, 684 (Mich. Ct. App. 1980); Northbrook Ins. Co. v. Am. States Ins. Co., 495 N.W.2d 450, 453 (Minn. Ct. App. 1993); Ins. Co. of Pa. v. W. Plains Air, Inc., 637 S.W.2d 444, 446 (Mo. Ct. App. 1982); Lindell v. Ruthford, 598 P.2d 616, 618 (Mont. 1979); Commercial Union Assur. Cos. v. Gollan, 394 A.2d 839, 842 (N.H. 1978); Atlas Assur. Co. v. General Builders, Inc., 600 P.2d 850, 852 (N.M. Ct. App. 1979); Long Island Lighting Co. v. Allianz Underwriters Ins. Co., 749 N.Y.S.2d 488, 494 (N.Y. App. Div. 2002); Little v. Blue Cross of W. N.Y., Inc., 424 N.Y.S.2d 553, 555 (N.Y. App. Div. 1980); Burgess v. N.C. Farm Bureau Mut. Ins. Co., 261 S.E.2d 234, 236 (N.C. Ct. App. 1980); Cincinnati Ins. Co. v. CPS Holdings, Inc., 875 N.E.2d 31, 34 (Ohio 2007); Nat’l Union Fire Ins. Co. v. Shane & Shane Co., 605 N.E.2d 1325, 1328 (Ohio Ct. App. 1992); Eddystone Fire Co. No. 1 v. Cont’l Ins. Cos., 425 A.2d 803, 805 (Pa. Super. 1981).

new car *that is* neither damaged nor defective.”⁷⁸ No one reading this particular sentence would conclude that the writer had made an offer to accept an undamaged and non-defective *used* car. True, “undamaged and non-defective” are essential characteristics of a new car – just as “unexpected and unintended injury” are essential characteristics of an “accident” – but the meaning is quite clear: the car must be new. In the same interpretive manner, for an “occurrence” to be found, even unintended injury must still result from an “accident.”

As one court has explained, the final clause to the “occurrence” definition “makes it clear that not all injuries from an intended act will be excluded, but only those injuries that were intended.”⁷⁹ And as another court has correctly observed: “There are two components that must be shown to establish an ‘occurrence’ under the policy: (1) an accident; and (2) personal injury or property damage neither expected nor intended from the standpoint of the insured.”⁸⁰

Courts that give independent meaning to the term “accident” persuasively conclude that sexual abuse and molestation is not an “occurrence,” even if such an injury was not expected or intended by the supervisor-insured. In contrast, those judicial decisions that conflate the two prongs of the “occurrence” definition do not explain how their particular approach can avoid offending the interpretative rule, emphasized in so many jurisdictions, that insurance contract provisions must be read as a whole, giving meaning to the entire document.⁸¹

Had the “occurrence” definition merely provided that “occurrence” means “property damage or bodily injury neither expected nor intended from the standpoint of the insured” – omitting the “accident” predicate – then whether the act itself was “accidental” would be beside the point. But given that “occurrence” is defined as “*an accident ... resulting in damage*

⁷⁸ See generally, *N. Crossarm, Inc. v. Chem. Specialties, Inc.*, No. 03-C-415-C, 2004 WL 602648 (W.D. Wis. Mar. 16, 2004); *Faris Mailing v. Dep’t of State Revenue*, 512 N.E.2d 480, 485 (Ind. T.C. 1987).

⁷⁹ *Great Am. Ins. Co. v. Gaspard*, 608 So. 2d 981, 985 (La. 1992); see also *United Pac. Co. v. McGuire Co.*, 281 Cal. Rptr. 375 (Cal. Ct. App. 1991) (“Since the word ‘event’ is not limited to fortuitous happenings, the phrase ‘not expected or intended’ cannot be read as language confirming the meaning of the term; . . . the phrase must be regarded as language of limitation, narrowing the coverage otherwise provided by the word ‘event.’”).

⁸⁰ *Norwalk Ready Mixed Concrete, Inc. v. Travelers Ins. Co.*, 246 F.3d 1132, 1137 (8th Cir. 2001) (quoting *W. Bend Mut. Ins. Co. v. Iowa Iron Works, Inc.*, 503 N.W.2d 596, 600 (Iowa 1993)).

⁸¹ See *supra* note 75 and accompanying text.

neither expected nor intended by the insured, a different intent is apparent. That is:

1. Something must happen that an ordinary person would regard as an “accident;”
2. If an “accident” has occurred, there is coverage if it results in bodily injury that is neither expected nor intended from the standpoint of the insured claiming coverage.

Nevertheless, the courts are still divided between those that grant meaning to the term “accident” within the “occurrence” definition, and those that focus exclusively on the “expected or intended” clause. Courts following the former line of decisions are likely to regard claims arising from sexual abuse and molestation as falling outside the subject of insurance coverage, while those courts following the latter line of decisions must determine whether the insured “expected or intended” the sexual abuse.⁸²

2. The “Objective” or “Classic Tort” Standard Applied to Insurance Claims Arising from Negligent Hiring or Supervision of a Molester

The crucial underlying legal requirement found in most clergy negligent hiring, negligent retention, and negligent supervision cases is largely based upon whether the priest or clergyman’s supervising church, bishop, diocese, or other religious organization *knew or should have known* of the offender’s sexual abuse toward minors.⁸³ The courts have been far from uniform in addressing this issue. As discussed earlier,⁸⁴ for many claims arising from sexual abuse, whether an “occurrence” has transpired frequently is determined according to whether the injury caused by the sexual misconduct was “expected or intended from the viewpoint of the insured.” This test is derived from the final clause of the “occurrence” definition, requiring that the injury has been neither “expected” nor “intended.”

⁸² See generally *infra* Part II.B (involving the molester-insured); *infra* Part II.C.2 (involving the supervisor-insured).

⁸³ See *supra* note 33 and accompanying text.

⁸⁴ See *supra* note 33 and accompanying text.

Only a few cases across the country have comprehensively analyzed whether liability insurers can defeat coverage by asserting that, based on their knowledge of the circumstances, an employer or supervisor “expected or intended” injury to a sexual molestation victim.⁸⁵ One commentator notes that some courts have applied an *objective standard* of what a reasonable supervisor-insured “knew or should have known,” involving the “substantial probability” that certain consequences would result; while other courts have applied a *subjective standard* involving what a particular supervisor-insured *actually* “knew or believed.”⁸⁶

A prime example of this *objective standard* is the case of *Diocese of Winona v. Interstate Fire & Casualty Co. et al.*⁸⁷ The particular circumstances surrounding this liability insurance coverage dispute involved a pedophilic priest, Father Adamson, who subjected several children to prolonged periods of sexual molestation.⁸⁸ The plaintiff, Mrozka, sued the Diocese and Archdiocese, alleging they negligently and recklessly supervised Adamson, allowing Adamson to sexually abuse Mrozka when he was a minor. Both the Diocese and the Archdiocese conceded negligence, but disputed their recklessness. “The jury awarded Mrozka \$821,250 in compensatory damages and, finding recklessness, awarded \$2,700,000 in punitive damages,” a punitive damage award that was later reduced to \$187,000.⁸⁹ The Minnesota Court of Appeals previously had found sufficient evidence “from which the jury could conclude that Church officials *repeatedly* and *knowingly* placed Adamson in situations where he could sexually abuse boys and then failed to properly supervise him and disclose his sexual problem.”⁹⁰

During the period Mrozka was sexually abused by Father Adamson, the Diocese and the Archdiocese had standard occurrence-based Commercial General Liability (CGL) policies from various insurers covering, among other things, “an accident, including continuous or

⁸⁵ See, e.g., Weinstein, *supra* note 4, at 50.

⁸⁶ *Id.*

⁸⁷ *Diocese of Winona v. Interstate Fire & Cas. Co.*, 89 F.3d 1386 (8th Cir. 1996) (applying Minn. law).

⁸⁸ See *Diocese of Winona v. Interstate Fire & Cas. Co.*, 858 F. Supp. 1407 (D. Minn. 1994) (detailing facts surrounding Father Adamson’s accused sexual molestation); *Mrozka v. Archdiocese of St. Paul & Minneapolis*, 482 N.W.2d 806 (Minn. Ct. App. 1992) (same).

⁸⁹ 89 F.3d at 1389.

⁹⁰ 482 N.W.2d at 813.

repeated exposure to conditions, which results in personal injury . . . *which is neither expected nor intended from the standpoint of the insured.*”⁹¹

The Eighth Circuit Court of Appeals stated that although “an insured has a reasonable expectation in securing a CGL policy that the policy will cover *some* negligent acts, it does not necessarily follow that *all* negligent acts are covered.”⁹² Accordingly:

[t]he issue then is whether a reasonably prudent person in the position of the Diocese and the Archdiocese *knew or should have known* that Adamson’s abuse of Mrozka was *substantially probable* as a result of the continuing exposure caused by their willful indifference. In defining substantial probability, this court has stated, “[t]he indications must be strong enough to alert a reasonably prudent man not only to the possibility of the results occurring but the indications also must be sufficient to forewarn him that the results are highly likely to occur.”⁹³

The case therefore was remanded to the federal district court to enter judgment in accordance with this *objective “reasonable person” standard*.⁹⁴

On the other hand, an example of a *subjective* or “*particular insured*” standard is found in the case of *Roman Catholic Bishop of San Diego v. Superior Court*,⁹⁵ where a parish priest, Father Omemaga, sexually abused 15-year-old Jane D. The plaintiff alleged that the Roman Catholic diocese and church negligently hired, retained, and supervised Omemaga, since it knew or should have known of his dangerous propensities as a sexual exploiter of children.

The church moved for summary judgment on the basis [that] it was not negligent because it did not know and had no reason to suspect Omemaga posed any risk to parishioners prior to Jane’s report. In essence, the church argued it had no civil duty to investigate its employees and the constitutional requirement separating church and state

⁹¹ 89 F.3d at 1389-91 (emphasis added).

⁹² *Id.* at 1392 (emphasis added).

⁹³ *Id.* at 1391 (emphasis added) (citations omitted).

⁹⁴ *Id.* at 1399.

⁹⁵ 50 Cal. Rptr. 2d 399 (Cal. Ct. App. 1996).

barred Jane's civil action for negligent hiring and supervision of a priest.⁹⁶

As evidence of negligent hiring and negligent supervision of Father Omemaga, the plaintiff submitted Bishop Robert Brom's interrogatory response stating that "depending on whether a priest is new to the Diocese or whether he is known within the Diocese, the Chancellor of the Diocese may ask priests ... whether they have any past or present problems with their celibacy, and whether anyone has ever made a claim of sexual misconduct against them." And "[a]lthough there were no detailed guidelines how a priest demonstrates his fitness," Father Thomas Doyle, a canon law expert, and an expert in the field of sexual abuse of children by clergy, testified "it is expected that a host bishop make specific inquiries as to the priest's background, his work record, and his character" and "Doyle expected bishops to be 'much more careful and even scrupulous when investigating the qualifications of priests who will work in their dioceses.'" ⁹⁷ Moreover, there was also evidence that Omemaga had two prior sexual relationships in the Philippines, and one sexual relationship in San Diego with a parishioner, and Jane's attorney argued that the church was negligent in hiring Omemaga because, as part of the screening process, the church failed to ask him "whether he had problems with his vows of celibacy."⁹⁸

Nevertheless, the California Court of Appeal observed that Jane D. did *not* have an actionable negligent hiring, negligent retention, or negligent supervision claim against the Diocese under a *subjective* "particular insured" standard. Opined the court: "Even if the church had learned of Omemaga's prior sexual affairs with adults, it is illogical to conclude the church should have anticipated Omemaga would commit sexual crimes on a minor."⁹⁹ The decision demonstrates how the subjective standard varies from the objective standard exemplified in cases such as *Diocese of Winona*. As one commentator notes, in jurisdictions that apply

⁹⁶ *Id.* at 400-01.

⁹⁷ *Id.* at 403.

⁹⁸ *Id.* at 401, 405.

⁹⁹ *Id.* at 405. But query: Why is it so "illogical" that a priest who has broken his vow of celibacy with adults may also break his vow of celibacy with minors as well? See also *Mark K. v. Roman Catholic Archbishop of Los Angeles*, 79 Cal. Rptr. 2d 73 (Cal. Ct. App. 1998) (holding that in an action for negligent retention and negligent supervision of a priest who sexually molested a child, the archdiocese failed to warn the victim of the priest's propensity for engaging in sexual misconduct with boys).

this *subjective standard*, “even the egregious facts in *Diocese of Winona* likely would not be sufficient to trigger the expected or intended exclusion” to liability insurance coverage.¹⁰⁰

Which is the better-reasoned interpretive approach—the *objective standard* as illustrated in the *Diocese of Winona* case, *supra*, or the *subjective standard* as illustrated in the *Bishop of San Diego* case, *supra*?

It is submitted that the *objective standard* clearly is the better-reasoned interpretive approach for four compelling reasons:

First, the claims of negligent hiring, negligent supervision, and negligent retention brought against church organizations and their supervisors for the sexual abuse of minors by priests or other clergymen all sound in *negligence* which traditionally is based upon an *objective* “reasonable person” standard of care.¹⁰¹ Moreover, in a liability insurance context involving claims of negligence, a court generally applies an “eight corners rule”—that is, the court will compare the “four corners” of the underlying tort complaint with the “four corners” of the insurance policy to determine coverage.¹⁰²

Second, the “objective” or “classic tort” standard for determining intentional acts in liability insurance coverage disputes, or alternately the “inferred intent” standard as applied to child sexual abuse cases, is generally recognized in an overwhelming majority of states as opposed to the minority “subjective” or “particular insured” standard, based upon strong public policy reasons.¹⁰³

Third, a substantial majority of courts have now recognized that the crucial underlying requirement in negligent hiring, negligent retention, and negligent supervision of clergy cases largely is based upon whether the priest or clergyman’s supervising church, bishop, diocese, or other

¹⁰⁰ Weinstein, *supra* note 4, at 50.

¹⁰¹ The law of negligence generally imposes on each person an obligation to conform to a reasonable person of ordinary prudence standard, an objective standard that is now well-established in American negligence law. *See, e.g.,* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32 (W. Page Keeton ed., 5th ed. 1984); *see also* DAN B. DOBBS, THE LAW OF TORTS § 258 (2000).

¹⁰² *See, e.g.,* Pekin Ins. Co. v. Dial, 823 N.E.2d 986, 990 (Ill. App. Ct. 2005) (finding no duty to defend the insured in a sexual molestation case).

¹⁰³ *See generally infra* Part II.B.

religious organization *knew or should have known* of the sexual offender's abuse toward minors—which, again, is an objective standard.¹⁰⁴

Fourth, and of primary importance, the crucial *causation requirement* in both tort law and insurance contract law *also* requires the application of an objective “efficient or predominant cause” interpretive analysis, as is discussed in more detail directly below.

3. Reassessing the Crucial Causation Requirement in Liability Insurance Coverage Disputes Involving Sexual Abuse of Minors

The *causation requirement* is a crucial factor in both tort law¹⁰⁵ and insurance law,¹⁰⁶ especially involving liability insurance coverage disputes.

¹⁰⁴ See Cooke, *supra* note 4, at 1063 (“If a reasonably prudent person in the position of the Church would expect or should expect that an employee is a danger to innocent life, the church should bear responsibility for all resulting liability.”).

¹⁰⁵ According to Professor William Lloyd Prosser, to establish a *bona fide* tort action sounding in negligence, the plaintiff must plead and prove: (1) that the defendant owed plaintiff a duty of due care to act in a reasonable manner toward the plaintiff; (2) that defendant breached this duty of due care to the plaintiff; (3) that defendant's acts were the *causal connection* between the defendant's conduct and the resulting injury; that is to say, it was the *cause in fact* and the *proximate cause* of plaintiff's injury or loss; and (4) actual damage or loss occurred to the plaintiff as a result of defendant's actions. See, e.g., Keeton, *supra* note 101, at 164-65. The proposed RESTATEMENT (THIRD) OF TORTS § 6 cmt. b (2010) states that there are five elements to any prima facie case in negligence: (1) “duty”; (2) “failure to exercise reasonable care”; (3) “*factual cause*”; (4) “physical harm”; and (5) “harm within the scope of liability (which historically has been called ‘*proximate cause*’)” (emphasis added).

¹⁰⁶ In an insurance law context, Professor Banks McDowell argues that the following four factors need to be considered: (1) the coverage provisions of an insurance policy; (2) the occurrence of the event; (3) the loss or damage; and (4) the *causal “connector”* between the event and the loss. Banks McDowell, *Causation in Contracts and Insurance*, 20 CONN. L. REV. 569, 575 (1988) (emphasis added). McDowell goes on to state that causation “should be limited to the connector between what, consistent with insurance terminology, may be called an ‘occurrence,’ and the loss suffered by the insured . . .” *Id.* at 575-76. See also Sidney I. Simon, *Proximate Cause in Insurance*, 10 AM. BUS. L.J. 33, 35-36 (1972) (“The insurance rule is that only the proximate cause of the loss, and not the remote cause, is to be regarded in determining whether recovery may be had under an insurance policy, and the loss must have been proximately caused by a peril insured against. . . . The proximate cause of loss or damage to an insured's property or injury to his person is not necessarily the last link in the chain of

In an insurance law context, the courts are split on whether to apply causation rules recognizing either: (1) the cause nearest the loss;¹⁰⁷ or (2) the efficient or predominant cause of the loss.¹⁰⁸ As one of the authors of this article previously has observed:

A growing number of American courts ... have rejected a strict immediate cause rule in favor of an efficient or dominant proximate cause rule, analogous to a tort-based proximate cause rule, in order to validate the reasonable expectations of the insured policyholder to coverage. Under this reasonable expectations hybrid of tort and contract causation law, there will be coverage if a risk of loss that is specifically insured against in the insurance policy sets in motion, in an unbroken causal sequence, the events that cause the ultimate loss, even though the last immediate cause in the chain of causation is an excluded cause.¹⁰⁹

preceding events, but the procuring, efficient cause from which the effect might be expected to follow without concurrence of any unforeseen circumstances.”).

¹⁰⁷ See, e.g., *Queen Ins. Co. of Am. v. Globe & Rutgers Fire Ins. Co.*, 263 U.S. 487, 492 (1924) (involving a war risk marine insurance policy) (“[T]he common understanding is that in construing these [insurance] policies we are not to take broad views but generally are to stop our inquiries with the cause nearest to the loss.”); *Pan Am. World Airways, Inc. v. Aetna Cas. & Sur. Co.*, 505 F.2d 989, 1007 (2d Cir. 1974) (applying N.Y. law) (involving aviation insurance) (“These cases establish a mechanical test of proximate causation for insurance cases, a test that looks only to the ‘causes nearest to the loss.’”). See also *Bruener v. Turin City Fire Ins. Co.*, 222 P.2d 833, 834-35 (Wash. 1950) (involving automobile insurance) (similar holding), *overruled by* *Graham v. Pub. Emps. Mut. Ins. Co.*, 656 P.2d 1077, 1081 (Wash. 1983) (involving a homeowners insurance coverage dispute) (adopted the efficient or predominant proximate cause rule).

¹⁰⁸ See, e.g., *TNT Speed & Sport Ctr., Inc. v. Am. States Ins. Co.*, 114 F.3d 731, 733 (8th Cir. 1997) (applying Mo. law) (involving commercial property insurance); *State Farm Mut. Auto. Ins. Co. v. Roberts*, 697 A.2d 667 (Vt. 1997) (involving automobile insurance). See generally Stempel, *supra* note 7, § 7.02; Jerry & Richmond, *supra* note 7, § 67[b].

¹⁰⁹ Peter Nash Swisher, *Causation Requirements in Tort and Insurance Law Practice: Demystifying Some Legal Causation “Riddles”*, 43 TORT TRIAL & INS. PRAC. L.J. 1, 23-24 (2007) (citing as authority *Graham*, 656 P.2d at 1081 (Wash. 1983) (involving homeowners insurance)). See also *John Drennon & Sons Co. v. N.H. Ins. Co.*, 637 S.W.2d 339, 341 (Mo. Ct. App. 1982) (involving machinery and equipment insurance).

This is especially true with *liability insurance* coverage issues, since in order to determine

whether an insurer has a duty to defend [or provide coverage for] its insured in a lawsuit, a court should generally apply an “eight corners rule”—that is, the court should compare the four corners of the underlying tort complaint with the four corners of the insurance policy and determine whether the facts alleged in the underlying complaint fall within, or potentially within, the insurance policy’s coverage.¹¹⁰

Next, this crucial causation “connector” requires proof by the plaintiff of the *probability of harm*—rather than a mere “possibility” of harm—based upon defendant’s conduct toward the plaintiff.¹¹¹

Finally, when two or more defendants actively cause the plaintiff harm, most courts will apply a “substantial factor” test, which holds that those defendants who were a “substantial factor” and constituted the “efficient or predominant cause” of the ultimate harm to the plaintiff, within an unbroken casual chain of events, will be the cause-in-fact and the proximate cause of the plaintiff’s injuries.¹¹² This “efficient or predominant

If the clergy sexual abuse was the “efficient or predominant cause” of the injury, and if it is excluded from coverage under an intentional acts exclusion in the policy, then the insured will *not* be able to recover under the liability insurance policy. This same result would also occur under “the cause nearest the loss” interpretive analysis.

¹¹⁰ *Pekin Ins. Co. v. Dial*, 823 N.E.2d 986, 990 (Ill. App. Ct. 2005) (finding there was no duty to defend the insured in a sexual molestation action).

¹¹¹ See generally Keeton, *supra* note 101, at 269-72; RESTATEMENT (SECOND) OF TORTS §§ 430-433 (1965). See, e.g., *Diocese of Winona v. Interstate Fire & Cas. Co.*, 89 F.3d 1386, 1391 (8th Cir. 1996) (applying Minn. law) (“The issue then is whether a reasonably prudent person in the position of the Diocese and the Archdiocese knew or should have known that Adamson’s abuse of Mrozka was substantially probable as a result of the continuing [clergy sexual abuse] exposure caused by their willful indifference. In defining substantial probability, this court has stated, ‘[t]he indications must be strong enough to alert a reasonably prudent man not only to the possibility of the results occurring but the indications also must be sufficient to forewarn him that the results are highly likely to occur.’”) (citations omitted).

¹¹² See, e.g., RESTATEMENT (SECOND) OF TORTS §§ 431, 432(2), 433, 435 (1965). See generally Dobbs, *supra* note 101, at 414-17, 447-51; Keeton, *supra* note 101, at 263-68.

cause” analysis is recognized in an insurance law context as well.¹¹³ But in a liability insurance context, what “efficient or predominant cause” would (or would not) constitute an “occurrence” in a causal chain of events involving more than one defendant?

Since few cases to date have comprehensively analyzed whether liability insurers can defeat coverage by asserting that a church organization, employer, or supervisor negligently “knew or should have known” of the “expected or intended” injuries to a sexual molestation victim initially caused by a priest or clergyman, especially from a necessary *causation* perspective, we need to analyze some analogous liability insurance cases dealing with this crucial *causation requirement*.

For example, in the analogous case of *Farmers Alliance Mutual Insurance Co. v. Salazar*,¹¹⁴ a homeowner’s insurer brought a declaratory judgment action, seeking judicial determination that it had no obligation to defend or indemnify either the insured son, Manuel Corrales, for his negligent entrustment of his gun to a fellow gang member, or the insured mother, Ofelia Salazar, for her negligent supervision of her 16-year-old son Manuel, based on wrongful death claims arising out of her son’s participation in the murder of another boy, Thomas Byus.¹¹⁵

The insurance company’s “duty to defend and indemnify Ms. Salazar and Manuel Corrales turns on whether Thomas Byus’s death was a ‘bodily injury . . . caused by an occurrence’” under the homeowners’ liability insurance coverage. Farmers Alliance Insurance Company argued that the murder of Thomas Byus, by firing the bullet into his head, was the event that must qualify as an “occurrence.” Byus’s administrator in this wrongful death action, however, “asks us to cast our focus further up the causal chain to Ms. Salazar’s negligent supervision of Manuel and Manuel’s negligent entrustment of the murder weapon to Jacob De LaCruz.”¹¹⁶

In a case of first impression, the Eighth Circuit Court of Appeals, applying Oklahoma law, stated:

Our search for “occurrence” policy case law addressing a causal chain that begins with a negligent act or omission

¹¹³ See generally Jerry & Richmond, *supra* note 7, § 67[b]; Stempel, *supra* note 7, § 7.02; see also Keeton, *supra* note 100, § 82 (Liability Insurance and its Impact on Tort Law).

¹¹⁴ 77 F.3d 1291 (10th Cir. 1996) (applying Okla. law).

¹¹⁵ *Id.* at 1293-94.

¹¹⁶ *Id.* at 1295.

and ends with an intentional tort has uncovered the decisional equivalent of a famine. We have located no cases addressing the issue facing us today. Therefore, we begin our analysis with cases that might help by analogy or deduction. Of the scores of decisions interpreting “occurrence” policies, two categories of cases prove particularly instructive. The first category answers the question of when an “occurrence” happens, and the second focuses on where.¹¹⁷

The court then discussed the generally prevailing rule, recognized by most courts, that “the time of an ‘occurrence’ generally is determined by ‘the time the complaining party was actually damaged,’” and “the location of an ‘occurrence’ is determined by the place where the injury happened; it does not matter that a precipitating event took place elsewhere.”¹¹⁸ Although these cases did not address the court’s causal link issue directly, the court found their reasoning to be dispositive. Accordingly, the court held in determining whether a bodily injury was “‘caused by an occurrence’ the question of whether there *was* an ‘occurrence’ should be resolved by focusing on the injury and its immediately attendant causative circumstances.”¹¹⁹

Based upon the facts of this particular case, the “occurrence” was when and where Jacob De La Cruz murdered Thomas Byus, which was an intentional act, and therefore it could *not* qualify as an “accident . . . [that was] neither expected nor intended from the standpoint of the insured.”¹²⁰ Consequently, the court concluded that it “need not reach the issue of whether Ms. Salazar or Manuel Corrales actually intended or expected Thomas Byus’s death, because intentional murder is not ‘an accident’ under the insurance policy’s ‘occurrence’ provision.”¹²¹

This same legal argument might also be applied in a liability insurance context when a priest or clergyman intentionally sexually abuses

¹¹⁷ *Id.*

¹¹⁸ *Id.* at 1296 (citation omitted).

¹¹⁹ *Id.*

¹²⁰ *Salazar*, 77 F.3d at 1297.

¹²¹ *Id.* Although the court did not directly address the negligent supervision allegation involving Ms. Salazar in this particular case, the court may also have utilized the same causation analysis found in analogous cases interpreting “Liquor Liability Exclusions” or “Assault and Battery Exclusions” as discussed below. *See supra* notes 95-103 and accompanying text.

a minor, which clearly is *not* an “accidental” occurrence under the policy coverage provisions.¹²²

Other analogous cases have dealt with “Liquor Liability Exclusions” or “Assault and Battery Exclusions,” which are conceptually similar to the “Intentional Act Exclusions” involved in clergy sexual abuse claims. For example, in the case of *Property Owners Ins. Co. v. Ted’s Tavern, Inc.*,¹²³ a tavern’s commercial general liability (CGL) insurance policy contained an exclusion—exclusion 2(c)—concerning bodily injury resulting from causing or contributing to the intoxication of a person, or furnishing alcoholic drinks to someone who was under the influence of alcohol.¹²⁴ When a motorist was killed by a drunk patron, who was driving home from the tavern, the personal representative of the deceased motorist brought a wrongful death action against the tavern’s liability insurance carrier, arguing that the Ted’s Tavern and its employees were liable under the CGL policy for their negligent hiring, negligence training, and negligent supervision, rather than coming under the policy’s liquor liability exclusion 2(c). But the Indiana Court of Appeals disagreed with the plaintiff’s argument, based upon relevant *legal causation* principles:

Regardless of the theories of liability a resourceful attorney may fashion from the circumstances of this case, the allegations [of negligently hiring, training, and supervising the tavern employees] are general “rephrasings” of the core negligence claim for causing/contributing to [the patron’s] drunk driving. The events outlined in [the plaintiff’s complaint] simply *are not wholly independent* of “carelessly and negligently” serving and continuing to serve alcoholic beverages to [the impaired patron] when the defendants *knew or should have known* he was intoxicated and soon thereafter could be driving drunk. To the contrary, the... negligent hiring, training, and supervision *are so inextricably intertwined* with the underlying negligence [under the liquor liability exclusion] that there *is no independent act* that would avoid exclusion 2(c). Hence, while a valiant effort to procure coverage, the creative pleadings of [negligent hiring, negligent training, and negligent supervision of the

¹²² See *supra* notes 64-81 and accompanying text.

¹²³ 853 N.E.2d 973 (Ind. Ct. App. 2006).

¹²⁴ *Id.* at 978.

employees] cannot hide the reality that *the immediate and efficient cause* of the injuries was drunk driving precipitated by the negligent service of alcohol. As such, exclusion 2(c) precludes coverage.¹²⁵

Thus, the *Ted's Tavern* court adopted an “efficient or predominant cause” analysis, where the liquor liability exclusion—exclusion 2(c)—barred any recovery from the liability insurance company, since the related allegations of negligent hiring, negligent training, and negligent supervision were *not wholly independent of*, and were *inextricably intertwined with*, the liquor liability exclusion.

Allegations of misconduct have been deemed to be “interdependent” with a negligence claim when the negligence claim incorporated the facts alleged to support deliberate misconduct.¹²⁶ Thus, for example, if Count I of the complaint alleges that the insured knew the molester presented a high level of risk of injury to children, and Count II of the complaint “incorporates and realleges” the facts set forth in Count I, then the court may conclude that the “negligence” count reflects an “expectation” of harm as well.

This holding is consistent with decisions from other jurisdictions as well.¹²⁷ A Delaware court, for example, considered a case in which, following the forcible removal of a patron from an amusement park, the patron sued the park alleging assault, battery, false imprisonment, and “injury with ill will, intent to injure or malice,” and also pled “negligent supervision.”¹²⁸ The court observed: “where negligence claims against an employer such as negligent hiring, negligent training, and negligent entrustment, are related to and interdependent on the intentional misconduct of an employee, the “ultimate question” for coverage purposes is whether the employee’s intentional misconduct itself falls within the definition of ‘occurrence.’” Likewise, a Missouri court observed, in an action against a bar owner for injuries inflicted by intoxicated patrons, that:

¹²⁵ *Id.* at 983 (emphasis added) (citations omitted). *See also* Scottsdale Ins. Co. v. Lankford, No. 07C-06-254 RRC, 2007 WL 4150212 (Del. Super. Ct. Nov. 21, 2007), *aff'd*, 947 A.2d 1121 (Del. 2008) (similar holding).

¹²⁶ *See, e.g.,* Collins Holding Corp. v. Wausau Underwriters Ins. Co., 666 S.E.2d 897, 900 (S.C. 2008).

¹²⁷ *See* Bituminous Fire and Marine Ins. Co. v. Huttu, No. 4:06CV67TSL-LAA, 2007 WL 188661, at *1 (S.D. Miss. Jan. 23, 2007).

¹²⁸ TIG Ins. Co. v. Premier Parks, No. Civ.A02C04126JRS, 2004 WL 728858 (Del. Super. Ct. Mar. 10, 2004).

The damages arise from the assault and battery. Without the underlying assault and battery, there would have been no injury and therefore no basis for plaintiffs' action against Harverfield for negligence. The assault and battery and Haverfield's negligence are not mutually exclusive; rather the acts are related and interdependent.¹²⁹

Courts in Texas have applied this doctrine in several other cases as well.¹³⁰

When a supervisor's liability is stated to be on account of its own negligence, but this negligence is alleged to be interrelated with deliberate misconduct, the deliberate misconduct, according to these courts, becomes determinative.¹³¹ When the negligent hiring or negligent supervision claims require "proof of misconduct" by the offender, the only question is whether the *offender's* acts are covered under the definition of "occurrence."¹³²

Accordingly, an emerging line of cases persuasively hold that when the insured's liability is "related to and interdependent on other tortious activities," the nature of that other tortious activity will determine whether the insurance policy covers the insured supervisor.¹³³ In *Mt. Vernon Fire Ins. Co. v. Stagebands*, for example, claims of "negligent design" (of a parking lot) did not permit a finding that injury was expected or intended. The court observed:

There is no question Cortes's injuries were caused by the gun-shot – even if the parking layout was an after-the-fact contributing and worsening cause. In sum, the fact that [the insureds'] parking design negligence may have

¹²⁹ *Hunt v. Capitol Indem. Corp.*, 26 S.W.3d 341, 345 (Mo. Ct. App. 2000).

¹³⁰ *See State Farm Lloyds v. Borum*, 53 S.W.3d 887 (Tex. App. 2001); *Folsom Invs. Inc. v. Am. Motorists Ins. Co.*, 265 S.W.3d 556, 559 (Tex. App. 2000).

¹³¹ *Cornhill Ins. PLC v. Valsamis, Inc.*, 106 F.3d 80, 87 (5th Cir. 1997) (applying Tex. law) (citing to *N.Y. Life Ins. Co. v. Travelers Ins. Co.*, 92 F.3d 336 (5th Cir. 1996) (applying Tex. law)).

¹³² *Id.*

¹³³ *See Am. States Ins. Co. v. Bailey*, 133 F.3d 363, 371 (5th Cir. 1998) (applying Tex. law); *Cornhill*, 106 F.3d at 87 (no duty to defend employer for negligent hiring and failure to provide safe workplace where employee sexually harassed another employee); *cf. Mount Vernon Fire Ins. Co. v. Stagebands Inc.*, 636 F. Supp. 2d 143 (D. R.I. 2009).

affected [the victim] after he was shot does not make it unrelated and independent of the assault.¹³⁴

When courts have applied this analysis to negligent supervision claims in the context of sexual abuse and molestation, they have held that the resulting injury was not an “occurrence” within the meaning of a general liability insurance policy:

If [the perpetrator] had not sexually molested the Isbell daughters, Linda Isbell would have no claim for damages against [the mother-defendant]. Thus, we find [her] liability to be ‘related to and interdependent on’ the tortious acts of [the perpetrator]. Because [the perpetrator’s] underlying acts are not encompassed within the definition of ‘occurrence,’ [the insurer] has no duty to defend.¹³⁵

These decisions reason that negligent hiring and supervision, in and of themselves, are not actionable, and hence immaterial, absent the non-accidental act of molestation.

Other cases are in accord with this persuasive and compelling causation analysis. For example, in the case of *Terra Nova Insurance Co. v. Nanticoke Pines, Ltd.*,¹³⁶ a liability insurer brought an action seeking a declaratory judgment that it had no obligation to defend or indemnify its insured tavern keeper for claims asserted by Kevin Gibbs, who was shot by the tavern’s security officer, John Hargett. The plaintiff argued that the liability insurance coverage was premised on the negligent hiring and the negligent supervision of the tavern’s security guard under the doctrine of *respondeat superior*.¹³⁷ The insurer argued, however, that it was *not* liable under its “assault and battery” exclusion in the policy.

The federal district court, applying Delaware law, held that:

¹³⁴ *Stagebands*, 636 F. Supp. 2d. at 148-49.

¹³⁵ *Am. Nat. Gen. Ins. Cos. v. Ryan*, 274 F.3d 319, 325 (5th Cir. 2001) (applying Tex. law); *accord* *W. Am. Ins. Co. v. Embry*, No. Civ.A. 3:04CV-47-H, 2005 WL 1026185 (W.D. Ky. Apr. 25, 2005); *Nw. G.F. Mut. Ins. Co. v. Norgard*, 518 N.W.2d 179, 184 (N.D. 1994).

¹³⁶ 743 F. Supp. 293 (D. Del. 1990).

¹³⁷ *Id.* at 294.

based on the assault and battery exclusion, the complaint does not allege a risk covered by the policy.... [T]he plain language of the exclusion bars coverage for any claim based on assault and battery.... All the issues the complaint raises about Nanticoke's negligence and recklessness [including allegations of negligent hiring and negligent supervision] concern conduct of Nanticoke *that helped make the assault possible*, and are thus *fundamentally premised on the assault itself*.¹³⁸

Delaware's "fundamentally premised" causation analysis is essentially the same as the "efficient or predominant cause" analysis adopted in the *Ted's Tavern* case, *supra*,¹³⁹ and a number of other cases also are in accord with this generally accepted causation analysis.¹⁴⁰

On the other hand, policyholders might contend that the "expected or intended" clause is not offended by affording coverage to a supervisor-insured, given that, in such a case, "the insured" claiming coverage is not the perpetrator. The *Terra Nova* court noted, without deciding, this particular distinction.¹⁴¹ Also, an Ohio court recently opined: "[T]orts like negligent supervision, hiring, retention, and entrustment are separate and distinct from the related intentional torts (committed by other actors) that make the negligent torts actionable. Thus, in determining whether a policy exclusion precludes coverage for that negligent act, we must examine the injuries arising from the negligent act on their own accord, not as part of the intentional act."¹⁴² The court reasoned that the negligent act, standing alone, was the "occurrence."

Insurers might respond that, given the inevitable presence of supervisors in connection with any such claim under a commercial liability

¹³⁸ *Id.* at 297 (emphasis added).

¹³⁹ See, e.g., *Scottsdale Ins. Co. v. Lankford*, No. 07C-06-254 RRC, 2007 WL 4150212, at *10 (Del. Super. Ct. 2007), *aff'd*, 947 A.2d 1121 (Del. 2008).

¹⁴⁰ See, e.g., *Terra Nova Ins. Co. v. Thee Kandy Store Inc.*, 679 F. Supp. 476, 478 (E.D. Pa. 1988) ("Regardless of the language of the allegations, the original cause of the harm arose from an alleged assault and battery"); *Terra Nova Ins. Co. v. North Carolina Ted, Inc.*, 715 F. Supp. 688, 691 (E.D. Pa. 1989) (similar holding); see generally Kimberly J. Winbush, Annotation, *Validity, Construction, and Effect of Assault and Battery Exclusion in Liability Insurance Policy at Issue*, 44 A.L.R. 5TH 91 (1996) (reporting that the vast majority of cases are in accord with this general causation principle).

¹⁴¹ *Nanticoke Pines*, 743 F. Supp. at 298 n. 9.

¹⁴² *Safeco Ins. Co. of N. Am. v. White*, 913 N.E.2d 426, 434 (Ohio 2009).

policy issued to an organization, the “fundamentally premised” doctrine properly serves to avoid nullifying the “expected or intended” clause. Further, courts applying the “fundamentally premised doctrine” to exclusions, consistently have supported their decisions as necessary to defeat “artful pleading” by underlying plaintiffs.¹⁴³ As stated in a decision recently affirmed by the Delaware Supreme Court in *Lankford v. Scottsdale Insurance Co.*, “[t]he purpose of Delaware’s ‘fundamentally premised’ analysis is to prevent an injured party from circumventing the clear terms of an insurance policy by allying with the insured and by fashioning expansive theories of liability.”¹⁴⁴ The *Lankford* court cited an American Law Reports annotation’s recognition of “the anomalous legal posture of an insured and a victim, adversaries in one case, siding against an insurer seeking to apply an ... exclusion to the litigated claims.”¹⁴⁵

In *Nationwide Mutual Fire Ins. Co. v. Lajoie*, for example, the Vermont Supreme Court rejected a claim for “negligent infliction of emotional distress” arising from the insured’s alleged sexual abuse of a minor as “simply a disingenuous attempt to create a factual dispute.”¹⁴⁶ Courts should seek to prevent the absurdity, and possible fraud upon the court, that might result if the law were to allow a superficial claim of “negligence” to supersede factual allegations that reveal intentional and deliberate conduct by the insured.¹⁴⁷

Accordingly, this “efficient or predominant cause” interpretive analysis may be applied—and, indeed, should be applied—to clergy sexual abuse claims. For example, a number of courts have held that various churches, bishops, dioceses, and other religious organizations may be held tortiously liable for their negligent hiring, negligent supervision, or negligent retention of a sexually abusive priest or clergyman if the church, bishop, diocese, or other religious organization *knew or should have known* of the priest’s or clergyman’s sexual misconduct.¹⁴⁸ But in a *liability insurance context*, if this negligent hiring, negligent supervision, or negligent retention of a sexually abusive priest or clergyman was so *inextricably intertwined with, interdependent, and not independent of*, the priest or clergyman’s sexual misconduct—which was excluded under the

¹⁴³ See, e.g., Winbush, *supra* note 140.

¹⁴⁴ See, e.g., *Scottsdale Ins. Co. v. Lankford*, No. 076-06-254 RRC, 2007 WL 4150212, at *8 (Del. Super. 2007), *aff’d*, 947 A.2d 1121 (Del. 2008).

¹⁴⁵ *Id.* at *8 n.47 (citing Winbush, *supra* note 140, at 91).

¹⁴⁶ *Nationwide Mut. Fire Ins. Co. v. Lajoie*, 661 A.2d 85, 86 (Vt. 1995).

¹⁴⁷ The distinction between *actual* “negligence” and the mere labeling of a claim as “negligence” is discussed in further detail below. See *infra* Part II.E.

¹⁴⁸ See *supra* notes 31-35 and accompanying text.

liability insurance policy's intentional act exclusion, and which was the "efficient or predominant cause" of the plaintiff's sexual abuse claim—then the supervising church, bishop, diocese, or other religious organization should *not* be covered by its liability insurer under generally accepted tort and insurance law cause-in-fact and proximate cause *causation principles*.¹⁴⁹

Consequently, if a priest or clergyman sexually abuses a minor, this sexual abuse generally will be barred under a liability insurance policy's "expected or intended" exclusion, under either an objective or "classic tort" analysis,¹⁵⁰ or under an "inferred intent" standard as applied to child sexual abuse cases.¹⁵¹ Likewise, if a supervisory church, diocese, bishop, or other religious organization objectively *knew or should have known* of the priest's or clergyman's sexual abuse of a minor—which was the "efficient or predominant cause" of the minor's sexual abuse claim—and this negligent hiring, supervision, or retention of the sexually abusive priest or clergyman was *connected to* and was *not independent from* the priest or clergyman's sexual misconduct, then liability insurance should not cover such negligence under relevant cause-in-fact and proximate cause principles either.

4. What is "Expected" Injury, and Does "Expected" have a Meaning Independent from "Intended"?

As discussed above, the question whether an insured "intended" injury has been regarded by a significant number of courts as governed by an "objective" standard or, with children, an "inferred intent" standard.¹⁵² If a reasonable person would have foreseen injury, then, consistent with tort law precedent, the insured's state of mind will be deemed to reflect intent.

¹⁴⁹ See *supra* notes 82-103 and accompanying text. See, e.g., *Diocese of Winona v. Interstate Fire & Cas. Co.*, 89 F.3d 1386 (8th Cir. 1996) (applying Minn. law); see also *Am. Commerce Ins. Co. v. Porto*, 811 A.2d 1185 (R.I. 2002) (holding that a separate negligent supervision claim was *not* covered since it was causally connected to the sexual molestation of a child, which was excluded from coverage under the parties' homeowners insurance policy). This same result would apply if a particular jurisdiction applies a more traditional "cause nearest the loss" interpretive analysis, rather than applying the modern and majority "efficient or predominant cause" interpretive analysis.

¹⁵⁰ See *supra* notes 41-44 and accompanying text.

¹⁵¹ See *supra* notes 56-63 and accompanying text.

¹⁵² See *infra* Part II.B.

In interpreting “expected” or “intended” provisions, however, the “expected” prong, inexplicably, is often overlooked. Yet it is as much an interpretive hurdle to a finding of coverage as the requirement that the injury would not have been “intended.” Thus, even when the injury was not “intended,” a second question still remains: If injury was not “intended,” might it nevertheless have been “expected”? The answer is “yes,” when supported by operative facts, according to those courts that have given independent meaning to *both* terms: *i.e.*, “expected,” as well as “intended.”

Some decisions, it should be noted, have deemed “expected” to be synonymous with “intended.”¹⁵³ A few courts have assumed there is no difference between the terms “expected” and “intended” in determining whether the “intentional acts exclusion” applies.¹⁵⁴ Other courts, however, have concluded that the terms “expected” and “intended” are *not* synonymous.¹⁵⁵ It has been observed: “Determining a person’s *expectation* involves a different inquiry than does determining his or her *intent*.”¹⁵⁶ If only “intention” needed to be considered, the use of the word ‘expected’ would be mere surplusage, which is a result to be avoided in interpretation.”¹⁵⁷

Generally speaking, an insured “expects an injury if he or she is *subjectively* aware that injury is substantially certain to result.”¹⁵⁸

¹⁵³ See, e.g., *Poston v. U.S. Fid. & Guar. Co.*, 320 N.W.2d 9, 11-12 (Wis. Ct. App. 1982).

¹⁵⁴ See, e.g., *Grange Mut. Cas. Co. v. Thomas*, 301 So.2d 158 (Fla. Dist. Ct. App. 1974); *Jones v. Norval*, 279 N.W.2d 388 (Neb. 1979); *State v. Glens Falls Ins. Co.*, 404 A.2d 101 (Vt. 1979); *Poston v. U. S. Fid. & Guar. Co.*, 320 N.W.2d 9 (Wis. Ct. App. 1982).

¹⁵⁵ See, e.g., *Badger Mut. Ins. Co. v. Murry*, 370 N.E.2d 295, 299-300 (Ill. Ct. App. 1977) (pointing out that if “intended” and “expected” were synonymous, there would be no point in including them both within the language of the intentional act exclusion); see also *Carter Lake v. Aetna Cas. & Sur. Co.*, 604 F.2d 1052 (8th Cir. 1979) (applying Iowa law); *Armstrong Cleaners, Inc. v. Erie Ins. Exch.*, 364 F. Supp. 2d 797 (S.D. Ind. 2005); *Farm Bureau Town & Country Ins. Co. of Mo. v. Turnbo*, 740 S.W.2d 232 (Mo. Ct. App. 1987); *Nw. Nat. Cas. Co. v. Phalen*, 597 P.2d 720 (Mont. 1979); *Seymour v. Lenoir Cnty.*, 567 S.E.2d 799 (N.C. Ct. App. 2002); *Abrams v. Gen. Star Indem. Co.*, 67 P.3d 931 (Or. 2003).

¹⁵⁶ *N. Sec. Ins. Co. v. Perron*, 777 A.2d 156, 158 (Vt. 2001) (citing *City of Burlington v. Ass’n of Gas and Electric Ins. Serv., LTD.*, 751 A.2d 284, 288 (Vt. 2000)); *Espinet v. Horvath*, 597 A.2d 307, 310 (Vt. 1991).

¹⁵⁷ *Horvath*, 597 A.2d at 310; see also *Phalen*, 597 P.2d at 726.

¹⁵⁸ *Perron*, 777 A.2d at 158 (citing *Horvath*, 597 A.2d at 310); accord *Jenkins v. Koester*, No. 268175 2007 WL 2429846, at *1 (Mich. Ct. App. Aug. 28, 2007);

However, given that the insured rarely will concede that he or she expected harm, the analysis usually turns on whether, objectively, the insured should be regarded as having expected injury.¹⁵⁹ The Eighth Circuit, in *Diocese of Winona* defined this standard as follows:

[U]nder the substantially probable test ... if an insured is alerted to the problem, its cause, and knows or should have known of the likelihood of the problem's recurrence, it cannot ignore such problem and then look to its insurer to reimburse it for the liability incurred by reason of such inaction.¹⁶⁰

Thus, even in jurisdictions that have not expressly recognized an objective test for "intended" injury, coverage may be barred for insureds that did not wish harm to anyone, if the insured expected such injury. A prominent case concerning expectation of harm in the context of insurance where injury is a "substantial probability" is the Eighth Circuit's decision in *City of Carter Lake v. Aetna Casualty & Surety Co.* There, the court held that "substantial probability" means "[t]he indications must be strong enough to alert a reasonably prudent man not only to the possibility of the results occurring, but the indications also must be sufficient to forewarn him that the results are highly likely to occur."¹⁶¹ Similarly, California courts have held that: "[t]he appropriate test for 'expected' damage is whether the insured knew or believed its conduct was substantially certain or highly likely to result in that kind of damage."¹⁶²

It is sometimes argued that giving the term "expected" its usual meaning, and precluding claims where the insured "should have known"

Queen City Farms, Inc. v. Cent. Nat'l Ins. Co. of Omaha, 882 P.2d 703, 721-27 (Wash. 1994).

¹⁵⁹ *Argento v. Vill. of Melrose Park*, 838 F.2d 1483, 1497 (7th Cir. 1988) ("whether [property damage] was expected is a subjective inquiry, but a subjective expectation can be inferred from objective evidence that the injury was the natural and probable result from the act.") .

¹⁶⁰ *Diocese of Winona v. Interstate Fire & Cas. Co.*, 89 F.3d 1386, 1392 (8th Cir. 1996) (applying Minn. law) (citing *City of Carter Lake v. Aetna Cas. & Sur. Co.*, 604 F.2d 1052, 1059 (8th Cir. 1979)); *accord* *Baystate Ins. Co. v. Wilson*, 451 N.E.2d 880, 882-83 (Ill. 1983); *cf.* *Lutheran Benevolent Ins. Co. v. Nat'l Catholic Risk Retention Grp.*, 939 F. Supp. 1506, 1513 (N.D. Okla. 1995).

¹⁶¹ *City of Carter Lake v. Aetna Cas. & Sur. Co.*, 604 F.2d 1052, 1059 (8th Cir. 1979) (applying Neb. law).

¹⁶² *FMC Corp. v. Plaisted & Cos.*, 72 Cal. Rptr. 2d 467 (Cal. Ct. App. 1998).

the harm would occur, cuts too broadly in precluding coverage for a “negligence” claim. However, in *Diocese of Winona*, the court explained that giving meaning to the term “expected” bars coverage only for some, but not all, negligence claims. “While an insured has a reasonable expectation in securing a CGL policy that the policy will cover some negligent acts, it does not necessarily follow that all negligent acts are covered.... [T]here may be instances when, although an insured was negligent, she knew or should have known that resulting damage was expected.”¹⁶³ Ordinary negligence has not been deemed sufficient reason to conclude that sexual abuse was “expected” by a supervisor or employer. In such instances, the “expected” prong has not been deemed to bar coverage.¹⁶⁴

The requisite level of “expectation” was well-explained in a homeowners insurance case in which the underlying complaint alleged that the parents had knowledge of their son’s deviant sexual propensities, and that he was a “continuing danger” to the claimant.¹⁶⁵ These facts, the court held, showed that “as competent adults, [the insureds] would have at least *expected* harm to result to [the claimants] as a result of their conduct.”¹⁶⁶ Similarly, under New Jersey law, if a spouse, even if ignorant of the actual abuse, has “special reason to know that it was likely to occur,” no insurance coverage exists. “Although the bodily injury for which she was being sued may have been unintended from her perspective ... it was not unexpected; consequently, it was not an accident from her perspective and it was outside the coverage of the policy.”¹⁶⁷

In a recent decision, an Ohio court of appeals observed that an insured’s denial of intent to harm was irrelevant when the act in question was “substantially certain to result in injury.”¹⁶⁸ There, the court held:

¹⁶³ *Diocese of Winona v. Interstate Fire & Cas. Co.*, 89 F.3d 1392 (8th Cir. 1996) (applying Minn. law) (citing *Auto Owners Ins. Co. v. Jensen*, 667 F.2d 714, 719 (8th Cir. 1981)).

¹⁶⁴ *See, e.g., Lutheran Benevolent Ins. Co. v. Nat’l Catholic Risk Retention Grp., Inc.*, 939 F. Supp. 1506, 1512-13 (N.D. Okla. 1995) (distinguishing ordinary negligence, which may give rise to a covered “occurrence,” from gross negligence, which may not); *accord* *Am. Family Mut. Ins. Co. v. Bower*, No. 1:07 CV 254, 2010 WL 4630486 (N.D. Ind. Nov. 5, 2010).

¹⁶⁵ *W. Va. Fire & Cas. Co. v. Stanley*, 602 S.E.2d 483, 498 (W.Va. 2004).

¹⁶⁶ *Id.* at 497.

¹⁶⁷ *J.C. v. Allstate Ins. Co.*, 762 A.2d 1062, 1064 (N.J. Super. Ct. App. Div. 2000) (citing *Allstate Ins. Co. v. Steele*, 74 F.3d 878, 880 (8th Cir. 1996)).

¹⁶⁸ *Cincinnati Ins. Co. v. Oblates of St. Francis de Sales*, No. L-09-1146, 2010 WL 3610451, at *4 (Ohio Ct. App. Sept. 17, 2010).

Based upon the Oblates' knowledge of Rapp's history and his need for supervision and ongoing treatment, the Oblates' decision to give Rapp unfettered access to Assumption's parishioners, without warning, was substantially certain to result in additional incidents of sexual molestation of boys. Accordingly, we find that the Oblates' actions did not cause accidental injury to Rapp's victim.¹⁶⁹

"Rather," the court concluded, "the injury to Rapp's victim was expected, *i.e.*, substantially certain to occur, and, therefore, the Oblates' actions were not 'occurrences' pursuant to CIC's policy."¹⁷⁰

Applied in this manner, the "expected" standard is akin to a gross negligence standard.¹⁷¹ Thus, where the claimant alleged that the perpetrator had a history of mistreating and assaulting female employees, and the supervisor-insured knew of at least one incident where the perpetrator had assaulted an employee, the court concluded the insured "knew full well what was potentially going to happen with their son [the employee-perpetrator] and the female employees and did not care."¹⁷² The insurer demonstrated that the perpetrator's "conduct was foreseeable and not unexpected" on the part of the supervisor. Thus, with a negligent hiring claim, "foreseeability of harm to the plaintiff is a prime factor in the duty analysis."¹⁷³ The court concluded: "Under such circumstances, we cannot conclude that the negligent hiring and supervision ... was an 'occurrence' or 'accident' within the meaning of the policy."¹⁷⁴

¹⁶⁹ *Id.*

¹⁷⁰ *Id.*

¹⁷¹ "Ordinary negligence" has been defined as "want of ordinary care and diligence" where "gross negligence" is defined as the "want of slight care and diligence." *See* Lutheran Benevolent Ins. Co. v. Nat'l Catholic Risk Retention Grp. Inc., 939 F. Supp. 1506, 1512 (N.D. Okla. 1995).

¹⁷² *Mountain States Mut. Cas. Co. v. Hauser*, 221 P.3d 56, 58 (Colo. App. 2009).

¹⁷³ *Id.* at 61 (citing *Raleigh v. Performance Plumbing & Heating, Inc.*, 130 P.3d 1011, 1016 (Colo. 2006)).

¹⁷⁴ *Id.* In light of the high degree of foreseeability required to establish negligent hiring/supervision, the court indicated that injury in such cases may, by definition, be "expected" (and thus ineligible for insurance coverage), though the court did not need to decide the point in light of the allegations that the insured knew of prior incidents.

“The terms ‘expected’ and ‘intended’ are not synonymous...; expectation is easier to prove...”¹⁷⁵ “Intended” injury will always be “expected,” but “expected” injury may not have been intended. This distinction between “expected” and “intended” is of the greatest significance where the insured was not the sexual abuser, and may not have intended injury. For example, a religious institution might be deemed to have “expected” its employee to sexually molest minors if that employee had a significant history of inappropriate conduct concerning minors.

In sum, “expected” appears to present a lower threshold than “intended,” coming into play in circumstances when the insured-supervisor’s error is principally one of omission rather than of commission. “Injury is ‘expected’ even when the damages are not accomplished by design or plan, *i.e.*, not ‘intended,’ but are ‘of such a nature that they should have been reasonably anticipated (expected) by the insured.’”¹⁷⁶ As the Eighth Circuit concluded, “[t]he difference between damages that are reasonably foreseeable and damages that are substantially probable is one of degree of expectability.”¹⁷⁷

D. DECISIONS CONSIDERING WHETHER “NEGLIGENT SUPERVISION” CAN EVER BE AN “OCCURRENCE”

A significant number of courts have concluded explicitly or implicitly that negligent supervision is, by itself, an “occurrence,”¹⁷⁸ and such courts will “examine the injuries arising from the negligent act on their own accord, not as part of the negligent acts.”¹⁷⁹

Decisions holding to the contrary, however, have reasoned that the tort of negligent supervision requires, as an essential element, damage to a

¹⁷⁵ *Argento v. Vill. of Melrose Park*, 838 F.2d 1483, 1497 (7th Cir. 1988) (applying Ill. law).

¹⁷⁶ *Westfield Mut. Ins. Co. v. Cont’l Cmty. Bank & Trust Co.*, 804 N.E.2d 601, 608 (Ill. 2003).

¹⁷⁷ *Diocese of Winona v. Interstate Fire & Casualty Co.*, 89 F.3d 1386, 1392 (8th Cir. 1996) (citing *Auto-Owners Ins. Co. v. Jensen*, 667 F.2d 714, 719 (8th Cir. 1981)).

¹⁷⁸ *See, e.g., Safeco Ins. Co. v. White*, 913 N.E.2d 426, 434 (Ohio 2009) (“torts like negligent supervision, hiring, retention, and entrustment are separate and distinct from the related intentional torts [committed by other actors] that make the negligent tort actionable.”).

¹⁷⁹ *Id.*

third party.¹⁸⁰ “The elements of a claim for negligent hiring are: (1) a specific tortious act by the employee; (2) the employee’s incompetence or unfitness; (3) the employer’s actual or constructive notice of the employee’s incompetency or unfitness; and (4) injury.”¹⁸¹ Absent the fourth element – “injury” – nothing of legal significance has “occurred.” As was said in another context, “negligence in the air, so to speak, will not do.”¹⁸² Hiring, supervision, and retention that fall short of the standard of care, without causing injury, are of no legal consequence.

A line of decisions reasons that, in cases of negligent supervision or hiring, the “accident,” for purposes of considering whether an “occurrence” happened, remains the injury-causing event – such as sexual molestation – rather than any precipitating negligence by the insured. The term “accident,” it has been held, “unambiguously refers to the event causing the damage, not the earlier [negligent hiring] creating the potential for future injury.”¹⁸³ Courts in Illinois and in the Eleventh Circuit have observed that a claim for negligence against an insured-employer does *not* transform a non-accident (sexual molestation) into an accident, even if the insured-employer did not expect harm.¹⁸⁴ In *SCI Liquidating Corp. v. Hartford Ins. Co.*, for example, the Eleventh Circuit Court of Appeals held that allegations of intentional sexual harassment, assault, and battery against a manager, which formed the predicate for a claim of “negligent retention” by the employer, are not ‘accidents’ and therefore do not constitute an “occurrence.” The insurance coverage inquiry, it has been held, must “focus on the ‘immediately causative circumstances.’”¹⁸⁵ Molestation, a deliberate act, may mean that allegations of mere negligent supervision are irrelevant, because “[t]he intentional act interrupts the causal chain between negligent supervision and injury.”¹⁸⁶

¹⁸⁰ *Canatillo Ind. Sch. Dist. v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa.*, 99 F.3d 695, 705 (5th Cir.1996) (applying Tex. law).

¹⁸¹ *White v. Consolidated Planning, Inc.*, 603 S.E.2d 147 (N.C. 2004), *rev. denied*, 610 S.E.2d 717 (N.C. 2005).

¹⁸² *Palsgraf v. Long Island R.R.*, 162 N.E. 99, 99 (N.Y. 1928), *cited in* *Cooper v. Eberly*, 508 P. 2d 943 (Kan. 1973).

¹⁸³ *Maples v. Aetna Cas. & Sur. Co.*, 148 Cal. Rptr. 80, 84 (Cal. Ct. App. 1978), *cited in* *Northern Sec. Ins. Co. v. Perron*, 777 A.2d 161, 162 (Vt. 2001).

¹⁸⁴ *Sears, Roebuck & Co. v. Nat’l Union*, 772 N.E.2d 247, 256 (Ill. 2002); *SCI Liquidating Corp. v. Hartford Fire Ins. Co.*, 181 F.3d 1210, 1214-17 (11th Cir. 1999).

¹⁸⁵ *SCI*, 181 F.3d at 1216-17 (applying Ga. law).

¹⁸⁶ *TIG Ins. Co. v. Premier Parks*, No. Civ.A.02C04126JRS, 2004 WL 728858, at *10 (Del. Super. Ct. Mar. 10, 2004).

In another case, the court considered a sexual assault lawsuit brought against the owner of a cab company that had hired a cab driver who sexually assaulted his customer. The court held that whether or not the cab company “expected or intended injury” was beside the point. Its hiring of the molester was not the accident. The cab company’s acts or omissions “merely created the potential for injury ... but was not itself the cause of the injury.”¹⁸⁷ And in a case of negligent supervision against a woman whose son committed murder, the court reasoned: “[t]hrough myriad other events of an earlier time and different place may have contributed to the claimed injury, to determine whether there was an ‘occurrence’ within the meaning of the policy we must focus on those events directly responsible for the injury.”¹⁸⁸

Each of these decisions reasons that hiring a bad actor, such as a pedophile, may be negligence, but it is not an “accident.” Certainly, negligent hiring may form part of the circumstances contributing to deliberate injury. Nevertheless, negligent hiring is not an “accident” within the ordinary use of that word, these courts observe, and therefore “sexual abuse” claims do not give rise to an “occurrence.” As one court opined, where abuse has been alleged, a negligent supervision claim does not exist without the damage caused by the sexual abuse.¹⁸⁹

E. CLAIMS IN WHICH NEGLIGENCE IS PLED ALONGSIDE FACTS
SHOWING ACTUAL KNOWLEDGE OR INTENT: LOOKING
“BEYOND THE LABEL OF NEGLIGENCE”

An issue of critical significance with regard to an insurer’s duty to defend the insured arises when a sexual molestation complaint pleads facts showing specific knowledge on the part of a religious organization, consistent with an expectation of harm, but adds a count for “negligence” as well. Should such a count be regarded as defeating the expectation of harm reflected by the complaint’s other allegations?

A considerable number of decisions acknowledge that when the complaint alleges facts consistent with an expectation of harm, further allegations that the insured “should have known” of the potential for injury,

¹⁸⁷ *Am. Empire Surplus Lines Ins. Co. v. Bay Area Cab Lease, Inc.*, 756 F. Supp. 1287, 1289-90 (N.D. Cal. 1991).

¹⁸⁸ *Farmers Alliance Mut. Ins. Co. v. Salazar*, 77 F.3d 1291, 1296-97 (10th Cir. 1996).

¹⁸⁹ *Canutillo Ind. Sch. Dist v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa.*, 99 F.3d 695, 705 (5th Cir. 1996) (applying Tex. law).

or that the insured acted “negligently and/or intentionally,” do not override factual allegations indicating intent. It has been said that, even when a complaint pleads a count for negligence, “we must look beyond the label of negligence to determine if the insurer had a duty to defend.”¹⁹⁰

Not all courts agree, and some have allowed a “negligence” allegation to override allegations of specific knowledge. A good example of this methodology is found in the Texas Court of Appeals decision in *Roman Catholic Diocese of Dallas v. Interstate Fire & Casualty Co.*¹⁹¹ There, the sexual abuse victim’s causes of action against the Diocese included:

- (1) failing to warn of known dangerous propensities;
- (2) knowingly breaching and participating in breaches of its fiduciary duties to plaintiff;
- (3) fraud;
- (4) acting with malice and conscious indifference; and
- (5) conspiring to cover up incidents of priests sexually abusing minors.

Notwithstanding these allegations, the Complaint also alleged the Diocese was negligent in hiring and retaining the priest-molester “when it [knew or] should have known of his dangerous sexual propensities.”¹⁹² Based on the “should have known” allegation, the court concluded the insurer was obligated to defend, because the latter allegations did not require the Diocese to have known about the perpetrator’s sexual propensities for the plaintiff to succeed. “Viewed from the Diocese’s viewpoint, if it did not know of [the perpetrator’s] sexual propensities, then his molesting [plaintiff] was both unexpected and unintentional, and [thus potentially] within coverage.”¹⁹³

In contrast, the vast majority of cases considering whether the mere label of negligence overcomes facts demonstrating a higher level of fault have concluded that when allegations of negligent supervision are accompanied by allegations of deliberate misconduct, the supervisor-

¹⁹⁰ *Collins Holding Corp. v. Wausau Underwriters*, 666 S.E.2d 897, 900 (S.C. 2008) (where insured distributed gambling machines equipped so as to permit manipulation, thus violating laws protecting the public from excessive gambling, the allegations failed to support a claim for negligent conduct).

¹⁹¹ *Roman Catholic Diocese of Dallas v. Interstate Fire & Cas. Co.*, 133 S.W.3d 887 (Tex. Ct. App. 2004).

¹⁹² *Id.* at 895.

¹⁹³ *Id.*

insured is not entitled to coverage.¹⁹⁴ Courts long have recognized that the nature of the liability set forth in the complaint is to be “determined by the quality and purpose of the transaction as a whole.”¹⁹⁵ Courts “looking beyond the label of negligence” examine the “‘quality and purpose’ of the complaint as a whole, not simply the use of a word such as ‘negligence.’”¹⁹⁶

In these decisions, the inclusion of a negligence count in the complaint does not trigger coverage when “the facts alleged in the complaint are inconsistent with unintentional conduct or injury.”¹⁹⁷ The nature of a tort action, such courts conclude, is not changed merely by deploying the word, “negligence.”¹⁹⁸ The focus is on the facts alleged rather than a label of “negligence.”¹⁹⁹

In this regard, the Court of Appeals for the Seventh Circuit has observed that the choice of legal theories in the complaint is not important in determining whether an insurance company has a duty to defend. Instead, the question is whether the “conduct as alleged in the complaint is at least arguably within one or more of the categories of wrongdoing that the policy covers.”²⁰⁰ Likewise, in *C.L. by Guerin v. School Dist. of*

¹⁹⁴ See, e.g., *Colony Ins. Co. v. Events Plus, Inc.*, 585 F. Supp. 2d 1148, 1156 (D. Ariz. 2008).

¹⁹⁵ *Messersmith v. Am. Fid. Co.*, 133 N.E. 432 (N.Y. 1921).

¹⁹⁶ *Cont’l Cas. Co. v. Moser*, No. 4:05CV00979 JLH, 2006 WL 827319, at *4 (E.D. Ark. 2006) (quoting *Fisher v. Travelers Indem. Co.*, 398 S.W.2d 892 (Ark. 1966)).

¹⁹⁷ *Serecky v. Nat’l Grange Mut. Ins.*, 857 A.2d 775, 781 (Vt. 2004) (citing *TBH ex rel. Howard v. Meyer*, 716 A.2d 31, 34 (Vt. 1998)).

¹⁹⁸ *Fisher v. Travelers Indem. Co.*, 398 S.W.2d 892 (Ark. 1966); *Standard Fire Ins. Co. v. Proctor*, 286 F. Supp. 2d 567, 572 (D. Md. 2003).

¹⁹⁹ “We must focus on the factual allegations in [the underlying complaint] and not on the legal theories asserted, and unless the complaint alleges facts within the coverage of the policies, [the insurer] has no duty to defend of indemnify.” *Meyer*, 716 A.2d at 34. See also *Carolina Cas. Ins. Co. v. Pinacol Assur. Co.*, 425 F.3d 921, 929 (10th Cir. 2005); accord *Colony Ins. Co. v. Events Plus, Inc.*, 585 F. Supp. 2d 1148, 1154-55 (D. Ariz. 2008) (“To conclude otherwise would only allow the parties to render such exclusions essentially meaningless through artful pleadings and would allow them to circumvent the terms and intent of the policy and its exclusions.”); *Link Snacks Inc. v. Fed. Ins. Co.*, No. 08-cv-714-slc, 2009 WL 3380383 (W.D. Wis. Oct. 20, 2009).

²⁰⁰ *Curtis-Universal, Inc. v. Sheboygan Emergency Med. Servs., Inc.*, 43 F.3d 1119, 1122 (7th Cir. 1994) (applying Wis. law). See also *St. Paul Fire and Marine Ins. Co. v. Hausman*, 604 N.W.2d 908, 911-12 (Wis. Ct. App. 1999) (“We

Menomonee Falls,²⁰¹ the court concluded that an insurance company was not obligated to defend an insured against a claim labeled “negligence” in the complaint, even though the policy – like any standard liability insurance policy – covered negligent conduct. The court observed that “the facts alleged involved sexual abuse (which is intentional conduct by definition),” and thus the complaint did not state a claim that would be covered by the policy. The legal theory denominated in the complaint was therefore irrelevant.

This approach may be particularly apt in sexual abuse cases involving the alleged “negligence” of a supervisor or employer. In such cases, courts have discounted nominal allegations of negligence when they are side-by-side with allegations of actual knowledge or purposeful action. Thus, in an insurance action brought by parents of the alleged molester, the court held: “Although the word ‘negligent’ is used in their allegations against [the parent-insureds], intentional conduct is actually described. For example, the complaint alleges that Glen and Helen Stanley had *actual* knowledge that Jesse possessed deviant sexual propensities and was a continuing danger to [the victim], but that they *permitted* him to continually sexually abuse and sexually exploit [the victim] [as a result of their conduct].”²⁰² These decisions analyze whether allegations such as “should have known” override allegations of specific knowledge.

The logic is worth exploring. Consider the following hypothetical allegations:

The Insured employer:

- (1) knew the molester had molested minors before;
- (2) knew the molester aimed to molest minors again;
- (3) knew and/or *should have known* the molester was a threat to minors.

In this example, does the inclusion of “should have known” in the third allegation mean the insured did not expect molestation? Only if the first two allegations are (improperly) overlooked. To illustrate, consider another analogous example:

determine whether insurance coverage exists by focusing on the incident itself and not the theory of liability.”).

²⁰¹ C.L. and T.W. *ex rel.* Guerin v. Sch. Dist. of Menomonee Falls, 585 N.W.2d 826, 830 (Wis. Ct. App. 1998).

²⁰² W. Va. Fire & Cas. Co. v. Stanley, 602 S.E.2d 483, 498 (W. Va. 2004).

The Apartment Building:

- (1) Has its top floor on the eighth floor.
- (2) Has an elevator with buttons one through eight.
- (3) Contains up to eight, and at least four, stories.

Does the equivocal third paragraph permit the conclusion that the building is less than eight stories high? Not in light of paragraphs one and two. So too in the first example above, the equivocal “and/or should have known” in paragraph three does not mean – in light of paragraphs one and two – that something other than intentional harm has occurred.

Such cases may be contrasted with the common claim of “negligence” involving a bouncer or similar employee of an insured tavern employer, who batters a bar patron, subjecting the insured to liability. In such cases, when the facts may equally suggest (i) an intent to injure, or (ii) merely an intent to relocate the patron outside the establishment, courts have found a potential “occurrence” under liability policies.²⁰³ The difficulty of judging specificity of intent in a situation where persons may or may not be acting to avoid injuries to third parties, rather than cause injuries, explains why the “bar patron” cases, with some justification, tend to find the alleged injury was neither “expected nor intended.”²⁰⁴ It is rare in such cases to find specific facts demonstrating both expectation of harm and intent to harm, in contrast to many clergy sexual abuse cases.

F. CONSPIRACY ALLEGATIONS AND “NEGLIGENCE”

Clergy abuse lawsuits in particular often allege a conspiracy among church officials to conceal, if not to permit, abuse by clergymen. Such complaints may allege a fact-based pattern of concerted efforts. For example, allegations against a religious order that supervised a priest accused of molestation stated that the supervisors:

agreed or otherwise conspired to cover up incidents of sexual abuse of minors by Salesian priests and/or educators and to prevent disclosure,

²⁰³ *E.g.*, *Britamco Underwriters, Inc. v. Weiner*, 636 A.2d 649 (Pa. Super. Ct. 1994); *cf.* *Gene’s Restaurant, Inc. v. Nationwide Ins. Co.*, 548 A.2d 246 (Pa. 1988).

²⁰⁴ *See Sans, et al. v. Monticello Ins. Co.*, 676 N.E.2d 1099 (Ind. Ct. App. 1999) (shooting that occurred during a bar fight did not necessarily mean the shooter “intended” injury).

prosecution and civil litigation including, but not limited to: failure to report incidents of abuse to law enforcement or child protection agencies; denial of abuse [they] had substantiated; aiding criminal child molesters in evading detection, arrest and prosecution; allowing criminal child molesters to cross state and international borders for purposes of gaining access to uniformed parents whose innocent children could be sexually abused; failure to warn; and failure to seek out and redress the injuries its priests and/or educators had caused.²⁰⁵

Conspiracy allegations do not reflect mere negligence, because the tort of civil conspiracy involves “actions intended by the insured” and therefore does not “meet the definition of ‘occurrence’” under the policy at issue.”²⁰⁶ There is no such thing as a “negligent conspiracy.” There is, rather, “a conscious, decision making [sic] element that takes civil conspiracies out of the range of behavior encompassed within the meaning of ‘occurrence.’”²⁰⁷

For these reasons, conspiracy allegations have generally been fatal to claims for insurance coverage, even when the underlying complaint includes allegations of “negligence.”²⁰⁸

G. THE “BODILY INJURY” REQUIREMENT

Standard commercial general liability policies provide coverage only for “Personal Injury” or “Bodily Injury.” Under such policies, even if injury was neither “expected nor intended,” and even if the injury was the result of an “accident,” there is no coverage unless the claimant suffered “bodily injury.”

Such injury sometimes is defined to mean: “bodily injury or if arising out of bodily injury, mental anguish.” “Bodily Injury” frequently is

²⁰⁵ *Nunnery v. Salesian Missions, Inc.*, No. 07-2091, 2008 WL 1743436, at *7 (D.N.J. Apr. 15, 2008).

²⁰⁶ *State Bancorp Inc. v. U.S. Fid. & Guar. Ins. Co.*, 483 S.E.2d 228 (W. Va, 1997), *quoted in* *W. Va. Fire & Cas. Co. v. Stanley*, 602 S.E.2d 483, 495 (W. Va. 2004).

²⁰⁷ *Fibreboard Corp. v. Hartford Accident & Indem. Co.*, 20 Cal. Rptr. 2d 376, 387 (Cal. Ct. App. 1993).

²⁰⁸ *See id.*

defined in commercial general liability policies to mean “bodily injury, sickness, or disease.” In contrast, other standard form policies define “bodily injury” to include mental harm, defining “bodily” or “personal injury” as “bodily injury, shock, mental anguish, sickness or disease, including death at any time resulting therefrom.”

Sexual abuse claims range from an abuser masturbating while in proximity to a plaintiff, to instances of penetration, including penetration resulting in physical damage. Sexual abuse involving clergy has included penetration by objects, penile or digital penetration, vaginally or anally, as well as oral copulation. Physical injury sometimes is alleged, though often complaints allege harm limited to “anxiety, embarrassment, and emotional distress.”

In considering whether the alleged sexual abuse equates to “bodily injury,” a number of courts have concluded that emotional damages arising from sexual molestation may constitute “bodily injury” under a commercial liability policy.²⁰⁹ These courts have held that bodily touching alone is a sufficient predicate to support coverage. Other courts, reasoning that physical *injury* and physical *touching* are not synonymous, conclude that emotional damage (even if arising from touching) is not “bodily injury.”²¹⁰ They have held that bodily injury, including sickness and disease, “does not include emotional distress, at least where, as here, the distress is not caused by physical trauma.”²¹¹

Quite a few courts have held that various forms of touching and fondling in the course of sexual abuse do not constitute “bodily injury.” A 2005 federal court decision catalogued insurance coverage cases nationwide in which plaintiffs’ private parts had been grabbed, squeezed or fondled, yet no “bodily injury” was deemed to have occurred. The court held: “The phrase ‘bodily injury’ simply cannot be read as synonymous with the phrase ‘physical *contact*.’”²¹² In 2008, the New Mexico Court of Appeals reasoned that “bodily injury” had not occurred where a neighbor molested a child by squeezing her chest through her clothes, and rubbing

²⁰⁹ Wayne Twp. Bd. of Sch. Comm’rs v. Ind. Ins. Co., 650 N.E.2d 1205, 1210 (Ind. Ct. App. 1995); Allstate Ins. Co. v. McCranie, 716 F. Supp. 1440, 1443 (S.D. Fla. 1989); Cnty. of Chemung v. Hartford Cas. Ins. Co., 496 N.Y.S.2d 933, 935 (Conn. Super. Ct. 1985).

²¹⁰ Am. & Foreign Ins. Co. v. Church Sch., 645 F. Supp. 628, 632 (E.D. Va. 1986); Chatton v. Nat’l Union Fire Ins. Co., 13 Cal. Rptr. 2d 318, 323 (Cal. Ct. App. 1992).

²¹¹ Allstate Ins. Co. v. Tozer, 392 F.3d 950, 953 (7th Cir. 2004) (applying Ind. law).

²¹² *Id.*

his hand up and down her leg.²¹³ These touchings “did not include any physical injury such as bruises, scrapes, or cuts.” Rather, the claim was confined to “the physical, cognitive or emotional manifestations of the effects of the sexual touching.”²¹⁴ In insurance cases where the injuries alleged are purely emotional or mental in nature, a number of courts have held that “bodily injury” coverage is not available.²¹⁵ In particular, that reasoning may be difficult to assail when the policy defines “bodily injury” as “bodily injury, sickness or disease,” with no reference to “mental anguish.”

In contrast, physical penetration of the body has been deemed to be a “violation of the bodily integrity of the victim, and therefore an infliction of actual physical injury on her, even if not accompanied by bleeding or broken bones.”²¹⁶ A number of jurisdictions have adopted this analysis.²¹⁷ No court has concluded that physical penetration in the course of sexual abuse would not represent “bodily injury” for purposes of insurance coverage.

The decisions that require some actual physical injury, such as penetration, as a predicate for insurance coverage, may be influenced by the fact that certain insurance policy forms are available to cover emotional damages, distress, and mental anguish. Policy forms that do not include these forms of non-bodily harm more likely will be read to preclude coverage in the absence of some bodily trauma caused by the sexual abuse.

III. CONCLUSION

Clergy sexual abuse and molestation of minors constitutes a grave contemporary social problem. But not all clergy sexual abuse claims can be

²¹³ *Hart v. State Farm Mut. Ins. Co.*, 193 P.3d 565, 568 (N.M. Ct. App. 2008).

²¹⁴ *Id.*

²¹⁵ *Nationwide Mut. Fire Ins. Co. v. Mrs. B.G.*, No. Civ.A. 05-578, 2005 WL 3434137 (W.D. Pa. Dec. 13, 2005) (collecting cases).

²¹⁶ *United Servs. Auto. Ass’n v. Doe*, 792 N.E.2d 708, 744-45 (Mass. Ct. App. 2003).

²¹⁷ See *Prof’l Staffing-A.B.T.S., Inc. v. Ill. Union Ins. Co.*, No. 8:04-CV-793T30EAJ, 2005 WL 2290243, at *1 (M.D. Fla. Sept. 19, 2005); *Allstate Ins. Co. v. Thomas*, 684 F. Supp. 1056, 1059-60 (W.D. Okla. 1988); *Allstate Ins. Co. v. Roefls*, 698 F. Supp. 815, 818, 821 (D. Alaska 1987); *J.C. Penney Cas. Ins. Co. v. M.K.*, 804 P.2d 689 (Cal. 1991); *Allstate Ins. Co. v. Troelstrup*, 789 P.2d 415, 417 n.5 (Colo. 1990) (en banc); *Auto-Owners Ins. Co. v. Gardipey*, 434 N.W.2d 220 (Mich. Ct. App. 1988); *N.N. v. Moraine Mut. Ins. Co.*, 450 N.W.2d 445 (Wis. 1990).

compensated through liability insurance coverage, which commonly excludes acts “that are expected or intended from the viewpoint of the insured.”

In a majority of states today, liability insurance coverage for the molester-insured generally is barred, either under an “objective” or “classic tort” standard for determining intentional acts, or under an “inferred intent” standard when applied to child sexual abuse cases.

The courts have not been uniform, however, in how they treat liability insurance coverage disputes pertaining to the sexual molester’s supervisory employer or religious organization, specifically when the supervisor-insured is sued for the *negligent* supervision, employment, or retention of a sexually abusive priest or clergyman, rather than based on the molester’s *intentional* acts *per se*.

Some courts have held that an underlying insured “occurrence” must also be “accidental,” and therefore “negligent supervision” of a sexual molester can never be an “accident.”²¹⁸

Other courts have applied an “objective” or “classic tort” interpretive standard to liability insurance claims arising out of the negligent hiring, supervision, or retention of a clergyman-molester, including the prominent *Diocese of Winona* case.²¹⁹

It is submitted that the objective *Diocese of Winona* approach applied to liability insurance coverage disputes involving supervisory-insureds of clergy sexual molesters is the better-reasoned interpretive approach for the following reasons: First, the claims of negligent hiring, negligent supervision, and negligent retention brought against church organizations and their supervisors for the sexual abuse of minors by priests or other clergymen all sound in *negligence* which traditionally is based upon an objective “reasonable person” standard of care. Second, this “objective” or “classic tort” standard for determining intentional acts in liability insurance coverage disputes, or alternately the “inferred intent” standard as applied to child sexual abuse cases, is recognized in an overwhelming majority of states, as opposed to the minority “subjective” or “particular insured” standard, based upon strong public policy reasons.

²¹⁸ See, e.g., *Mountain States Mut. Ins. Co. v. Hauser*, 221 P.3d 56, 60 (Colo. Ct. App. 2009). But see *contra* *Safeco Ins. Co. of N. Am. v. White*, 913 N.E.2d 426 (Ohio 2009) (holding that torts like negligent supervision, hiring, and retention are separate and distinct from the related intentional torts committed by the original actor, such as a priest or clergyman-molester).

²¹⁹ See *Diocese of Winona v. Interstate Fire & Cas. Co.*, 89 F.3d 1386 (8th Cir. 1996) (applying Minn. law).

Third, a substantial majority of courts now recognize that the crucial underlying requirement in negligent hiring, negligent supervision, and negligent retention cases is based upon whether the priest or clergyman's supervising church, bishop, diocese, or other religious organization *knew or should have known* of the sexual offender's abuse toward minors—which, again, is an objective standard. Fourth, and of primary importance, the crucial *causation requirement* in both tort law and insurance contract law *also* requires the application of an objective “efficient or predominant cause” interpretive analysis. Thus, in a liability insurance context, if the negligent hiring, negligent supervision, or negligent retention of a sexually abusive priest or clergyman was so *inextricably intertwined with*, and *not independent of*, the priest or clergyman's sexual misconduct, then the supervising church, bishop, diocese, or other religious organization should *not* be covered under generally accepted tort and insurance law causation principles.

In sum, the most commonly litigated issue, as discussed at length in this article, is whether injury resulting from clergy sexual abuse and molestation was “intended” or “expected” by the molester-insured and the supervisor-insured. It is our conclusion that determining this issue according to the “objective” insured test is the better-reasoned approach, and is most in accord with generally accepted tort law and insurance law principles. This means that when the supervisor-insured has knowledge that harm was substantially likely to occur to the sexual abuse victim, then coverage usually will be deemed to have been “intended.” However, this would normally involve a gross negligence standard, rather than an ordinary negligence standard, for precluding coverage.

The “intent” interpretive issue has dominated many liability insurance coverage disputes, sometimes to the exclusion of other important interpretive issues raised by liability insurance policy provisions. The most important of these, which may need to be resolved regardless of whether an insured “intended” injury or not, are: (1) whether the insured “expected” injury; (2) whether the injury arose from an “accident”; and (3) whether “bodily injury” occurred. Courts, policyholders, and insurers must also be prepared to confront each of these issues in the context of insurance claims for sexual abuse.

THE STANDARD OF MATERIALITY FOR MISREPRESENTATIONS UNDER NEW YORK INSURANCE LAW – A STATE OF UNWARRANTED CONFUSION

ANDREW AMER*
LINDA H. MARTIN**

Under New York law, an insurer generally is entitled to rescind an insurance policy if an insured makes a material misrepresentation in the insured's application for insurance. But determining whether or not a misrepresentation is "material" can depend on a variety of questions. This article focuses on materiality from the perspective of the insurer, and how courts, arbitrators and juries are required under New York law to determine if a misrepresentation is material to an insurer in any particular case. In short, in whose eyes does the misrepresentation have to be material? Is the test one of *subjective* materiality — that the *particular* insurer at issue would not have issued the same policy under the same terms had it known the truth, regardless of what any other insurer might have done? Or is the test an *objective* one focused on what a "reasonable insurer" would have done in a similar situation?¹

* Andrew Amer is a litigation partner with the firm of Simpson Thacher & Bartlett LLP. He received his undergraduate degree in engineering from Cornell University and his law degree from the University of Pennsylvania. He has served as national coordinating counsel for various insurers, has represented insurers and reinsurers in coverage actions involving asbestos, pollution, nuclear radiation and other mass tort claims, and is a frequent speaker at insurance and reinsurance coverage seminars.

** Linda H. Martin is a litigation partner with the firm of Simpson Thacher & Bartlett LLP. She received her undergraduate degree in government from Harvard University, and her law degree from Duke University School of Law. Ms. Martin has extensive experience in a broad range of large, complex commercial litigations and international arbitrations. Many of her cases involve insurance issues, and she has represented insurance and reinsurance clients at the counseling, trial, arbitration and appellate levels. Both Ms. Martin and Mr. Amer extend their thanks to Abigail A. Hazlett, Ryan A. Kane, Rita K. Maxwell, Sara A. Ricciardi, Jeffrey Roether, C. Ryan Soots, Lindsay N. Thomas, and Jonathan S. Zelig for their research and other support in the preparation of this note.

¹ As discussed in some of the case law cited in this note, other considerations sometimes analyzed in deciding whether a material misrepresentation has been made—none of which are addressed in this article—might include whether a question on an insurance application called for subjective knowledge of an insured or an objective fact; whether a misrepresentation was innocently or knowingly

In 1937, the New York Court of Appeals directly answered that question in *Geer v. Union Mut. Life Ins. Co.*, making clear that a misrepresentation “is material where it appears that a reasonable insurer would be induced by the misrepresentation to take action which he might not have taken if the truth had been disclosed.”² Thus, New York’s highest court has determined that the test is an *objective one*, not dependent on what the particular insurer at issue would have done.

The subjective-objective distinction has significant ramifications on issues of proof in litigation (including in confidential arbitrations, where the question often arises), and very often has the potential to be case determinative. Under a subjective standard, the insurer claiming there is a material misrepresentation must prove through witness testimony (such as the testimony of its claims representative or underwriter who handled the specific policy at issue), specific language in its own claims manuals, or other similar evidence, that *it* would not have issued the policy on the same terms but for the misrepresentation, regardless of industry practice or what any other insurer would have done. By contrast, under an objective standard, the test of materiality is whether a “reasonable insurer” would have offered the same insurance on the same terms if there had been no misrepresentation. Evidence regarding the particular insurer’s practices (or vagaries) may be one piece of proof in determining the “reasonable insurer” standard, but a “reasonable insurer” test also can be satisfied without any evidence at all of the individual insurer’s practices.

Issues such as these become particularly significant if there are missing witnesses or evidence about the particular insurer’s practices, including evidence lapses that routinely arise with the passage of time. If the underwriter who negotiated the specific policy is no longer with the company, is deceased, or cannot be located, or if claims manuals from years (or often decades) earlier cannot be located, an insurer will have a very difficult time proving what *it* would have done in a specific situation, with respect to a specific policy, if it had known a particular piece of information. Similarly, given that claims often arise years after a policy is written, written communications between the insured and the insurer/underwriter—whether electronic or in hard copy—may no longer exist, once again defeating any chance that an insurer can prevail if a subjective test is applied. By contrast, where evidence of industry practice

made; or whether there is a causal connection between the misrepresentation and later events, among other issues.

² *Geer v. Union Mut. Life Ins. Co.*, 7 N.E.2d 125, 130 (1937).

can be introduced through the testimony of experts who have years of experience in the industry at issue, these issues of proof can be overcome.

With such significance riding on this issue, it is not surprising that the New York Court of Appeals—over 65 years ago—took pains through its decision in *Geer* to make clear that under New York law, an objective, “reasonable insurer” test is to be applied when determining if a misrepresentation is material to an insurer in any particular case. Since then, however, beginning with the subsequent 1939 enactment of New York Insurance Law Section 149 (now codified as New York Insurance Law Section 3105),³ the issue has devolved into a murky quagmire, with disputed interpretations of legislative intent and inconsistent and usually unreasoned pronouncements by lower courts, even though the Court of Appeals has never veered from its “reasonable person” standard and New York’s legislature has never clearly abrogated it. This article explores the wayward history resulting in the current confusion among New York’s lower courts. Despite this wayward history, however, given the clear and unwavering direction from the New York Court of Appeals, which has not been abrogated by any subsequent legislation, courts are obligated to use an objective standard when applying New York law to determine if a misrepresentation is material to an insurer in any particular case.

I. THE COURT OF APPEALS SETS THE STANDARD FOR MATERIALITY IN THE *GEER* CASE

In 1937, the New York Court of Appeals directly addressed the question of what standard governs the question of whether a misrepresentation in an application for insurance is material to an insurer in any particular case. In *Geer*, the plaintiff sought recovery under a life insurance policy after her husband died of carbon monoxide poisoning. The insurer denied coverage on the grounds that the decedent had failed to disclose certain material information in his application for insurance. The application had required the decedent to state whether he had had any treatment at any hospital within the past five years and to list all physicians

³ N.Y. INS. LAW § 3105 (McKinney 1984). In 1984, Insurance Law § 149 was re-enacted as Insurance Law § 3105 but its provisions remained unchanged. For purposes of simplicity, and because many of the cases cited in this article were issued prior to 1984 and thus refer to § 149 rather than § 3105, this article will refer to the statute as § 149. A fuller discussion of the specific provisions of Insurance Law § 149 (now Insurance Law § 3105) is set forth in Part IV below.

he had consulted over the past ten years.⁴ The decedent listed only one physician on his insurance application and failed to disclose that, four years earlier, he had visited another physician and was briefly hospitalized with flu symptoms, after which he was temporarily diagnosed with paratyphoid and ultimately with nervousness.⁵

The plaintiff-insured prevailed at trial, after the jury concluded that the misrepresentation was not material to the risk because the fact that the decedent visited a physician and was diagnosed with nervousness had no effect on the risk of dying of carbon monoxide poisoning.⁶ On appeal, the insurer took issue with the jury instruction on materiality, arguing that it is entirely reasonable for an insurer to inquire into the medical history of an insured and that the mere fact that such an inquiry was made on the application establishes its materiality.⁷ The Appellate Division affirmed, concluding that in light of the evidence, the trial court properly presented the question of materiality to the jury as a question of fact and that the jury's determination was not against the weight of the evidence.⁸ In its decision, the Appellate Division focused on the fact that decedent had been forthcoming with information and that the evidence did not reflect any intent "to suppress the truth or to conceal or evade facts."⁹

The Court of Appeals (New York's highest court) reversed, concluding that the failure to disclose the information was a material misrepresentation and, further, that the misrepresentation was material *as a matter of law*. The Court reasoned that:

[W]here an applicant for insurance has notice that before the insurance company will act upon the application, it demands that specified information shall be furnished for the purpose of enabling it to determine whether the risk should be accepted, any untrue representation, however innocent, which either by affirmation of an untruth or suppression of the truth, substantially thwarts the purpose for which the information is demanded and induces action

⁴ Geer, 7 N.E.2d at 126.

⁵ *Id.* at 126-27.

⁶ *Id.* at 127.

⁷ *Id.* at 131.

⁸ Geer v. Union Mut. Life Ins. Co., 288 N.Y.S. 359, 363 (N.Y. App. Div. 1936).

⁹ *Id.* at 360-62.

which the insurance company might otherwise not have taken, is material as a matter of law.¹⁰

Central to the Court's analysis was its determination that an insurer is free to choose the risks it will assume. As the Court explained:

[The] question in such case is not whether the insurance company might perhaps have decided to issue the policy even if it had been apprised of the truth, the question is whether failure to state the truth where there was duty to speak prevented the insurance company from exercising its choice of whether to accept or reject the application upon a disclosure of all the facts which might reasonably affect its choice.¹¹

Significantly, however, the Court did not limit its decision to the question of whether a misrepresentation was or could be material as a matter of law. Rather, the Court went on to address the central topic of this article: whether materiality of a misrepresentation to the insurer should be judged by an objective or subjective standard. The Court held that "misrepresentations cannot defeat or seriously affect the insurance company's right to reject the application where a disclosure of all the facts could not 'reasonably' affect the choice of the insurer."¹² The Court further explained that "a misrepresentation through concealment of fact in regard to a condition of health or physicians consulted . . . is material where it appears that a *reasonable insurer* would be induced by the

¹⁰ *Geer*, 7 N.E.2d. at 127.

¹¹ *Id.*

¹² *Id.* at 129. It was then and is now settled law in New York that "[r]easonable belief" is an objective standard." *Donovan v. Kaszyski & Sons Contractors, Inc.*, 599 F. Supp. 860, 871 (S.D.N.Y. 1984); *see also* *Agway v. Travelers Indem. Co.*, No. 93-CV-557, 1993 WL 771008, at *12 (N.D.N.Y. Dec. 6, 1993) (holding that policy notice provision formulated in terms of reasonableness gives rise to an objective standard); *Unigard Sec. Ins. Co. v. North River Ins. Co.*, 762 F. Supp. 566, 591 n.9 (S.D.N.Y. 1991), *rev'd in part on other grounds*, 4 F.3d 1049 (2d Cir. 1993) ("Although North River's expert stated that standard should be subjective, his description of the test, based on reasonableness, clearly indicated an objective one."); *People v. Perretta*, 228 A.D. 420, 423 (N.Y. App. Div. 1930) (noting that the use of an objective standard would require an examination of the actions of a reasonable man).

misrepresentation to take action which he might not have taken if the truth had been disclosed.”¹³

In reaching this holding, the Court of Appeals acknowledged that its test was formulated “somewhat different from that approved in *Penn Mut. Life Ins. Co v. Mechanics’ Sav. Bank & Trust Co.* and *Mutual Life Ins. Co. v. Ontario Metal Products Co.*” but that the test was nonetheless “essentially the same” as in those cases.¹⁴ In *Penn Mut. Life Ins. Co.*, the court discussed extensively the admission of evidence on the issue of materiality through “witnesses who had been long engaged in the . . . insurance business,”¹⁵ and a long line of cases handed down by English courts on this question. The *Penn Mutual* court cited numerous instances in which evidence was admitted through industry practitioners and experts with significant knowledge on general underwriting practices, and while various courts rejected the ability of an expert to opine on the ultimate issue of whether a misrepresentation was “material”—a question the courts most frequently determined had to be decided by the jury—few if any of the courts questioned the propriety of admitting evidence of industry practice through these experts.¹⁶ Thus, the *Penn Mutual* court determined as follows:

A fair test of the materiality of a fact is found, therefore, in the answer to the question whether reasonably careful and intelligent men would have regarded the fact, communicated at the time of effecting the insurance, as substantially increasing the chances of the loss insured against. The best evidence of this is to be found in the usage and practice of insurance companies in regard to raising the rates or in rejecting the risk on becoming aware of the fact. If the rates are not raised in such a case, it may be inferred that reasonably careful men do not regard the

¹³ *Geer*, 7 N.E.2d at 130 (emphasis added).

¹⁴ *Id.* (citing *Penn Mut. Life Ins. Co. v. Mechanics’ Sav. Bank & Trust Co.*, 72 F. 413, 423 (6th Cir. 1896), and *Mutual Life Ins. Co. v. Ontario Metal Prod. Co.*, [1925] A.C. 344 (P.C.) 351-52 (appeal taken from Can.)) (internal citations omitted).

¹⁵ *Penn Mut.*, 72 F. at 423.

¹⁶ *See id.* at 427-31. The *Penn Mutual* court also considered whether the rule should be different among fire, health, life, or other types of insurance, ultimately concluding that there was no reason for the rule to differ among these types of insurance. *See id.* at 430.

fact as material. If the rates are raised, or the risk is rejected, then they do.¹⁷

And in *Ontario Metal*, the Privy Council, substantially concurring with the lower court on most issues, stated the rule as whether “had the facts concealed been disclosed, they would not have influenced a reasonable insurer so as to induce him to refuse the risk or alter the premium.”¹⁸

Both the *Penn Mutual* and *Ontario Metal* courts applied an objective, “reasonable insurer” test, which the *Geer* court then explicitly endorsed in determining that an objective test governs under New York law.

II. THE COURT OF APPEALS REAFFIRMS GEER IN SUBSEQUENT YEARS

In the years following *Geer*, the New York Court of Appeals passed over numerous opportunities to revisit, amend, or overturn *Geer*’s objective standard. Just two years after the decision in *Geer*, the New York state legislature re-codified the insurance law. Section 149 of the re-codified insurance law, (which amended and replaced the former New York Insurance Law Section 58 (1906)), included new provisions governing materiality for misrepresentations in insurance contracts,¹⁹ and some have suggested that these new provisions abrogated the holding in *Geer* and provide that whether a misrepresentation is material to an insurer must be determined using a subjective standard. These new insurance law provisions and the cases that arose under them potentially set the stage for a re-evaluation of the objective standard. Yet the New York Court of Appeals never regarded the re-codification as a mandate to depart from the objective standard. In each of the cases it considered following the passage of Insurance Law Section 149, the Court of Appeals continued to cite *Geer*

¹⁷ *Id.* at 429. In reaching this holding, while the court stated that “[m]ateriality of fact, in insurance law, is subjective,” this was because “it concerns rather the impression which the fact claimed to be material would reasonably and naturally convey to the insurer’s mind before the event, and at the time the insurance is effected, than the subsequent actual causal connection between the fact, or the probable cause it evidences, and the event.” *Id.* at 428. In other words, “subjectivity” as used in this context, meant what could or might have happened if events had happened differently, rather than something that could be objectively determined after the fact.

¹⁸ *Mutual Life Ins. Co.*, [1925] A.C. 344 (P.C.) at 351-52.

¹⁹ N.Y. INS. LAW § 149(3) (McKinney 1939).

as good law. To this day, the Court of Appeals has not departed from the objective standard for the materiality of misrepresentations it established in *Geer*.

Since the enactment of Section 149, the Court of Appeals has engaged in a decades-long discussion on the merits of finding materiality *as a matter of law*, without ever changing its position that an *objective*, or “reasonable insurer” test, should be applied in determining whether a misrepresentation is material to an insurer. In *Glickman v. New York Life Ins. Co.*, 50 N.E.2d 538 (N.Y. 1943), decided just four years after the enactment of Insurance Law Section 149, neither the majority nor the dissent even suggested that Section 149 had the effect of replacing the objective standard endorsed by *Geer* with a new subjective standard. The opinions instead focused on whether the omission of a condition unrelated to the insured’s death ought to be found material as a matter of law. The majority affirmed an appellate division reversal of the trial court’s decision in favor of the plaintiff-insured, reasoning that any non-trivial ailment that goes undisclosed should be found material as a matter of law.²⁰ Although the dissent referenced Section 149 as intended “to overcome the legal affect” of *Geer*, it did so only with specific reference to whether materiality should be determined as a matter of law or a question of fact, making clear that this, and not any change to the objective standard test set out in *Geer*, was the purpose of amending Section 149:

The purpose of the Legislature [in passing Insurance Law § 149] is not open to debate Whether a false representation or suppression of a fact for which information is requested by the insurer as a condition antecedent to the completion of a contract of insurance tends to diminish or increase the risk of loss and is material to the risk or whether a breach of warranty, if one such exists, materially increases the risk of loss are no longer questions for the court but *are now questions of fact* which must be determined as such²¹

Equitable Life Assur. Soc. v. Milman, 50 N.E.2d 553 (N.Y. 1943), a case decided the same day as *Glickman*, reversed a lower court decision approving the rescission of a life insurance policy where the insured did not disclose that he had consulted physicians for minor health issues. The

²⁰ *Glickman*, 50 N.E.2d at 540.

²¹ *Id.* at 541 (emphasis added).

Court ruled that a “reasonable construction of the scope of the disclosure required” does not include minor ills that “do not impair [the insured’s] general health.”²² The Court then explicitly reaffirmed the central holding in *Geer*: that the relevant inquiry for materiality is whether the undisclosed facts were ones which “might *reasonably* affect the choice of the insurance company as to whether to accept or reject the application.”²³

Thirty years later, in *Vander Veer v. Continental Casualty Co.*, the Court narrowly ruled to reverse a jury verdict in favor of the insured based on a determination by the jury that there had been no material misrepresentation.²⁴ The questions presented to the *Vander Veer* Court centered on (1) whether the plaintiff misrepresented his health as a matter of law and (2) whether the misrepresentation was material as a matter of law.²⁵ The Court of Appeals found that each question should have been decided as a matter of law, rather than be submitted to the jury.²⁶ In reaching its holding, the Court cited with approval to *Geer* for the proposition that a failure to disclose is equivalent to a false affirmative statement.²⁷ The court did not comment or veer in any way, however, from its holding in *Geer* that whether a misrepresentation is material to an insurer must be determined by an objective or “reasonable insurer” standard.²⁸

The Court took similar action two years later in *Leamy v. Berkshire Life Ins. Co.* where once again it ruled narrowly on the facts in determining that the insured had made two material misstatements by failing to disclose persistent fainting and dizziness, as well as a recent trip to the hospital.²⁹ The *Leamy* Court cited *Geer* for the proposition that the question of whether there has been a material misrepresentation may sometimes be answered by the trier of fact.³⁰ The *Leamy* court never commented, however, on the endorsement of an objective standard in *Geer*, and the *Leamy* ruling focused exclusively on the holding that the insured’s misrepresentations were material as a matter of law.³¹

²² Equitable Life Assur. Soc. v. Milman, 50 N.E.2d 553 (N.Y. 1943).

²³ *Id.* at 554 (emphasis added).

²⁴ *Vander Veer v. Cont’l Cas. Co.*, 312 N.E.2d 156, 157 (N.Y. 1974).

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ *See id.*

²⁹ *Leamy v. Berkshire Life Ins. Co.*, 347 N.E.2d 889, 890 (N.Y. 1976).

³⁰ *Id.*

³¹ Through its decisions in *Vander Veer* and *Leamy*, the Court of Appeals clarified that although the materiality of a misrepresentation is typically treated as

In *L. Smirlock Realty Corp. v. Title Guarantee Co.* the New York Court of Appeals again reaffirmed *Geer* without directly reaching the issue of the standard of materiality, citing to *Geer* with approval in support of the majority's finding that it was "manifest" that certain information "would have affected defendant's choice of insuring the risk covered by the policy issued to plaintiff."³²

Although the Court of Appeals, since *Geer* and since the enactment of Section 149, has not provided further detailed analysis regarding whether materiality should be judged from an objective or subjective standard, it never has disavowed the objective standard it so clearly articulated and established in *Geer*. The Court instead has embarked on a lengthy debate about whether materiality can be decided as a matter of law, and repeatedly has cited *Geer* as good law.

III. THE *GEER* DISSENT SETS THE STAGE FOR UNCERTAINTY

The *Geer* court was not unanimous, with Judge Edward Ridley Finch writing a vigorous dissent. Judge Finch voiced concern that the majority's test for determining materiality improperly treated nearly all

a matter of fact for the jury's consideration under Section 149, materiality can be a matter of law under certain circumstances. Without any further insight from the Court of Appeals, the Appellate Division has construed these cases as allowing the court to decide materiality as a matter of law "where the evidence concerning materiality is clear and substantially uncontradicted." *Kroski v. Long Island Sav. Bank*, 689 N.Y.S.2d 92, 93 (N.Y. App. Div. 1999); *see also Aguilar v. U.S. Life Ins. Co.*, 556 N.Y.S.2d 584, 585 (N.Y. App. Div. 1990). The Appellate Division recently has treated this as a subjective inquiry, finding materiality to be clear and substantially uncontradicted when the insurer presents "documentation concerning its underwriting practices, such as underwriting manuals, bulletins or rules pertaining to similar risks, to establish that it would not have issued the same policy if the correct information had been disclosed in the application." *Precision Auto Accessories, Inc. v. Utica First Ins. Co.*, 859 N.Y.S.2d 799 (N.Y. App. Div. 2008); *see also Shirmer v. Penkert*, 840 N.Y.S.2d 796, 799 (N.Y. App. Div. 2007); *Curanovic v. N.Y. Cent. Mut. Fire Ins. Co.*, 762 N.Y.S.2d 148, 151 (N.Y. App. Div. 2003). Thus, while a subjective standard may be applied in determining materiality for purposes of summary judgment — *i.e.*, that there is uncontroverted evidence that the particular insurer at issue would not have issued the particular policy at issue under the same terms and conditions — a court or jury still is obligated to apply an objective standard if the case proceeds past summary judgment.

³² *L. Smirlock Realty Corp. v. Title Guarantee Co.*, 418 N.E.2d 650, 653 (N.Y. 1981).

misrepresentations, even those innocently made, as material.³³ The dissent flatly rejected the insurer's contention that all misrepresentations or omissions concerning health and consultations with physicians were material as a matter of law.³⁴ According to Judge Finch, such a test unfairly prevented recovery by the insured and vitiated Section 58 of the New York Insurance Law (the precursor to Section 149), which had been enacted to protect insureds by providing that statements in an insurance policy are, in the absence of fraud, representations and not warranties.³⁵ Thus, Judge Finch viewed the majority's holding that a material misrepresentation could be proven as a matter of law simply by demonstrating that the insurer had asked for the information violated Section 58 and unfairly and unjustifiably give too much power to insurers to determine materiality.

Notably, however, Judge Finch did not take issue with the majority's use of an objective, "reasonable insurer" standard for deciding materiality of a misrepresentation. In fact, in his dissent, Judge Finch cited with approval language from the same Sixth Circuit decision cited by the *Geer* majority which held that "[a] fair test of the materiality of a fact is found . . . in answer to the question whether reasonably careful and intelligent men would have regarded the fact, communicated at the time of effecting the insurance, as substantially increasing the chances of the loss insured against."³⁶ The dissent also cited with approval the Privy Council's *Ontario Metal Products* decision referenced by the majority which set forth a "reasonable insurer" standard as the proper test for materiality.³⁷ A close look at the opinions in *Geer* thus reveals that the conflict between the

³³ *Geer v. Union Mut. Life Ins. Co.*, 7 N.E.2d 125, 132 (N.Y. 1937).

³⁴ In so doing, the dissent distinguished cases relied upon by the defendant-insurer on the grounds that they involved instances in which the insured or beneficiary refused to waive the doctor-patient privilege, reasoning that "[o]bviously the courts could not permit the insured or the beneficiary to argue that the omission or misrepresentation was not material while he prevented the insurance company from showing its materiality." *Id.* at 134.

³⁵ *Id.* at 126.

³⁶ *Id.* at 132 (citing *Penn Mut. Life Ins. Co. v. Mechanics Sav. Bank & Trust Co.*, 72 F. 413, 429 (6th Cir. 1896)).

³⁷ *Id.* at 133 (citing *Ontario Metal Products Co. v. Mutual Life Ins. Co.* [1925] A.C. 344 (P.C.) [351–52] (appeal taken from S.C.C.) ("[I]t is a question of fact in each case whether, if the matters concealed or misrepresented had been truly disclosed, they would, on a fair consideration of the evidence, have influenced a *reasonable insurer* to decline the risk or to have stipulated for a higher premium.") (emphasis added)).

majority and dissent was limited to the extent to which materiality could be considered a matter of law. By contrast, with respect to the question addressed in this article—what standard should be applied in determining whether a particular misrepresentation was material to an insurer in any particular case—both the majority and the dissent agreed that an objective or “reasonable insurer” standard applies.

IV. A NEW INSURANCE STATUTE RESULTS IN FURTHER CONFUSION

In 1937, the same year that *Geer* was decided, the Insurance Department of New York began an effort to re-codify the existing insurance law and released tentative drafts of several proposed statutes. This included an initial draft of what later would become Insurance Law Section 149, which, while it was a new statutory provision, essentially restated long-standing common law principles, including those set out in its precursor, Section 58. In the two years between the issuance of *Geer* and the enactment of Section 149, several New York courts cited *Geer*, but without any substantive discussion of whether to apply an objective or subjective standard to determine materiality of a misrepresentation to an insurer.³⁸ As enacted into law two years later, Section 149 provided in relevant part as follows:

(a): A representation is a statement as to past or present fact, made to the insurer by or by the authority of the applicant for insurance or the prospective insured, at or before the making of the insurance contract as an inducement to the making thereof. A misrepresentation is a false representation, and the facts misrepresented are those facts which make the representation false.

³⁸ See e.g., *Wersba v. Equitable Life Assur. Soc. of U.S.*, 1 N.Y.S.2d 677, 679 (N.Y. App. Div. 1938) (citing *Geer* to support its conclusion that a misrepresentation was material as a matter of law); *Equitable Life Assur. Soc. of U.S. v. Schusterman*, 5 N.Y.S.2d 368, 371 (N.Y. App. Div. 1938) (quoting *Geer* to frame the issue of materiality as a determination of “whether the company has been induced to accept an application which it might otherwise have refused,” and not as a determination of “whether the company might have issued the policy even if the information had been furnished.”); *Woodworth v. Prudential Ins. Co.*, 13 N.Y.S.2d 145, 150 (N.Y. Sup. Ct. 1939) (citing *Geer* for the position that an insured can “avoid the policy on the ground of misrepresentation as to a material fact even though such misrepresentation was innocently made.”).

(b): No misrepresentation shall avoid any contract of insurance or defeat recovery thereunder unless such misrepresentation was material. No misrepresentation shall be deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to make such contract.

(c): In determining the question of materiality, evidence of the practice of the insurer which made such contract with respect to the acceptance or rejection of similar risks shall be admissible.³⁹

While the legislature is empowered to overrule unpopular or problematic court decisions if it so desires, it has become a subject of some debate among legal commentators and certain lower courts whether the enactment of Section 149 was, indeed, intended to overrule the two-year old *Geer* decision and, if so, whether in whole or in part.

Those arguing that the legislature intended to overrule *Geer* point to two factors. First, the statute refers throughout to “the insurer,” rather than referring to “an insurer” or “the reasonable insurer.” Second, while an early draft of the statute provided for admissibility of the practices of other insurers (in addition to the practices of the particular insured at issue) for the purpose of determining whether a misrepresentation was material to an insurer, the statute as enacted only refers in subsection (c) to the admissibility of the practices of “the insurer which made such contract,” which some argue makes clear, or at least suggests, that only the practices of the particular insurer at issue are relevant to determining materiality.

A. “THE INSURER” AND “A REASONABLE INSURER”

The repeated use throughout the statute of the phrase “the insurer,” rather than “a reasonable insurer” or “a prudent insurer,” might suggest that the legislature intended to impose a subjective standard for materiality, rather than the objective standard established by the Court of Appeals in

³⁹ N.Y. INS. LAW § 149 (McKinney 1939). Section 149 also contains a subsection (d), which provides that misrepresentations that fail to disclose previous medical treatment by applicants for life or accident and health insurance are deemed to misrepresent that the applicant has not had the disease or ailment for which he or she received treatment. If the insurer proves such a misrepresentation in an action to rescind the insurance contract, then under certain circumstances the misrepresentation is presumed material.

Geer.⁴⁰ And, indeed, some of the legislative history surrounding the enactment of Section 149 suggests as much. A Historical Note to the draft legislation asserts that “[s]ubsection 2 makes the ultimate test the effect of the misrepresentations in inducing the particular insurer.”⁴¹ The Historical Note directly addresses *Geer*, stating that “the majority opinion contains language inconsistent with the rule of subsection 2 above, but the decision in that case was based upon peculiar facts.”⁴²

Notably, however, the Historical Note is internally inconsistent. The Note states that the rule proposed in the draft legislation “is in accord with the able dissenting opinion by Judge Finch” in *Geer*, in which he “relie[d] upon the decision of the Privy Council of England.”⁴³ The commentators appear to suggest by this language that the statute conforms with the *Geer* dissent but not the *Geer* majority. As discussed above in Part I, however, the Privy Council decision cited approvingly by Judge Finch (*Ontario Metal*) applied an *objective* standard of materiality, just like the *Geer* majority.⁴⁴ Moreover, since the *Geer* dissent did not take issue with the majority’s imposition of an objective standard, but rather with the majority’s determination that materiality could be determined as a matter of law, the statement referenced in the Historical Note might be better read as relating to the latter point.

Significantly, the leading commentary on Section 149, published in 1940 and endorsed by the then New York Superintendent of Insurance, explains that the drafters intended Section 149 to codify existing “common law principles long established in the field of insurance.”⁴⁵ As an example of the existing common law, the Commentaries cite to the following holding in *Cox v. C.G. Blake Co.*, 166 N.Y.S. 294 (N.Y. Sup. Ct. 1917):

The duty on the part of the assured to disclose material facts is not limited to facts which have a direct bearing on

⁴⁰ See *Geer*, 7 N.E.2d. at 127.

⁴¹ N.Y. INS. LAW § 149 (McKinney 1939) (Historical Note).

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Ont. Metal Prod. Co. v. Mutual Life Ins. Co. of N.Y.*, [1925] A.C. 344 (P.C.) [352] (appeal taken from S.C.C.) (“In this finding their Lordships substantially concur, although they would have expressed the finding somewhat differently and would have preferred to say that had the facts concealed been disclosed, they would not have influenced a reasonable insurer so as to induce him to refuse the risk or later the premium.”).

⁴⁵ ABRAHAM KAPLAN & GEORGE I. GROSS, COMMENTARIES ON THE REVISED INSURANCE LAW OF NEW YORK (“Commentaries”) 338 (1940).

the extent of the risks or dangers, to which the subject of the insurance will be exposed. *All facts are material which would affect the mind of a rational underwriter, governing himself by the principles on which underwriters in practice act*, as to either of the following points: First, whether he will take the risk at all; second, at what premium he will take it.⁴⁶

The test set out in *Cox*, phrased in terms of whether a fact would “affect the mind of a rational underwriter,” clearly is objective in nature.

B. SUBSECTION (3) OF SECTION 149

While repeated references to “the insurer” in Section 149 have raised questions, subsection (3) and its legislative history have raised even more. As noted above, subsection (3) provides that in determining materiality, “evidence of the practice of the insurer which made such contract with respect to the acceptance or rejection of similar risks shall be admissible.”⁴⁷ This differs from the language originally proposed, which allowed a court to admit evidence “of the practices of the insurer which made such contract *and of other insurers* in reference to the making of similar insurance contracts.”⁴⁸

Some have argued that the omission in the enacted version of the “and of other insurers” language precludes a court from admitting evidence regarding industry custom and practice, thus negating an objective or “reasonable insurer” standard.⁴⁹ The Historical Note following the enacted text provides some support for this argument, stating that “[u]nder the rule laid down by the Privy Council of England the ultimate test is the effect of the misrepresentation upon a ‘prudent insurer.’ Under subsection 3 above,

⁴⁶ Commentaries at 340, citing *Cox v. C.G. Blake Co.*, 166 N.Y.S. 294, 297 (N.Y. Sup. Ct. 1917) (emphasis added) (internal quotation marks omitted).

⁴⁷ N.Y. INS. LAW § 149(3) (McKinney 1939).

⁴⁸ LOUIS H. PINK, INS. DEP’T OF N.Y., INSURANCE LAW REVISION OF THE STATE OF NEW YORK, TENTATIVE DRAFT § 63(4), at 143 (1937) (emphasis added) (the italicized language, subsequently omitted, originally was released in a draft under Art. VII § 63(4)).

⁴⁹ See, e.g., Edwin W. Patterson, *Misrepresentations by Insured under the New York Insurance Law*, 44 COLUM. L. REV. 241, 243 n.16 (1944) (arguing that the “and of other insurers” language “was eliminated in order to avoid possible confusion of the ‘individual insurer’ test, here adopted, with the ‘prudent insurer’ test”).

proof of what a prudent insurer would have done . . . is not the conclusive test.”⁵⁰

However, once again the Historical Note does not clearly rule out an objective test, saying only that a “prudent insurer” analysis is “not . . . conclusive,”⁵¹ and in fact the Historical Note raises more questions than it answers. The Historical Note provides that “proof of what a prudent insurer would have done is merely evidence to show what the insurer in question would have done,”⁵² although as just noted the enacted text makes no reference to the admissibility of evidence relating to industry custom and practice. The Historical Note also provides: “Subsection 3 gives the plaintiff an opportunity to rebut the insurer’s evidence that it would have rejected the application if the misrepresentation had not been relied upon, by permitting the insured to show the practices of other insurers.”⁵³ It is interesting to consider why the Historical Note refers to the admissibility of evidence relating to “practices of other insurers” when the enacted text makes no such reference. Does this indicate that the insured can provide evidence of industry practice only to rebut an insurer’s subjective showing of materiality? One possible explanation is that the Historical Note relates to the earlier draft of the subsection, and does not actually explain the intent behind the statute as finally amended.

Another explanation may be found in the change from the use of the word “may” to the use of the word “shall” in Subsection (3). Draft statute Section 63 (a draft precursor to Section 149) provided that evidence of the practices of other insurers “*may* be admitted in the discretion of the trial court.”⁵⁴ As enacted, the statute only provides the type of evidence that “*shall* be admissible.”⁵⁵ It is very possible that the legislature removed reference to evidence of the practices of other insurers because they wanted to keep its admission at the discretion of the trial court, but chose to ensure the admissibility of evidence of the practices of the individual insurer by making a definitive statement that it “shall be” admissible under all circumstances.

⁵⁰ N.Y. INS. LAW § 149 (McKinney 1949) (Historical Note).

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.*

⁵⁴ PINK, *supra* note 48, at § 63(4) (emphasis added).

⁵⁵ N.Y. INS. LAW § 149(3) (McKinney 1949) (emphasis added).

V. PRACTICES OF OTHER STATES IN APPLYING AN OBJECTIVE OR SUBJECTIVE TEST

The same issues of interpretation present in the New York courts also exist in other jurisdictions. Several states have statutes with language similar to New York's, and courts in those states have interpreted their statutes to support the use of an objective test in determining materiality. While the statutory language in these states, as in New York, ostensibly suggests a subjective test by focusing on the actions of "*the insurer*" in question, the highest courts in these states nevertheless have concluded their statutes support an objective test.⁵⁶

The Supreme Judicial Court of Maine has provided the most thorough analysis on the issue in *York Mutual Insurance Co. v. Bowman*, 746 A.2d 906, 909 (2000). Maine's statutory text finds a misrepresentation to be material when "the insurer in good faith" would have acted differently "if the true facts had been known to *the insurer* as required" by the policy or contract.⁵⁷ Notwithstanding this language, Maine's highest court explicitly held that the test of materiality is whether disclosure by the insured "would have influenced a *reasonable insurer* in deciding whether to accept or reject the risk of entering into the contract, fixing the premium rate, in fixing the amount of insurance coverage, or in providing coverage with respect to the hazard resulting in the loss."⁵⁸ According to the Supreme Court of Maine, the relevant inquiry did not involve the particular instances of the loss in question, but rather an objective examination from the point of view of the "reasonable insurer."⁵⁹ Indeed, the court noted that while there is disagreement among jurisdictions with similar statutes as to other issues relating to materiality, they all used an objective test, stating that the "common factor [among these states] is that materiality is treated as an objective test."⁶⁰

⁵⁶ For the most part, these statutes do not contain a provision similar to § 149(3), regulating the admissibility of evidence of the practices of "the insurer." As discussed below, Michigan is a notable exception.

⁵⁷ ME. REV. STAT. ANN. tit. 24-A, § 2411(2) (1990) (emphasis added).

⁵⁸ *York Mut. Ins. Co. v. Bowman*, 746 A.2d 906, 909 (Me. 2000) (emphasis added).

⁵⁹ *Id.*

⁶⁰ *Id.* (citing *Woods v. Independent Fire Ins. Co.*, 749 F.2d 1493, 1497 (11th Cir. 1985); *Singer v. Nationwide Mut. Fire Ins. Co.*, 512 So.2d 1125, 1128–29 (Fla. Dist. Ct. App. 1987); *Central Nat'l Life Ins. Co. v. Peterson*, 529 P.2d 1213, 1216 (Ariz. Ct. App. 1975); *Massachusetts Mut. Life Ins. Co. v. Allen*, 416 P.2d 935, 941 (Okla. 1965); *John Hancock Mut. Life Ins. Co. v. Conway*, 240 S.W.2d

Arizona's insurance statute governing misrepresentations employs a similar substantive form as that of Maine, also utilizing the phrase "the insurer."⁶¹ Consistent with Maine's highest court, Arizona's Court of Appeals explicitly has held that the statutory language supports an objective rather than a subjective test. The court in *Valley Farms, Ltd. v. Transcontinental Insurance Co.*, 206 Ariz. 349, 353 (Ct. App. 2004) stated that the test for materiality "is whether the facts, if truly stated, might have influenced a reasonable insurer in deciding whether to accept or reject the risk."⁶² The Ninth Circuit, in applying Arizona insurance law in *Mutual Life Insurance Co. of New York v. Morairty*, 178 F.2d 470, 474 (9th Cir. 1950), also explicitly held that the test for materiality under Arizona law is an objective one, explaining that the inquiry is to be examined from the perspective of a "reasonable insurer."⁶³ More recently, in 2008, the Arizona federal district court in *Medical Protective Co. v. Pang*, 606 F. Supp. 2d 1049, 1058 (D. Ariz. 2008) reiterated the previous endorsement of an objective test by holding that "materiality exists if the facts, if truly stated, might have influenced a reasonable insurer in deciding whether to accept or reject the risk."⁶⁴

Florida and West Virginia also have followed suit behind Maine and Arizona in interpreting their respective statutory provisions regarding materiality of misrepresentations as requiring an objective test, despite references to "the insurer" and not "an insurer" or "reasonable insurer" in the statutory language of each state.⁶⁵ Courts in each of these states have interpreted the provision as focusing on how a reasonably prudent insurer

644, 646 (Ky. Ct. App. 1951); *Massachusetts Mut. Life Ins. Co. v. Allen*, 416 P.2d 935, 941 (Okla. 1965); *Powell v. Time Ins. Co.*, 382 S.E.2d 342, 349–50 (W.Va. 1989)).

⁶¹ ARIZ. REV. STAT. ANN. § 20-1109(3) (2010) ("The insurer in good faith would either not have issued the policy, or would have not issued a policy in as large an amount, or would not have provide coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise.").

⁶² *Valley Farms v. Transcontinental Ins. Co.*, 78 P.3d 1070, 1074 (Ariz. Ct. App. 2003).

⁶³ *Mutual Life Ins. Co. v. Morairty*, 178 F.2d 470, 474 (11th Cir. 1949) ("The test of materiality is whether the facts, if truly stated, might have influenced a reasonable insurer in deciding whether to accept or reject the risk; the insurer need not show that it would have rejected the applicant had it known of the falsity of the claim.").

⁶⁴ *Med. Protective Co. v. Pang*, 606 F. Supp. 2d 1049, 1058 (D. Ariz. 2008).

⁶⁵ See FLA. STAT. § 627.409 (2005); W. VA. CODE § 33-6-7(c) (2006).

would have proceeded if not for the misrepresentation.⁶⁶ Georgia's statutory language mirrors that of New York, Florida, Maine, Arizona and West Virginia in its use of the phrase "the insurer."⁶⁷ Both the Eleventh Circuit applying Georgia law and the Court of Appeals of Georgia definitively characterize the standard by which materiality is examined as objective, stating that the "standard has been interpreted to be an objective one."⁶⁸

Michigan is the only state which appears to use language similar to Subsection (3) of New York's Section 149 in its statute governing materiality of misrepresentations.⁶⁹ While historical decisions by Michigan courts have interpreted M.C.L.A. § 500.2218 to require a subjective test, the more recent trend is towards an objective test for determining materiality. Older Michigan case law is explicit in its support of a subjective test, describing the analysis as focused on the "reliance or non-reliance of the particular insurance company involved" and excluding evidence of what other insurers, similarly situated, may have done.⁷⁰ However, more recently, the highest court in Michigan has employed plainly objective language, describing the inquiry as one analyzing the decisions of a "reasonable" insurer.⁷¹ Thus, with respect to language in the

⁶⁶ See *Singer v. Nationwide Mut. Fire Ins.*, 512 So.2d 1125, 1128-29 (Fla. Dist. Ct. App. 1987) ("A misrepresentation is material if it does not enable a reasonable insurer to adequately estimate the nature of the risk in determining whether to assume the risk."); *Powell v. Time Ins. Co.*, 382 S.E.2d 342, 350 (W. Va. 1989) (adopting a test for materiality of "whether a reasonably prudent insurer would consider the misrepresentation material to the contract").

⁶⁷ GA. CODE ANN. § 33-24-7(b)(3) (2003) ("The insurer in good faith would either not have issued the policy or contract or would not have issued a policy or contract in as large an amount or at the premium rate as applied for or would not have provided coverage with respect to the hazard resulting in the loss of the true facts had been known to the insurer as required either by the application for the policy or contract or otherwise.").

⁶⁸ *Am. Gen. Life. Ins. Co. v. Schoenthal Family L.L.C.*, 556 F.3d 1331, 1340 (11th Cir. 2009); *Lively v. S. Heritage Ins. Co.*, 568 S.E.2d 98, 100 (Ga. Ct. App. 2002).

⁶⁹ See MICH. COMP. LAWS. § 500.2218 (2008) ("In determining questions of materiality, evidence of the practices of the insurer which made such contract with respect to the acceptance or rejection of similar risks shall be admissible.").

⁷⁰ See *Mannino v. Dominion Life Assurance Co.*, 539 F. Supp. 323, 327 (E.D. Mich. 1982); *Clark v. John Hancock Mut. Life Ins. Co.*, 447 N.W.2d 783, 785 (Mich. Ct. App. 1989).

⁷¹ See *Oade v. Jackson Nat'l Life Ins. Co. of Mich.*, 632 N.W.2d 126, 131 (Mich. 2001) (The "inquiry under the statutory 'materiality' test is whether a

Michigan statute similar to Subsection (3) of Section 149, the current trend in Michigan law supports the conclusion that Michigan courts read their statutory language as requiring an objective test when determining materiality.

It therefore is clear from a survey of the case law of various other states that courts in those states have applied an objective test when determining materiality despite references to “the insurer” in their statute.⁷²

VI. POST-*GEER* APPLICATION OF A SUBJECTIVE STANDARD BY LOWER COURTS IN NEW YORK

A. POST-*GEER* RULINGS APPLYING NEW YORK LAW

Since the enactment of Section 149, many lower courts in New York have departed from *Geer*’s objective standard, and instead have determined materiality based on how the specific insurer at issue would have acted if it had known the true facts. It is entirely unclear, however, how these courts have determined which standard to apply, and even less clear that they collectively could or have established a new regime of subjectivity in New York. No court in New York, either appellate or otherwise, has ever expressly stated that *Geer* no longer is good law on the

reasonable underwriter would have regarded [the plaintiff’s revised answers to the health questionnaire] sufficient grounds for rejecting the risk or charging an increased premium . . .”).

⁷² It is important to note that California courts, cited for their steadfast adherence to the subjective test in determining materiality, have interpreted vastly different statutory language when making that determination. Rather than leaving the interpretative burden to their courts, the California legislature specifically defined materiality as a subjective test inquiry. *See* CAL. INS. CODE § 334 (2005) (“Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due, in forming his estimate of the disadvantages of the proposed contract, or in making his inquiries.”); *Superior Dispatch, Inc. v. Ins. Corp. of N.Y.*, 181 Cal. App. 4th 175, 191 (2010) (explaining that the test of materiality is a “subjective test view from the insurer’s perspective”); *Coca Cola Bottling Co. v. Columbia Cas. Co.*, 11 Cal. App. 4th 1176, 1189 n.4 (1992). The only other state which appears to use language similar to that in the California statute is North Dakota. *See* N.D. CENT. CODE § 26.1-29-17 (2010) (“Materiality is to be determined not by the event, but solely by the probable and reasonable influence of the facts upon the party to whom the communication is due in forming the party’s estimate of the disadvantages of the proposed contract or in making the party’s inquiries.”). While still good law, the North Dakota statute has been cited only a handful of times.

issue of applying an objective standard for determining whether a misrepresentation is material to an insurer.

In fact, not one lower New York court appears to have conducted a thorough analysis into Section 149's ambiguous and inconsistent legislative history.⁷³ The lower court dockets frequently have encountered cases, however, that involved the use of or reference to a subjective or objective standard, even in cases where the standard itself was not at issue. Without additional guidance from the highest court, the lower courts have wandered and sometimes departed from the objective standard precedent of *Geer*. The lower courts often wander and depart from *Geer* by using phrases like "the insurer" instead of "an insurer," but without even realizing they have made a choice between two very different standards. Indeed, in many cases, the lower courts have assumed the standard to be subjective without actually justifying that assumption. Despite arguments from some commentators, however, these lower court rulings do not amount to an abrogation of *Geer*, nor do they constitute a justifiable shift away from the objective standard.

There are several prominent examples among these cases. In *Metropolitan Life Ins. Co. v. Goldberger*, the trial court rejected plaintiff insurance company's action to rescind defendant's insurance policies when it ruled as a matter of law that the misrepresentations made on plaintiff's applications were not material.⁷⁴ The court opined that misrepresentations could be material only if "knowledge by the insurer of the facts misrepresented would have led to its refusal to issue the policy."⁷⁵ In support of using a subjective standard, the court cites a 1944 note in the *Columbia Law Review* entitled *Misrepresentation by Insured Under the New York Insurance Law*.⁷⁶ This note clearly is not an authoritative source on the meaning of Section 149 and most certainly does not trump the law set down by the New York Court of Appeals in *Geer*.

Other more recent New York cases where lower courts appear to embrace a subjective test for materiality include rulings in *Zilkha v. Mut. Life Ins. Co. of N.Y.* ("A misrepresentation is material if *the* insurer would

⁷³ Of course, the Court of Appeals, the highest court in New York, also has not conducted a thorough analysis of this issue since the enactment of Section 149.

⁷⁴ *Metro. Life Ins. Co. v. Goldberger*, 155 N.Y.S.2d 305, 306 (N.Y. Sup. Ct. 1956).

⁷⁵ *Id.*

⁷⁶ *Id.* (citing Edwin W. Patterson, *Misrepresentation by Insured Under the New York Insurance Law*, 44 COLUM. L. REV. 24 (1944)).

not have issued the policy had it known the facts misrepresented.”⁷⁷ and *Feldman v. Friedman* (“A fact is material so as to avoid ab initio an insurance contract if, had it been revealed, *the* insurer or reinsurer would either not have issued the policy or would have only at a higher premium.”),⁷⁸ both appellate level decisions handed down in 2001 and 1997, respectively.⁷⁹ Because the courts fail to offer robust explanations of their rulings, it is not particularly clear whether they have endorsed or applied a subjective standard based on a thorough examination of the legislative history and case law. In fact, in each of these cases—as appears to be the case in decisions by many other courts—references to “the” insurer, which arguably imply subjectivity, may simply be a loose choice of words not intended to have any precedential or substantive meaning. Indeed, these two appellate court decisions provide only a cursory quotation to the term “the insurer” in the statutory text or cite to past decisions that also use subjective language without explanation. None of these sources constitutes a binding interpretation of the statute, and none of them amounts to an abrogation of the standard set forth by the Court of Appeals in *Geer*.

Another case which has engendered significant confusion among lower courts is the Appellate Division’s decision in *Aguilar v. U.S. Life Insurance Company*.⁸⁰ In *Aguilar*, the court encountered an appeal of summary judgment entered in favor of the insurance company, which had moved to rescind the life insurance policy of plaintiff for failure to disclose certain mental disorders.⁸¹ The court actually cited *Geer* throughout, yet

⁷⁷ *Zilkha v. Mut. Life Ins. Co. of N.Y.*, 732 N.Y.S.2d. 51, 52 (N.Y. App. Div. 2001) (emphasis added).

⁷⁸ *Feldman v. Friedman*, 661 N.Y.S.2d. 9, 10 (N.Y. App. Div. 1997) (quoting *Christiana Gen. Ins. Corp. v. Great Am. Ins. Co.*, 979 F.2d 268, 278 (2d Cir. 1992)) (emphasis added).

⁷⁹ For further examples see *Penn Mut. Life Ins. Co. v. Remling*, 268 A.D.2d 572, 573 (N.Y. App. Div. 2000) (citing Insurance Law § 3105(b) and *Gugleotti v. Lincoln Sec. Life Ins. Co.*, 234 A.D.2d. 514 (N.Y. App. Div. 1996), to support the proposition that “for a misrepresentation to warrant the voiding of an insurance policy, the misrepresentation must be material, meaning that had *the insurer* known the truth, it would not have issued the policy.”) (emphasis added); *Gugleotti*, 234 A.D.2d. at 514-15 (finding that revelation of scuba diving activities would have resulted in a different classification of the insured by *the insurance company* and permitting the insurance company to rescind the policy) (emphasis added).

⁸⁰ *Aguilar v. U.S. Life Ins. Co.*, 162 A.D. 209, 211 (N.Y. App. Div. 1990).

⁸¹ *Id.* at 209-10.

also repeatedly referred to what “the insurer” would have done, seemingly applying, based on *Geer*, a subjective test on materiality. Thus, the *Aguilar* case quotes *Geer* for the proposition noting that a showing that the misrepresentation “substantially thwarts the purpose for which the information is demanded and induces action which the insurance company might otherwise not have taken.”⁸² The court also includes the following cite from *Geer*: “The question in such case is not whether the company *might have issued* the policy even if the information had been furnished; the question in each case is whether the company had been induced to accept an application which it *might otherwise have refused*.”⁸³ The *Aguilar* court then “appl[ies] this test” and affirms the lower court.⁸⁴ But what test did the court apply, exactly? The language from *Geer* cited in *Aguilar* cannot resolve the issue because it only tells half the story. Gone from *Aguilar* is the language of the “reasonable” or “prudent” insurer that featured so prominently in *Geer* and that is critical to the quotations lifted out of context by the court in *Aguilar*. And deciding whether an objective or subjective standard applies was not central to the issue decided by the *Aguilar* court.

Even more problematic and egregious is the ruling in *Greene v. United Mut. Life Ins. Co.*,⁸⁵ in which the trial court rejected the jury’s findings and granted a directed verdict in favor of the insured as to whether material misrepresentations had been made. Here, the trial court directly took on the question of “[w]hat constitutes a material misrepresentation sufficient to justify an avoidance of the policy.”⁸⁶ The trial court referred to the Corpus Juris Secundum which stated “the test to be ‘whether knowledge of the true facts would have influenced a prudent insurer in determining whether to accept the risk or in fixing the amount of premiums.’”⁸⁷ The *Greene* court then continued, reaching a shocking conclusion:

However, the test in New York has been laid down by its Court of Appeals in *Geer v. Union Life Ins. Co.* It gives a narrower test, it is not the test of what any other

⁸² *Id.* at 210-211 (quoting *Geer v. Union Mut. Life Ins. Co.*, 273 N.Y. 261, 271) (1937)).

⁸³ *Id.* at 211 (quoting *Geer*, 273 NY at 269) (emphasis in original).

⁸⁴ *Id.*

⁸⁵ *Greene v. United Mut. Life Ins. Co.* 38 Misc. 2d 728 N.Y.S. 2d 809, 815-16 (N.Y. Gen. Term 1963).

⁸⁶ *Id.* at 731, 813.

⁸⁷ *Id.* (citing 45 C.J.S. *Insurance* § 595).

insurance company would have done, but what the particular insurance company might have done. It is not the test stated in the dissenting opinion of that case, quoting from an opinion in the Federal reports of Judge, later Chief Justice TAFT, i.e. “whether reasonably careful and intelligent men would have regarded the fact, communicated at the time of effecting the insurance, as substantially increasing the chances of loss insured against.” Judge LEHMAN, speaking for the court, declared the test to be “The question . . . is not whether the company *might have issued* the policy even if the information had been furnished; the question in each case is whether the company *might have issued* the policy even if the information had been furnished; the question in each case is whether the company has been induced to accept an application which it *might otherwise have refused*.”⁸⁸

One has to wonder if the *Greene* court simply stopped reading the *Geer* opinion after a few pages, and how it completely missed the fact that both the majority AND the dissent cite to the decision by Justice Taft for the same purpose, i.e., that an *objective* test applies in determining materiality.⁸⁹ Thus, as held in *Geer* and agreed by the *Geer* dissent, but completely ignored by the *Greene* Court, under New York law:

[M]ateriality is a matter of degree and a misrepresentation through concealment of a fact in regard to a condition of health or physicians consulted, is material where it appears that a reasonable insurer would be induced by the misrepresentation to take action which he might not have taken if the truth had been disclosed.⁹⁰

While the *Green* court ultimately found enough evidence that the insured’s misrepresentation was material and directed verdict in favor of the insurer, its reference to *Geer* for application of a subjective standard is entirely inexplicable.

⁸⁸ *Id.* (citing *Geer*, 273 N.Y. at 269, 277) (emphasis in original; internal page citations omitted).

⁸⁹ *Penn. Mut. Life Ins. Co. v. Mechanics’ Sav. Bank & Trust Co.*, 72 Fed. Rep. 413 (1896).

⁹⁰ *Geer*, 273 N.Y. at 272.

B. COMMENTATORS

One group of commentators has suggested that New York lower courts are correct to assume that Section 149 overrules the legal effect of *Geer* in every capacity, including the use of a “prudent insurer” (or objective) test for determining materiality of misrepresentations.⁹¹ These commentators refer in a footnote, for example, to seven New York Appellate Division decisions which purportedly “disregard *Geer*” and incorporate a subjective test.⁹² In reaching their conclusion, the commentators also rely heavily on the Appellate Division’s decision in *Giuliani v. Metropolitan Life Insurance Co.*, 56 N.Y.S.2d 475 (N.Y. App. Div. 1945), and the Historical Note to Section 149’s citation to Judge Finch’s dissent in *Geer*, which the commentators purport, read together, “makes clear” the legislature’s rejection of an objective test.⁹³ The authorities they cite cannot bear the weight the authors place upon them.

The Appellate Division cases cited by these commentators simply do not support the proposition for which they are cited. In five of the seven footnoted cases, the issue was not whether the materiality test was objective or subjective from the perspective of the insurer, but rather whether the insurer had sustained its burden on a motion for summary judgment to establish materiality *as a matter of law*. In each of those cases, the courts merely ruled that the insurer had not met its burden to establish materiality as matter of law and that the issue remained one for the trier of fact to decide.⁹⁴ In the sixth case, the court actually cited with approval to

⁹¹ Richard Jacobs, QC, Lorelie S. Masters & Paul Stanley, *LIABILITY INSURANCE IN INTERNATIONAL ARBITRATION: THE BERMUDA FORM 239-40* (Hart Publishing 2004).

⁹² *Id.* at 243; see Patterson *supra* note 49.

⁹³ *Id.* at 239-40.

⁹⁴ See *Zilkha v. Mut. Life Ins. Co. of N.Y.*, 732 N.Y.S.2d 51, 52 (N.Y. App. Div. 2001) (“Here, there are issues of fact as to whether . . . any such alleged misrepresentations were material.”); *Carpinone v. Mut. of Omaha Ins. Co.*, 697 N.Y.S.2d 381, 383 (N.Y. App. Div. 1999) (“The materiality of an applicant’s misrepresentation is ordinarily a factual question unless the insurer proffers clear and substantially uncontradicted evidence concerning materiality, in which event the matter is one of law for the court to determine.”); *Campese v. Nat’l Grange Mut. Ins. Co.*, 689 N.Y.S.2d 313, 314 (N.Y. App. Div. 1999) (reinstating complaint where “the [trial] court erred . . . in determining that the misrepresentations were material as a matter of law”); *Cutrone v. Am. Gen. Life Ins. Co.*, 606 N.Y.S.2d 491, 492 (N.Y. App. Div. 1993) (“Summary judgment was

Geer in support of its holding and confirmed the trial court's entry of judgment against the insured on the jury's finding that the insured's misrepresentation was material.⁹⁵ Finally, in the seventh case, the court's decision does not even address whether the misrepresentation was material or not under any standard.⁹⁶

Moreover, this group of commentators highlight that the main point of Section 149 was to treat the materiality of a misrepresentation as a matter of fact for the jury's consideration. As previously discussed, Judge Finch's dissent in *Geer* was based upon his disagreement with materiality being treated as a matter of law.⁹⁷ With respect to the subjective-objective standard holding, Judge Finch was in absolute agreement with the majority that a "reasonable insurer" (or objective) standard applies, and he approvingly cited to cases (also cited by the majority) which applied an objective standard.⁹⁸

Finally, in *Giuliani*, also relied on by these commentators, the only issue on appeal was whether the trial court erred in treating materiality as an issue of fact, and the court did not consider explicitly whether an objective or subjective test should be used.⁹⁹ The appellate court recognized that prior to the enactment of Section 149, "the tendency of the courts was to determine that every misrepresentation, except the most trivial ones, was material and thus voided the policy."¹⁰⁰ Relying on Section 149, the *Giuliani* court held that except in cases where "misrepresentations and the facts misrepresented were so serious that their very seriousness would establish their materiality as a matter of law," the

properly denied, however, because defendant failed to meet its burden of establishing the materiality of the misrepresentations in the reinstatement application 'sufficiently to warrant the court as a matter of law in directing judgment' in its favor.") (citations omitted); *Sonkin Assoc., Inc. v. Columbian Mut. Life Ins. Co.*, 541 N.Y.S.2d 611, 612 (N.Y. App. Div. 1989) (affirming denial of summary judgment where insurer had failed to establish "as a matter of law" that insured's misrepresentation was material).

⁹⁵ *Meagher v. Exec. Life Ins. Co. of N.Y.*, 607 N.Y.S.2d 361, 361-62 (N.Y. App. Div. 1994) (citing *Geer*, 273 N.Y. at 269).

⁹⁶ *Tennenbaum v. Ins. Corp. of Ir., Ltd.*, 579 N.Y.S.2d 351-52 (N.Y. App. Div. 1992).

⁹⁷ See *supra* Part III.

⁹⁸ *Id.*

⁹⁹ *Giuliani v. Metro. Life Ins. Co.*, 56 N.Y.S.2d 475, 477 (N.Y. App. Div. 1945).

¹⁰⁰ *Id.* at 479.

question of materiality should be a question of fact for the jury.¹⁰¹ Notably, however, while *Giuliani* did not expressly address the standard that should be used to determine materiality, it implied that an objective standard should be used, stating that “it cannot be said as a matter of law that a prudent insurer like the defendant would have or would not have rejected the application.”¹⁰²

The authorities cited by this group of commentators for the proposition that the courts have established a subjective standard in New York by openly disregarding *Geer* and embracing a subjective reading of Section 149, in fact stand for the proposition that courts have departed from *Geer* in only a single respect: that materiality should be treated as an issue of fact. To argue that these authorities indicate Section 149 completely superseded *Geer* in every respect and thus marked the end of the objective “prudent insurer” standard is to extract more from these authorities than is warranted.

Other commentators similarly have opined—although with less specific analysis—that under New York law, a subjective test must be applied in determining whether an insurer would have considered a misrepresentation to be material.¹⁰³ However, the key case they most often cite, *Mut. Benefit Life Ins. Co. v. Lindenman*, similarly does not support the conclusion reached by these commentators. Rather, *Lindenman* addressed only the issue of what evidence is needed to determine materiality as a matter of law:

Whether there has been a misrepresentation, and whether it is material are usually questions for the jury. However,

¹⁰¹ *Id.*

¹⁰² *Id.* (emphasis added).

¹⁰³ See Joseph K. Powers, *Pulling the Plug on Fidelity, Crime and All Risk Coverage: The Availability of Rescission as a Remedy or Defense*, 32 TORT & INS. L.J. 905, 915 n. 63 (Summer 1997) (“Materiality may be proven through evidence of the insurer’s practice concerning similar risks or the insurer’s manuals (where they exist), or testimony of qualified employees of the insurer, or where common sense dictates that the misrepresentation was significant to the underwriting process.”) (citing *Mut. Benefit Life Ins. Co. v. Lindenman*, 911 F. Supp. 619, 624-25 (E.D.N.Y. 1995)); see also Susan Koehler Sullivan & David A. Ring, *Recurring Issues in Rescission Cases*, 42 TORT & INS. L.J. 51, 56 n. 27 (Fall 2006) (citing *Lindenman* for the proposition that “[m]ost states measure materiality from the subjective viewpoint of the insurer.”). See also Edwin W. Patterson, *Misrepresentation by Insured Under the New York Insurance Law*, 44 COLUM. L. REV. 24 (1944).

where the evidence is “clear and substantially uncontradicted,” the court may determine it. . . . For the court to determine materiality as a matter of law, unequivocal evidence is required of the insurer’s practice concerning similar risks, or the insurer’s manuals, or “testimony of qualified employees of the insurer that the insurer would not have issued the particular contract it did if the facts had not been disclosed.”¹⁰⁴

The *Lindenman* court determined that there was sufficient evidence (including internal memoranda and uncontested underwriting guidelines of the insurer) to find materiality as a matter of law, and to grant summary judgment in favor of the insurer.¹⁰⁵ The *Lindemnman* court never considered, discussed, analyzed, or in any way addressed the standard that would apply if the question of materiality was not decided as a matter of law, but rather became an issue of fact to be determined by the jury at trial. And, notably, as discussed above in Part IV, Section 149(3) only addresses what evidence “shall” be admissible at trial, and never excludes other evidence which “may” be admissible, such as practices of other underwriters, expert testimony, and general industry practice.¹⁰⁶

VII. THE BETTER READING: *GEER* REMAINS GOOD LAW AND AN OBJECTIVE STANDARD APPLIES

The case law regarding the objective/subjective standard is far from consistent. Although the majority of New York Appellate Division decisions since *Geer* appear to apply a subjective standard for materiality, others explicitly have stated that materiality should be determined objectively.¹⁰⁷ For example, in *Horton*, the court quoted *Geer* at length in

¹⁰⁴ *Mut. Benefit Life Ins. Co.*, 911 F. Supp. at 624-25.

¹⁰⁵ *Id.* at 626.

¹⁰⁶ It also is interesting to note that at least one of these group of commentators may not even appreciate the difference between the two standards, stating both that Missouri applies a “subjective” standard, Sullivan, *supra* note 103, at 56 n. 27 (citing *Coots v. United Employers Fed’n*, 865 F. Supp. 596, 603 (E.D. Mo. 1994)), while just sentences later stating that Missouri applies an “objective” standard. *Id.* at 57 n.29 (citing *Crewse v. Shelter Mut. Ins. Co.*, 706 S.W.2d 35, 39 (Mo. Ct. App. 1985)).

¹⁰⁷ See *Horton v. Prudential Ins. Co. of Am.*, 363 N.Y.S.2d 130, 132 (N.Y. App. Div. 1975); see also, Giuliani, 56 N.Y.S.2d. at 479 (finding that “it cannot be

support of its decision to reverse the trial court's denial of the defendant insurer's motion to dismiss on the ground of a material misrepresentation. The court used an objective standard, stating that a misrepresentation is material when a "reasonable insurer would be induced by the misrepresentation to take action which he might not have taken if the truth had been disclosed."¹⁰⁸

In addition, other jurisdictions and the federal judiciary have held that, under New York law, materiality is determined by an objective test. In *Hoechst Celanese Corp. v. National Union Fire Insurance Co.*, 1990 WL 96400 at *1 (Del. Super. July 6, 1990), the Superior Court of Delaware (citing *Geer* as relevant precedent) recognized that under New York law, "fraudulent concealment can serve as a bar to recovery under an insurance contract if the contract contains a representation made by the insured that is false and material and that was relied upon by insurer in issuing the policy."¹⁰⁹ The court provided a thorough analysis on misrepresentations under New York law, providing in part: "Materiality is judged by an objective standard; that is, would industry practice consider the allegedly concealed information as material to an insurer's decision to renew the policy."¹¹⁰ Similarly, the Southern District of New York twice has held that the test for materiality under New York law is an objective one, and depends on whether industry practice would consider the undisclosed information material as to the insurer's decision to participate in the insurance contract.¹¹¹

Despite the potential confusion created by the enactment of Section 149 and the inconsistent holdings of lower New York courts, there has been one constant for applying an objective test: the New York Court of Appeals. When a statute is enacted, it becomes the responsibility of the

said as a matter of law that *a prudent insurer like the defendant* would have or would not have rejected the application.") (emphasis added).

¹⁰⁸ *Horton*, 363 N.Y.S.2d at 132 (quoting *Geer v. Union Mut. Life Ins. Co.*, 273 N.Y. 261, 272 (N.Y. 1937)).

¹⁰⁹ *Hoechst Celanese Corp. v. Nat'l Union Ins. Co. of Pittsburgh*, No. 89C-SE-35, 1994 WL 721653, at *2 (Del. Super. Ct. Mar. 31, 1994).

¹¹⁰ *Id.* at *3.

¹¹¹ See *John Jovino Co. v. Fireman's Fund Ins. Co.*, No. 90 Civ. 7486, 1992 WL 176956, at *7 (S.D.N.Y. July 14, 1992) ("The standard by which materiality is judged is an objective one."); *Am. Home Assurance Co. v. Fremont Indem. Co.*, 745 F. Supp. 974, 977 (S.D.N.Y. 1990) ("It remains to be seen whether under the standard by which materiality is judged, an objective one, industry practice would consider the [insured's] loss projections as material to a reinsurer's decision to participate . . .").

courts to interpret the law. If the legislature believes the courts have misinterpreted the law, the legislature can step in and make a correction. The legislature never has expressly abrogated *Geer*'s objective standard of materiality. Moreover, other jurisdictions as well as New York federal courts and certain lower states courts in New York have concluded, correctly, that New York law applies an objective standard of materiality.

Fundamentally, New York statutory law means what the New York Court of Appeals says it means, and the New York Court of Appeals says that a misrepresentation "is material where it appears that a reasonable insurer would be induced by the misrepresentation to take action which he might not have taken if the truth had been disclosed."¹¹² The Court of Appeals continues to treat *Geer* as good law, and Section 149 did not expressly abrogate, nor is it inconsistent with, this holding. It is time for all courts and tribunals applying New York law to end the unnecessary confusion, give precedential effect to the ruling of the New York Court of Appeals, and consistently apply the objective standard set down by New York's highest court.

¹¹² *Geer v. Union Mut. Life Ins. Co.*, 273 N.Y. 261, 272 (1937).

THE COMPLEXITY OF THE MANDATORY MEDICARE SECTION 111 REPORTING RULES AND ITS PRACTICAL LEGAL AFFECTS – IS THERE A BREAK IN SIGHT?

Crystal L. Fraser*

I. INTRODUCTION

Medicare is a health insurance program for people age 65 or older, people under 65 with certain disabilities, and people of all ages with end-stage renal disease.¹ Medicare was originally considered a primary payer system because “the private health insurance industry made its coverage secondary to [M]edicare’s.”² As a result, at its inception, Medicare was considered “the ‘secondary’ payer only for medical services covered by workers’ compensation, and the ‘primary’ payer for all other eligible medical services provided to eligible participants.”³ In response to the increasing financial burdens on the Medicare system and in an attempt to shift the burden of costs to private sources, Congress enacted a series of amendments to the Medicare provisions of the Social Security Act in 2007 which provided numerous circumstances under which Medicare was no longer a primary payer.⁴ “Medicare Secondary Payer” (hereinafter “MSP”)

* Crystal L. Fraser, Esq. is a 2011 graduate of the University of Connecticut School of Law. She is currently employed as an associate at the West Hartford office of Seiger Gfeller Laurie LLP. A special thank you to Partner Mark Seiger of Seiger Gfeller Laurie, for his assistance in selecting and researching this complex subject.

¹ Michael A. de Freitas, Annotation, *Validity, Constriction and Application of Medicare Secondary Payer Provisions of Social Security Act (42 U.S.C.A. § 1395y(b)) and Regulations Promulgated Thereunder*, 126 A.L.R. FED. 553 (1995).

² *Id.*

³ Christopher S. Berdy & W. Steven Nichols, *The Medicare, Medicaid & SCHIP Extension Act of 2007: A Practitioner’s Introduction to Resolving Personal Injury Liability. Claims by Medicare Beneficiaries*, 76 DEF. COUNS. J., Oct. 2009, at 393, 394.

⁴ See *id.* §5; de Freitas, *supra* note 1; See also Sonja P. Morgan-Marshall, *Federal Medicare Secondary Payer Compliance and Now Mandatory Insurer Reporting – What’s Next?*, TRIAL ADVOC. Q., Summer 2009, at 6 (“[M]edicare is not expected to pay for medical services as long as payment ‘has been made, or can reasonably be expected to be made, promptly, under a workmen’s compensation law or plan of the U.S. or under an automobile or liability insurance policy or plan (including self-insured plan) or under no-fault insurance’”).

is the term commonly used to refer to situations where the Medicare program does not have primary payment responsibility.⁵ Today, Medicare is the “secondary” payer in two circumstances. First,

Medicare is a secondary payer to [group health plans] for Medicare beneficiaries who are eligible Medicare beneficiaries . . . and who have [group health plan] coverage on the basis of their own or their spouse’s current employment with an employer that has [at] least twenty employees for beneficiaries aged sixty-five or older, or at least 100 employees for the disabled, or have end stage Renal disease and who have [group health plan] coverage on any basis.⁶

Second, Medicare is a secondary payer where certain other forms of insurance are responsible for a Medicare-eligible individual’s health care expenses.⁷ In this context, Medicare is essentially secondary where an individual is treated for an injury or illness which is work-related, was caused by an accident, or where either a no-fault insurance or group health plan will cover such illness or injury.⁸

On December 29, 2007, President George W. Bush signed into law the Medicare, Medicaid and SCHIP Extension Act of 2007 (hereinafter “MMSEA”).⁹ Section 111 of MMSEA imposes onerous new reporting requirements on liability (including self-insurers), no-fault and worker’s compensation insurers with respect to Medicare beneficiaries who have coverage under group health plan (hereinafter “GHP”) arrangements, as well as for Medicare beneficiaries who receive settlements, judgments, or other awards or payments from liability insurance (including self-

⁵ CTRS. FOR MEDICARE & MEDICAID SERVS., MMSEA SECTION 111 MEDICARE SECONDARY PAYER MANDATORY REPORTING: LIABILITY INSURANCE (INCLUDING SELF-INSURANCE), NO-FAULT INSURANCE, AND WORKERS’ COMPENSATION USER GUIDE, at 12 (2d ed.2009).

⁶ Berdy & Nichols, *supra* note 3.

⁷ *Id.* at 394-95 (citing 42 U.S.C. § 1395y(b)(2)(A)(ii) (2008); Memorandum from Ctrs. For Medicare & Medicaid Servs., Introduction to Section 111 Mandatory Medicare Secondary Payer Reporting. 1 (Feb. 23, 2009), *available at* <http://www.cms.hhs.gov/MandatoryInsRep/Downloads/RevisedSection111022309.pdf>).

⁸ Morgan-Marshall, *supra* note 4.

⁹ Roy A. Franco et al., *Mission Impossible: Resolution of a Case with a Medicare Claimant?*, FOR THE DEF., May 2009, at 8.

insurance), no-fault insurance, or worker's compensation.¹⁰ The passage of this new legislation reinforces the notion that the federal government is intent on ensuring that Medicare is always treated as the payer of last resort in these situations and is intended to provide Medicare with new and additional tools to enforce this right. Under the MMSEA, parties designated as "Responsible Reporting Entities" (hereinafter "RREs"), are required to report certain information to the Centers for Medicare and Medicaid Services (hereinafter "CMS").¹¹ In response to the enactment of the Section 111 reporting requirements, it is imperative that RREs and those parties who represent RREs in any capacity take significant and proactive steps to reasonably consider the interests of Medicare when resolving insurance claims involving current or future Medicare beneficiaries; of utmost importance is developing a thorough understanding of the Section 111 statutory scheme and how to comply with its tedious reporting requirements.¹²

The MMSEA is a complicated web which has just recently begun to be unraveled.¹³ CMS has been presented many questions which, although the act was passed in 2007, remain without clear answers. As a result, the implementation date for the reporting requirements has been pushed back numerous times. The implementation date has already been delayed two full years from the initial January 1, 2009 date; RREs are currently expected to begin testing the reporting system on January 1, 2010 and to begin mandatory reporting in the first quarter of 2011.¹⁴ The purpose of this Article is to provide detailed instructions on complying with the Section 111 registration requirements and to analyze the new reporting requirements and the significant issues they present for insurers and their attorneys and to present a variety of solutions which, if acted upon by the appropriate party or entity, will help ensure compliance with the requirements and prevent the imposition of severe penalties.

Section II discusses RREs in greater detail, particularly regarding who qualifies as an RRE. Additionally, it argues that one of the most onerous tasks faced by the insurance industry is determining if an

¹⁰ 42 U.S.C. §§ 1395y(b)(7)-(8) (2008).

¹¹ *Id.*

¹² See Berdy & Nichols, *supra* note 3, at 393-405.

¹³ It is important to note that this body of law is continuously changing and developing. Indeed, from this paper's initial drafting through its publication CMS issued numerous updates and clarifications. As such, it is highly likely that after publication certain areas will be further developed.

¹⁴ MMSEA 111 WHAT'S NEW, https://www.cms.gov/MandatoryInsRep/04_Whats_New.asp#TopOfPage (last visited October 4, 2010).

organization is or is not considered an RRE for Section 111 reporting purposes. This section outlines the importance of making this determination.

Section III briefly explains Medicare entitlement and eligibility and argues that RREs may have extreme difficulty in obtaining the information necessary to make a determination as to a claimant's Medicare beneficiary status. It concludes that RREs should make mandatory reporting of a claimant's social security number a prerequisite to receiving any settlement or other form of payment and/or that defense counsel should include requests for this information in interrogatories served on any plaintiff. However, this section also highlights the particular difficulties presented by "older" claims where some of the suggested solutions may be ineffective.

Section IV outlines the reporting process for RREs including registering with CMS and detailing what information must be submitted to CMS and when the information must be submitted. It argues that the use of agents for reporting purposes by RREs may provide an additional point of liability for the RRE and therefore concludes that RREs should not use agents as a means of attempting to comply with the Section 111 reporting requirements.

Section V discusses the penalties faced by RREs for non-compliance with the Section 111 reporting requirements. It argues that imposing heavy monetary fines for non-compliance, particularly in the scenario where a claimant has failed to provide the RRE with requested information is a violation of the Eighth Amendment's Excessive Fines Clause and is therefore unconstitutional. As a result, this section concludes that any penalties which may be imposed on an RRE should instead be shifted to the claimant and/or the claimant's attorney on a strong showing from the RRE that the claimant has failed to provide the information required by the RRE to ensure compliance with the Section 111 reporting requirements. Section V further suggests a process which RREs should use to ensure they have any information necessary to challenge any fines for non-compliance with the Section 111 reporting requirements.

Section VI presents a variety of solutions to the numerous problems presented by the Section 111 reporting requirements. In particular it discusses the development of errors and omissions policies to protect RREs from potential non-compliance; it suggests this solution as particularly useful to self-insureds. Second, it discusses and advocates the mandatory use of Medicare set aside arrangements, patterned after the current requirement for workers' compensation, for liability (including self-insurance) and no-fault insurers as an alternative method of protecting

Medicare's financial interests and to the strict reporting requirements advocated in the MMSEA.

II. RESPONSIBLE REPORTING ENTITIES

The first major issue posed by the MMSEA is determining who should be designated as an RRE. Section 111 requires only RREs to report information to CMS. Medicare holds the RRE solely responsible for the accurate and timely filing and reporting of claims and it is therefore critical to identify the proper RRE.

However, the process of identifying who qualifies as an RRE has proven difficult and confusing. For example, in the summer of 2009, ACE USA, a retail operating division of ACE Group, offering property, casualty, risk-management and accident and health insurance products through retail brokers, released information advising that its insureds would be the RRE for almost all policy types.¹⁵ In October 2009, ACE USA released the following statement: "While we believe there is merit to the position that our insured could be properly designated as the RRE for claims against deductible liability policies, we recognize the information received from CMS can be interpreted in several ways."¹⁶ Therefore, in the October 2009 release ACE USA assumed responsibility as the appropriate RRE.¹⁷ These two press releases clearly show the ambiguities in Section 111 and the complications in interpreting its requirements.

A. GHP RRES

GHP RREs are generally insurers or third party administrators ("TPAs"). A TPA is an entity that pays and/or adjudicates claims and may perform other administrative services on behalf of the GHP, the plan or the plan insurers.¹⁸ In instances where an insurer, an entity that, in return for the receipt of premium, assumes the obligation to pay claims described in the insurance contract and assumes the financial risk associated with such payments, does not process GHP claims itself, but contracts with a TPA to

¹⁵ Press Release, ACE USA, Update Information: ACE and the Medicare, Medicaid & SCHIP Extension Act (Summer 2009) (on file with author).

¹⁶ Press Release, ACE USA, Updated Information: ACE and the Medicare, Medicaid & SCHIP Extension Act (October 5, 2009).

¹⁷ *Id.*

¹⁸ See § 42 U.S.C. 1395y(b)(7) (2008).

perform such services, the TPA has the responsibility of reporting.¹⁹ Employers are Section 111 RREs for GHP purposes under only very limited circumstances.

B. LIABILITY INSURANCE (INCLUDING SELF-INSURANCE) AND NO-FAULT INSURANCE

For non-GHP purposes (liability insurance, self-insurance, no-fault insurance or workers' compensation), the RRE is the "applicable plan."²⁰ The term "applicable plan" means the "following laws, plans, or other arrangements, including the fiduciary or administrator for such law, plan, or arrangement: (i) [l]iability insurance (including self-insurance); (ii) [n]o fault insurance; (iii) [w]orkers' compensation laws or plans."²¹ The Health Care Financing Administration (hereinafter "HCFA"), which administers Medicare, defines an applicable plan as "any arrangement, oral or written, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness."²²

A non-GHP [RRE] is an employer or defendant's insurance carrier (i.e., workers' compensation insurer, general liability insurer, or no-fault insurer). For example, if an employer is self-insured for workers' compensation or liability insurance, the employer may be an RRE.²³ An insurance carrier may choose to handle claims processing on its own or to outsource these responsibilities to another entity. However, this distinction is irrelevant in relation to the determination of the RRE and an insurer is considered an RRE regardless of whether or not it handles its own claims processing.²⁴

1. Liability Insurance

Liability insurance is defined in the regulations implementing the MMESA as

¹⁹ *Id.*

²⁰ CTRS. FOR MEDICARE & MEDICAID SERVS., INTRODUCTION TO SECTION 111 MANDATORY MEDICARE SECONDARY PAYER REPORTING (2009).

²¹ 42 U.S.C. § 1395y(b)(8).

²² 42 C.F.R. § 411.21 (2006).

²³ Berdy & Nichols, *supra* note 3 at 399; OLLIS & CO., SECTION 111 OF THE MEDICARE, MEDICAID AND SCHIP EXTENSION ACT OF 2007 (MMSEA), *available at* http://ollisinsurance.com/wp-content/uploads/2009/07/section_111.pdf.

²⁴ RRE Overview, http://www.piattconsulting.com/index.php?option=com_content&view=article&id=131&Itemid=91 (last visited Oct. 4, 2010).

Insurance (including a self-insured plan) that provides payment based on legal liability for injury or illness or damage to property. . . . Liability insurance payment means a payment by a liability insurer, or an out-of-pocket payment, including a payment to cover a deductible required by a liability insurance policy, by any individual or other entity that carries liability insurance or is covered by a self-insured plan.²⁵

Essentially, liability insurance (including self-insurance) “is coverage that indemnifies or pays on behalf of the policyholder or self-insured entity against claims for negligence, inappropriate action, or inaction which results in injury to an individual or damage to property.”²⁶ Liability insurance includes the following: homeowners’ liability insurance, automobile liability insurance, product liability insurance, malpractice liability insurance, uninsured motorist liability insurance, underinsured motorist liability insurance, etc.²⁷

2. Self-Insureds

In *Mason v. Am. Tobacco Co.*,²⁸ the United States District Court interpreted “self-insured plan” as used in the Medicare as Secondary Payer (hereinafter “MSP”) statute as involving an “entity that has assumed posture similar to that of an insurance company.”²⁹ The Code of Federal Regulations defines a self-insured plan as “a plan under which an individual, or private or governmental entity carries its own risk instead of taking out insurance with a carrier.”³⁰ The Health Care Financing Administration has ruled that “the mere absence of insurance purchased from a carrier does not necessarily constitute a ‘plan’ of self-insurance.”³¹ In determining the defendants’ status as possible “self-insured plans,” the court in *Mason* stated that “one requirement for an entity to be a self-insured plan is ‘the provider must establish a fund with an independent fiduciary which is documented by a written agreement that includes legal

²⁵ 42 C.F.R. § 411.50 (2006).

²⁶ CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 5.

²⁷ *Id.*

²⁸ *Mason v. Am. Tobacco Co.*, 212 F. Supp. 2d 88, 91 (E.D.N.Y. 2002).

²⁹ *Id.*

³⁰ 42 C.F.R. § 411.50.

³¹ Medicare as Secondary Payer and Medicare Recovery Against Third Parties, 54 Fed. Reg. 41716, 41727 (Oct. 11, 1989).

responsibilities and obligations required by State laws' for payment of medical expenses of those injured by its products."³²

In a May 2010 alert issued by CMS, CMS stated that it will consider payments by sponsors of clinical trials for any injuries or complications arising out of clinical trials to be self-insurance; as such, the sponsors are considered to be RREs and must report these payments to CMS.³³ As early as 2004, CMS had maintained the position Medicare would not make payments in situations where the clinical trial sponsor agreed to cover payments not otherwise covered by another payer.³⁴ However, CMS, until May 2010, consistently failed to give clarification as to whether or not the sponsor's agreement to make such payments constituted a liability insurance plan.³⁵ As such, prior to that date, sponsors of clinical trials were unable to determine their status as RREs and begin the required registration process. In the event CMS had not further extended the initial reporting date, these sponsors would have faced severe penalties. This situation illustrates the ongoing difficulty in determining whether or not an entity has self-insurance and the problems that difficulty presents.

3. No-fault insurance

The regulations implementing MMSEA define no-fault insurance as

Insurance that pays for medical expenses for injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile, regardless of who may have been responsible for causing

³² *Mason*, 212 F. Supp. 2d at 92 (quoting *Mt. Diablo Med. Ctr. v. Blue Cross & Blue Shield Ass'n*, Dec. No. 96-D40, 1996 WL 862610, at *6 (P.R.R.B. July 1, 1996)).

³³ Memorandum from Ctrs. For Medicare & Medicaid Servs., ALERT: Clinical Trials & Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation (May 6, 2010), *available at* <http://www.cms.gov/MandatoryInsRep/Downloads/AlertClinicalTrailsNGHP.pdf>.

³⁴ Janice Ziegler et al., *CMS Issues Section 111 Alert in NGHP Context Regarding Clinical Trials*, MONDAQ, June 17, 2010, http://www.mondaq.com/unitedstates/article.asp?article_id=103200.

³⁵ *Id.*

the accident. This insurance includes but is not limited to automobile, homeowner's, and commercial plans.³⁶

No-fault insurance is essentially a plan of "insurance that pays for health care services resulting from injury to an individual or damage to property in an accident, regardless of who is at fault for causing the accident."³⁷

III. MEDICARE ENTITLEMENT, ELIGIBILITY AND ENROLLMENT

As mentioned above Medicare, is a federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people of all ages with end-stage renal disease.³⁸ It is distinguishable from Medicaid, which consists of state run health insurance programs designed to provide health insurance to low income pregnant women, children under the age of 19, people 65 and older, people who are blind, people who are disabled and people who need nursing home care.³⁹ It is possible to qualify for both Medicare and Medicaid; however, the Section 111 reporting requirements concern only Medicare beneficiaries.⁴⁰

Medicare is comprised of two "parts." Medicare Part A, commonly referred to as "hospital insurance," helps a qualifying individual pay for inpatient care received in a hospital, skilled nursing facility, or hospice, and, if certain conditions are satisfied, home health care.⁴¹ The second part, Medicare Part B, commonly referred to as "medical insurance" helps a qualifying individual pay for "medically-necessary doctors' services and other outpatient care."⁴² Medicare Part B also pays for certain preventative services and services that may prevent an illness from progressing.⁴³

³⁶ 42 C.F.R. § 411.50 (2006).

³⁷ CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 5, at 13.

³⁸ de Freitas, *supra* note 1, at § 2a.

³⁹ DEP'T OF HEALTH AND HUMAN SERV., WHAT IS MEDICARE?, *available at* <http://www.medicare.gov/Publications/Pubs/pdf/11306.pdf> (last visited Oct. 4, 2010).

⁴⁰ *See id.*

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Id.*; Medicare beneficiaries may also choose to enroll in Medicare Part D, which is Medicare's prescription drug coverage plan or in Medicare Part C, which are commonly referred to as "Medicare Advantage Plans."

A. DETERMINING A CLAIMANT'S MEDICARE BENEFICIARY STATUS

Another issue for RREs involves determining the Medicare beneficiary status of claimants. There are a variety of ways by which an RRE may determine a claimant's Medicare status. "An RRE can request that the claimant provide his or her Health Insurance Claim Number, which is the number on the claimant's Medicare card. RREs may also obtain a benefits statement from the Social Security Administration by searching through the CMS-developed 'Query System,' or by using the claimant's first and last names, Social Security Number, and Social Security Consent Form signed by the claimant."⁴⁴ In the alternative, rather than requesting a claimant provide the information necessary to perform a query check, an RRE may request the claimant provide information as to their Medicare beneficiary status.⁴⁵

Each method for determining a claimant's Medicare beneficiary status poses serious problems and highlights significant obstacles for RREs. First, if the RRE requests the claimant provide it with information as to its Medicare beneficiary status or social security number (hereinafter "SSN") and other information, the RRE may not always be able to rely on the truthfulness or completeness of the claimant's response to the RRE's request.⁴⁶ For their part, claimants may decide to withhold that information. CMS has provided space on the forms to be used by RREs in requesting a claimant's Health Insurance Claim Number (hereinafter "HICN") and SSN for a claimant to "explain the reason(s) for refusal to provide requested information"; this indicates CMS's awareness that claimants may choose not to provide crucial information to RREs.⁴⁷ Furthermore, an alert issued by CMS merely advises potential claimants that it is appropriate for an RRE to request their SSN and/or HICN; unfortunately for RREs, the alert does not advise or require compliance with any such requests.⁴⁸ In order for the Coordination of Benefits

⁴⁴ Berdy & Nichols, *supra* note 3, at 399.

⁴⁵ Kenneth R. Meyer & Genevieve M. Spires, *Beware of Added Complications in Claims Involving Medicare Beneficiaries*, NEW JERSEY L. J. Sept. 28, 2009 at 2.

⁴⁶ *See id.*

⁴⁷ Richard L. McConnel, et. al, *No Port in a Storm? Crucial Safe Harbor Still in Doubt Under New Medicare Section 111 Reporting Requirements*, INS. COVERAGE 4, Dec. 4, 2009, at 3, 5.

⁴⁸ Press Release, Collection of Medicare Health Insurance Claim Numbers (HICNs), Social Security Numbers (SSNs) and Employer Identification Numbers (EINs) (Tax Identification Numbers) – ALERT (April 6, 2010).

Contractor (hereinafter “COBC”) to make a determination as to a claimant’s Medicare beneficiary status it must be able to exactly match either a Health Insurance Claim Number or SSN exactly and match at least three of the four remaining criteria (first initial of the first name, first 6 characters of the last name, date of birth and gender) exactly.⁴⁹ A claimant who refuses to provide the requested information to an RRE therefore makes it impossible for both the RRE and the COBC to make a determination of the claimant’s Medicare beneficiary status. As a result, a claimant who refuses to provide the requested information makes it impossible for an RRE to comply with the Section 111 reporting requirements.

An alternative method to obtaining beneficiary status includes submitting “a query to CMS’ Coordination of Benefits Contractor to determine whether a claimant is a Medicare beneficiary.”⁵⁰ An RRE should perform regular query checks through the “Query System” for every claimant in an attempt to determine Medicare beneficiary status; this includes performing a check at the inception of the claim and prior to any settlement or payment. It is particularly important to perform multiple query checks on claimants who were initially identified as not being eligible Medicare beneficiaries because such a claimant’s status may change over the course of processing the claim. The information required to complete such an inquiry include: the claimant’s date of birth, SSN and sex of the claimant.⁵¹ Therefore, completing an investigation into a claimant’s Medicare status will likely involve the need to obtain the claimant’s Social Security Number (hereinafter “SSN”).⁵² However, non-health group plans cannot compel a claimant to provide such information and as noted above, in other instances the claimant may simply refuse to provide this information.⁵³ Also, as noted above RREs cannot rely on claimant’s to receive honest or complete answers to requests for this information. In a town hall teleconference held on October 22, 2009 CMS advised insurers that a “claimant who is a Medicare beneficiary would have an obligation to provide their HICN or SSN to the insurer, but that a claimant who is not a Medicare beneficiary would not be obligated to

⁴⁹ CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 5, at 35.

⁵⁰ McConnel et al., *supra* note 47.

⁵¹ *Id.*

⁵² Joe Herbers, *Medicare Data Requirements to Boost Workers Compensation Costs*, PINNACLE NEWS, July 2009, at 1-2.

⁵³ *Id.*; Kevin Quinley, *Baring its Teeth*, CLAIMS MAGAZINE, Oct. 6, 2009.

respond,” though it is unclear what statutory or regulatory authority supports this assertion.⁵⁴

A solution to this problem is for claims handlers to include a condition to their settlements which requires “that the claimant (or claimant’s attorney) provide the Social Security number to enable the settling party to comply with MMSEA.”⁵⁵ Where a claimant commences a lawsuit against an RRE to obtain payment, defense counsel should, in their interrogatories, request the claimant reveal whether or not he or she is a Medicare beneficiary or when he or she expects to begin receiving Medicare benefits.⁵⁶ Defense counsel may also use interrogatories to “seek information about the plaintiff’s Medicare Identification Number, when Medicare entitlement began, and whether any claim for the plaintiff’s medical care related to the injuries alleged in the lawsuit have been paid by, or filed with, Medicare.”⁵⁷ However, these methods may not be successful for an RRE’s existing claims and therefore a retrospective process should be developed to gather the necessary data on existing claims. Specifically, RREs must develop procedures to claims where settlements have been reached but the RRE maintains ongoing responsibility for medicals, after July 1, 2009 and for lawsuits in which discovery has closed.

In response to these troubling issues some industry professional have advocated a “safe-harbor” provision that would apply to RREs that have attempted in good faith to obtain the necessary information from claimants but are unable to do so or are provided inaccurate information regarding whether a particular claimant is receiving Medicare.⁵⁸ It appears that CMS has adopted a limited “safe-harbor” provision.⁵⁹ In an alert

⁵⁴ McConnel et al., *supra* note 47, at 5.

⁵⁵ Quinley, *supra* note 53.

⁵⁶ Sharon Caffrey et al, *Medicare Secondary Payer Statute: New Reporting Requirements for Products Liability and Toxic Torts Clients*, 198 N.J.L. J. 868 (2009).

⁵⁷ *Id.* at 869.

⁵⁸ McConnel, et al., *supra* note 47, at 3-4 (A “safe-harbor” makes sense in the context of liability insurers and self-insured entities that have no contractual relationship with the claimant, do not control the claimant’s actions, and have no legally enforceable means for obtaining information from the claimant.); Franco, *supra* note 9, at 9.

⁵⁹ See Press Release, Ctrs. for Medicare & Medicaid Servs., CMS Alert: Compliance Guidance Regarding Obtaining Individual HICNs and/or SSNs for Non-Group Health Plan (NGHP) Reporting Under 42 U.S.C. § 1395y(b)(8) (Aug. 24, 2009). However, a note to the Alert reads: “This process does not provide a ‘safe-harbor’ to any reporting entity attempting to use it to avoid reporting MSP

published on its website, CMS advised that an RRE would be considered “compliant” if it has obtained a copy of the form used to request necessary information signed by the claimant.⁶⁰ This limited “safe-harbor” provision fails to address the scenario where an insured or self-insured transmits the necessary forms for requesting the required information to the claimant but the claimant fails or refuses to return the form. It is likely that many claimants will simply disregard the insured’s or self-insured’s request for the form because “claimants have little or no incentive to provide the requested information to liability insurers or self-insured entities, and in some circumstances, they arguably have an incentive *not* to make the disclosure.”⁶¹ This will undoubtedly leave RREs liable for unreported information which cannot possibly be obtained. CMS has indicated it may shift its “safe-harbor” position by expanding the protections for insurers and self-insured entities.⁶² However, as CMS representatives have advised in their town hall teleconferences, the Liability Insurance (Including Self-Insurance), No-Fault Insurance and Workers’ Compensation User Guide (hereinafter “User Guide”) and other written alerts produced by CMS are the official source of information where discrepancies exist and as of the drafting of this paper those sources contain no expanded “safe-harbor” provision.

The safe-harbor provisions proposed by industry professionals pose a different problem, i.e., that such a provision undermines the intent of the Section 111 reporting requirements. The goal of Section 111 is to protect Medicare’s future financial interests by ensuring that Medicare is, where appropriate, the secondary payer. A “safe-harbor” provision would allow certain claims to remain unchecked by the CMS system and therefore leaves open the possibility that Medicare will make unnecessary payments or will be ill-informed to collect reimbursements for past conditional payments. As discussed below a solution to this problem with the safe-harbor provision is to transfer the penalties to the party responsible for non-compliance.

data about an individual known to the reporting entity to be a Medicare beneficiary.” *Id.*

⁶⁰ *Id.*

⁶¹ McConnel et al., *supra* note 47, at 4.

⁶² *Id.* (In a town hall teleconference on September 30, 2009, CMS representatives appeared to depart from the written guidance contained in the alert and implied that the safe-harbor might extend more broadly if the insurer could prove it has a “process” in place to obtain information from claimants and that the request form was delivered to a specific claimant by certified mail or otherwise).

IV. REPORTING REQUIREMENTS

During the investigation of a liability claim, if the claimant is a Medicare beneficiary, the RRE must place the CMS COBC on notice of the loss.⁶³ “An RRE does not need approval from the Medicare beneficiary to make this notice.”⁶⁴ “[T]he trigger to report involves whether there is an expectation of making a payment. If there is no liability and no expectation of making any type of payment, there is no duty to report.”⁶⁵ Those required to report under MMSEA were required to commence collection of the data required for reporting prior to the testing of the reporting process which is scheduled to commence on January 1, 2011.⁶⁶

A. REGISTERING WITH CMS

Any RRE who has an expectation of making payments to a claimant must register with CMS in order to comply with the Section 111 reporting requirements. As noted above, “[e]ntities who are RREs for purposes of the Section 111 liability insurance (including self-insurance), no-fault insurance, or workers’ compensation are not required to register if they will have nothing to report.”⁶⁷ CMS has an admittedly “hard” and “complicated” registration and reporting process for RRE’s. Prior to commencing the registration process, RREs must determine how they will submit Section 111 files to the COBC and how many Section 111 Responsible Reporting Entity Identification Numbers (hereinafter “RRE ID”) will be needed.⁶⁸ An RRE who wishes to use different agents to

⁶³ See 42 C.F.R. § 411.25(a) (2010).

⁶⁴ *Id.*; 42 U.S.C. § 1395y(b)(8)(A)-(B) (2006).

⁶⁵ Franco, *supra* note 9, at 10; Meyer & Spires, *supra* note 45.

⁶⁶ Alan Cooper, *Will New Law Require Set-Asides for Medicare in P.I. Cases?*, VA. LAW. WKLY, Nov. 23, 2009.

⁶⁷ Ctrs. for Medicare & Medicaid Servs., *supra* note 5, at 23 (“For example, if an entity is self-insured solely for the deductible portion of a liability insurance policy but it always pays any such deductible to its insurer, who then pays the claim, it may not have another to report. However, those who do not register initially because they have no expectation of having claims to report, must register in time to allow a full quarter for testing if they have future situations where they have a reasonable expectation of having to report.”).

⁶⁸ Ctrs. for Medicare & Medicaid Servs., *supra* note 5, at 33 (“Only one Claim Input File may be submitted on a quarterly basis for each RRE ID. Due to corporate organization, claim system structures, data processing systems, data centers and agents that may be used for file submission, RREs may want to submit

submit workers' compensation claims and liability and no-fault claims must register twice to obtain two RRE IDs.⁶⁹ An RRE who establishes multiple RRE IDs must submit a quarterly Claim Input File for every RRE ID formed, regardless of whether or not they have any reportable claims for the reporting period.⁷⁰

The registration process begins with the RRE entering the COB secure website and providing basic information about the RRE and its authorized representative.⁷¹ The authorized representative is "the person who's able to essentially legally bind the RRE to [a contract and the terms and] requirements of the Section 111 reporting"; the authorized representative is generally a person at the executive level in the organization.⁷² The authorized representative is the person responsible for, among other things, reporting, signing off on any information provided by the RRE during registration and signing off on who an RRE appoints as its account manager.⁷³ Essentially, the authorized representative has "ultimate accountability for the RRE's compliance with Section 111 reporting requirements."⁷⁴ Once CMS has received this information, a letter is mailed US Post to the authorized representative; the letter will contain a personal identification number (hereinafter "PIN").⁷⁵

Once the authorized representative has received the PIN, he or she will provide that information to the account manager.⁷⁶ The account manager is the person who manages the day to day activities, including processing and account information.⁷⁷ The account manager may be an employee of the RRE or, if the RRE chooses, may be an agent assigned the reporting tasks.⁷⁸ The account manager must then return to the COB secure website to complete the account setup process. The account manager will be required to provide information about themselves, develop their own personal login ID and password, and set up the remainder of the RRE's

more than one Claim Input File to the COBC on a quarterly basis and therefore will need more than one RRE ID in order to do so.").

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ Telephone interview with Bill Decker, Pat Ambrose, Barbara Wright, and Bill Zavoina (Jan. 22, 2009).

⁷² *Id.*

⁷³ *Id.*

⁷⁴ Ctrs. for Medicare & Medicaid Servs., *supra* note 5, at 31.

⁷⁵ Telephone interview with CMS (Jan. 22, 2009).

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 5, at 24.

account information, which includes information relating to the agent that will be used in the file transfer.⁷⁹

Once the account manager has completed the second step in the process, “the system will generate a profile report and issue that profile report to [the] authorized representative via email.”⁸⁰ The authorized representative then reviews the information, signs the last page of the report and returns it to CMS.⁸¹ Further, after account managers have completed their step in the registration process they have the ability to invite an unlimited number of individuals, both employees of the RRE and outside agents, to become account designees.⁸² The account designees are individuals who assist the account manager with the reporting process they “are able to upload and transfer files, monitor file statistics and so on.”⁸³

RRE’s were required to register with CMS by September 30, 2009, however the complications in determining who is considered an RRE has led to flexibility in this registration deadline.⁸⁴ The registration process for RREs will remain open indefinitely to allow for ongoing registration.⁸⁵ Practitioners recommend registering with CMS as soon possible because RREs are required to “test their abilit[ies] to upload files in early 2010”⁸⁶ and to begin making quarterly reports of all payments to all Medicare beneficiaries in January 2011. CMS advises allowing an entire quarter of testing prior to commencing mandatory reporting. Therefore, RREs who failed to register prior to January 1, 2010 are likely to face penalties for non-compliance. There is no exception to penalties for RREs who were required and able to register prior to that date, but simply failed to do so. RREs that are not prepared for the reporting process to begin face the possibility of being fined for unreported claims.⁸⁷

⁷⁹ Telephone interview with CMS (Jan. 22, 2009).

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.*

⁸⁴ Sharon Caffrey, et al., *Have you Registered Under MMSEA? New Reporting Obligations & Penalties for Medicare Secondary Payers*, MONDAQ (October 19, 2009).

⁸⁵ CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 5, at 26.

⁸⁶ Caffrey, et al., *supra* note 84.

⁸⁷ *Id.*

1. Foreign RREs⁸⁸

As late as October 22, 2009, nearly a month after the initial September 30, 2009 registration deadline, CMS had no registration process available for foreign RREs and no guidelines as to what steps these entities should take to ensure compliance with the Section 111 reporting requirements.⁸⁹ A foreign entity is “an entity that does not have a U.S. address and/or a U.S. Tax Identification Number (TIN) or Employer Identification Number (EIN).”⁹⁰ CMS initially advised these RREs “what [they] should do is wait.”⁹¹ On December 29, 2009, CMS finally released registration guidance for RREs who are foreign entities. Foreign RREs are advised by CMS to obtain a United States EIN by completing the Internal Revenue Service SS-4 application.⁹² As a result of the late date at which CMS released this information foreign RREs were not required to register until April 1, 2010.⁹³ However, it is important to note that this delay in registration does not change the reporting requirements of foreign RREs; foreign entities are required to follow the same registration and reporting procedures as domestic RREs once they have obtained a U.S. EIN.⁹⁴ The delay was not anticipated to change the reporting date requirements associated with Ongoing Responsibility for Medicals or with ‘Total Payment Obligation to Claimant’ amounts.⁹⁵ Therefore, foreign RREs were expected to register at a later date than domestic RREs yet were required to

⁸⁸ An interesting and yet unresolved legal issue surrounding foreign RREs is whether or not CMS may assert extraterritorial jurisdiction on these RREs who make direct claims payments to U.S. residents. *See* Federation of Regulatory Counsel, Inc., *Medicare Secondary Payer Reporting: Extraterritorial Applicability of Requirements to Foreign Insurers*, 21 FORC J. 2 (2010).

⁸⁹ Telephone interview with CMS (Oct. 22, 2009).

⁹⁰ Press Release, Ctrs. for Medicare & Medicaid Servs., Office of Financial Management/Financial Services Group, ALERT: Registration Guidance for Liability Insurance (Including Self-Insurance), No-Fault Insurance, or Workers’ Compensation Responsible Reporting Entities (RREs) Who Are Foreign Entities (Dec. 29, 2009).

⁹¹ Telephone interview with CMS (Oct. 22, 2009).

⁹² *See* Press Release, Ctrs. for Medicare & Medicaid Servs., *supra* note 90.

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.*

gather and prepare their information for reporting to begin on the same date as domestic RREs.

B. USE OF AGENTS FOR REPORTING PURPOSES

According to the CMS MMSEA Section 111 Medicare Secondary Payer Mandatory Reporting: Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide (hereinafter "MMSEA User Guide"), agents are not RREs "for purposes of the MSP reporting responsibilities."⁹⁶ However, an RRE may "contract with an entity to act as an agent for reporting purposes."⁹⁷ The RRE is responsible for registering, reporting and filing and will designate the agent who will be reporting during the registration process.⁹⁸ It is important to note that an RRE may not shift its Section 111 reporting responsibility to its agent, whether the attempt to do so is by contract or otherwise. The RRE remains the party solely responsible and accountable for understanding of and compliance with the Section 111 requirements and for the accuracy of the data submitted.⁹⁹

While it is likely numerous companies and organizations will form with the purpose of taking on the reporting responsibilities of RREs, it is not advisable to procure an agent to satisfy reporting requirements. The use of agents in the reporting process raises potential liability for the RRE because the RRE lacks control over the reporting process engaged in by the hired agent yet is still held responsible through monetary fines for any non-compliance with the reporting requirements. The RRE can ultimately be liable for any and all misdoings and errors made by the agent during the reporting process, a possibility that can be easily eliminated by an RRE retaining, rather than delegating the responsibility of reporting.

⁹⁶ Ctrs For Medicare & Medicaid Servs., *supra* note 5, at 22 ("Agents may include, but are not limited to, data service companies, consulting companies or similar entities that can create and submit Section 111 files to the COBC on behalf of the RRE.").

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ *Id.*

C. CLAIM THAT TRIGGERS A REPORTING REQUIREMENT AND
REPORTING THRESHOLDS

Whether or not a claim triggers reporting requirements depends on the type of insurance in question. For liability lines of coverage, the reporting requirements are triggered by any kind of payment made on or after October 1, 2010 to a Medicare beneficiary for a claim or potential claim as a result of bodily or person injury, and/or ongoing responsibility for payment of medical services.¹⁰⁰ For worker's compensation and other Ongoing Responsibility for Medicals (ORM) payments, CMS requires a look back for ORMs paid from January 1, 2009, in which the file is closed by the insurer, but can be reopened if further medicals are submitted.¹⁰¹

Certain claims can be excluded from the mandatory Section 111 reporting requirements because they do not meet the CMS-established reporting thresholds. For liability insurance (including self insurance) and workers' compensation total payment obligation to the claimant (hereinafter "TPOC") the established thresholds are:

- (a) For TPOCs dates of January 1, 2010 through December 31, 2010, TPOC amounts of \$0.00 - \$5,000.00 are exempt from reporting except as specified in (d) below.
- (b) For TPOCs dates of January 1, 2011 through December 31, 2011, TPOC amounts of \$0.00 - \$2,000.00 are exempt from reporting except as specified in (d) below.
- (c) For TPOCs dates of January 1, 2012 through December 31, 2012, TPOC amounts of \$0.00 - \$600.00 are exempt from reporting except as specified in (d) below.
- (d) Where there are multiple TPOCs reported by the same RRE on the same record, the combined TPOC amounts must be considered in determining whether the reporting exception threshold is met.¹⁰²

¹⁰⁰ Press Release, MARSH & Am. Soc. For Healthcare Risk Mgmt., MMSEA Section 111 Non-Grp. Health Plan Liab. Ins. (including Self Ins.), No-Fault Insurance, and Workers' Comp. Frequently Asked Questions 2 (2009).

¹⁰¹ *Id.*

¹⁰² *Id.* at 5.

There are further situations where a case-by-case analysis must be made to determine whether or not an entity is considered an RRE and whether it must submit information on certain claims.¹⁰³ For example, in the context of reinsurance, stop loss insurance, excess insurance, umbrella insurance, guaranty funds and patient compensation funds which have some responsibility beyond a certain limit may be required to report claim in certain situations. “The key in determining whether or not reporting . . . is required for these situations is whether or not the payment is to the injured claimant/representative of the claimant vs. payment being made to the self-insured entity to reimburse the self-insured entity.”¹⁰⁴ If the payment is made to the self-insured in the form of a reimbursement then the self-insured is the RRE. However, if the payment is made to the injured claimant or her representative then the insurer is the RRE for reporting purpose.¹⁰⁵ It is therefore advisable in these situations to make payments to a party other than the injured claimant or their representative. Development of such a policy prevents those entities named above from becoming RREs.

D. WHAT TO REPORT

Initial reports made to CMS must include “information for all claims involving a settlement, judgment, award or other payment made to a Medicare beneficiary” after July 1, 2009 for ORM and January 1, 2010 for TPOC.¹⁰⁶ “The Claim Input File is the data set transmitted from a MMSEA Section 111 RRE to the COBC that is used to report liability insurance (including self-insurance), no-fault insurance, and workers’ compensation claim information where the injured party is a Medicare beneficiary and medicals are claimed and/or released or the settlement, judgment, award, or other payment has the effect of releasing medicals.”¹⁰⁷ When making that report to the COBC, an RRE is required to obtain and report approximately 130 data points. These data fall into five distinct categories:

¹⁰³ Ctrs. for Medicare & Medicaid Servs., *supra* note 5, at 75-78 (For example, a payment made specifically as a one-time payment for defense evaluation does not trigger the reporting requirement if made directly to the provider or other physician; “[w]here there is a settlement, judgment, award or other payment with no establishment/acceptance of responsibility for ongoing medicals, the RRE is not requirement to report, etc.”).

¹⁰⁴ *Id.* at 75.

¹⁰⁵ *Id.*

¹⁰⁶ Meyer & Spires, *supra* note 45.

¹⁰⁷ Ctrs. for Medicare & Medicaid Servs., *supra* note 5, at 34.

- (1) The Injured Party/Medicare beneficiary Information: Includes identification information, date of injury, cause of injury, venue, injury information, product identification and insurance/self-insurance claim and contact information
- (2) Injured party attorney information []: includes detailed attorney contact information along with attorney/law firm TIN
- (3) Settlement, Judgment, Award or Other payment information []: includes amounts and dates for ongoing responsibility for medical and total payment obligations
- (4) Claimant information, if other than injured party []: includes contact information for estate or other claimant in survival or wrongful death actions.
- (5) Claimant (other than injured party) attorney []: includes attorney contact information along with TIN.

¹⁰⁸

Once the data is transmitted in the form of a Claim Input File, COBC will use the file to determine whether or not a particular claimant is considered an eligible Medicare beneficiary by matching the information provided in the Claim Input File with already existing Medicare data.¹⁰⁹

Initially, uncertainty surrounding reporting requirements existed where an RRE had a claim in which it has an ongoing responsibility for future medical requests, as of the implementation date, even where the claim had been closed in the RRE's records. In a January 2009 teleconference CMS indicated it was still looking at "how far back [it] will require [RREs] to go in terms of cases that are already closed" as of the implementation date.¹¹⁰ It now appears CMS will require RRE's to report any claims where an ongoing responsibility exists as of July 1, 2009, regardless of when the RRE initially settled the claim.¹¹¹ This will likely require a significant look-back period and cause an already onerous process to become more challenging.

¹⁰⁸ *Id.* at 108-46.

¹⁰⁹ *Id.*

¹¹⁰ Telephone interview with CMS (Jan. 22, 2009).

¹¹¹ Meyer & Spires, *supra* note 45.

E. WHEN TO REPORT

Claims information must be reported after the RRE assumes ongoing responsibility for medicals or after a TPOC settlement has been reached, or a judgment, award or any other payment has occurred.¹¹² Claim Input files must be submitted to COBC on a quarterly basis during an RRE's assigned 7-day file submission time frame.¹¹³ There is a grace period when the settlement, judgment, award or other payment is made within 45 days prior to the start of the seven-day file submission time frame.¹¹⁴

Quarterly Claim Input File Submission Timeframes¹¹⁵

Dates	1st Month	2nd Month	3rd Month
01 - 07	Group 1	Group 5	Group 9
08 - 14	Group 2	Group 6	Group 10
15 - 21	Group 3	Group 7	Group 11
22 - 28	Group 4	Group 8	Group 12

V. PENALTIES

Section 111 contains provisions which provide for serious consequences upon the failure of an RRE to comply with its terms.¹¹⁶ The statute states, “[a]n applicable plan that fails to comply with the requirements under subparagraph (A) with respect to any claimant shall be subject to a civil money penalty of \$1,000 for each day of noncompliance with respect to each claimant. . . .”¹¹⁷ At the present time it appears as though insurers will be strictly liable under this section for failure to comply with the reporting requirements.

In addition, CMS is entitled to recover penalties based on any other available remedy. For example, RREs may be required to reimburse

¹¹² Ctrs. for Medicare & Medicaid Servs., *supra* note 5, at 34.

¹¹³ *Id.* at 33. (RREs receive their Claim Input File submission timeframe with the profile report sent after the COBC has processed their registration and account setup.).

¹¹⁴ Press Release, MARSH & Am. Soc. For Healthcare Risk Mgmt., *supra* note 100.

¹¹⁵ Ctrs. for Medicare & Medicaid Servs., *supra* note 4, at 33.

¹¹⁶ 42 U.S.C. § 1395y(b)(8)(E)(2008).

¹¹⁷ *Id.*

Medicare for any conditional payments made. Section 1395y(b)(2)(B)(iii), states, in pertinent part, when Medicare makes a conditional payment for medical services received as a result of an injury caused by another party, the government has a right of recovery for the conditional payment amount against any entity responsible for making the primary payment.¹¹⁸ A conditional payment is: “A Medicare benefit payment made for any item or service to which the exclusion for third-party payers applies, [which] is conditioned on reimbursement to the appropriate Medicare Trust Fund when notice or other information is received regarding a beneficiary’s entitlement to payment under a primary plan.”¹¹⁹

In a recent decision, *United States v. Harris*, the United States District Court for the Northern District of West Virginia was asked to examine the ability of CMS to recover monies owed by a beneficiary from such beneficiary’s attorney.¹²⁰ The court noted that to recover payment, “the government may ‘bring an action against any or all entities that are or were required or responsible . . . to make payment with respect to the same item or service . . . under a primary plan.’”¹²¹ Primary plan is defined as a group health plan or large group health plan and a workmen’s compensation law or plan, an automobile or liability insurance policy or plan (including a

¹¹⁸ 42 U.S.C. § 1395y(b)(2)(B)(iii). “In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan.” *Id.*; see also *Cox v. Shalala*, 112 F.3d 151, 154 (4th Cir. 1997) (“When such a conditional payment is made for medical care, the government has a direct right of recovery for the entire amount conditionally paid from any entity responsible for making primary payment.”).

¹¹⁹ 70C AM. JUR. 2D *Social Sec. & Medicare* § 2473 (2009).

¹²⁰ *U.S. v. Harris*, No. 5:08CV102, 2009 WL 891931, at *1 (N.D. W. Va. March 26, 2009) (holding that Plaintiff’s attorney became liable to Medicare immediately when he made payment to his client, a Medicare beneficiary. Mr. Harris’ client in a personal injury case had received Medicare benefits in the amount of \$22,549.67. Mr. Harris settled the personal injury action for \$25,000. He then distributed the settlement proceeds without reimbursing Medicare for its conditional payments. Medicare reduced its claim to \$10,253.59, taking into account Mr. Harris’ attorney’s fees, costs, and the amount of the settlement. Having already disbursed the settlement funds, Mr. Harris ignored Medicare’s rights. Thereafter, Medicare pursued Mr. Harris in court to recover its conditional payment).

¹²¹ *Id.* at *3 (quoting 42 U.S.C. § 1395y(b)(2)(B)(iii)).

self-insured plan) or no fault insurance.¹²² The government may also “recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity.”¹²³ Such an entity is defined as “a beneficiary provider, supplier, physician, attorney, State agency, or private insurer that has received a primary payment.”¹²⁴ Under *Harris*, an attorney may be held liable for monies due to CMS if her beneficiary client fails to make such payment. However, it appears as though this situation has rarely arisen. A Freedom of Information Act (hereinafter “FOIA”) request submitted to CMS revealed on three instances in which “CMS or its agents took action to recover conditional payments under the [MSP] Program.”¹²⁵

Under 42 U.S.C. § 1395y, liability for conditional payments made by Medicare can be further extended to the RRE. There are a variety of methods by which an RRE may protect itself from lawsuits to recover conditional payments. First, an RRE may make a payment directly to Medicare for the conditional payments which have been made and then make any remaining payment to the claimant. Second, the RRE may name Medicare as an additional payee as a material term to the settlement agreement. Alternatively, the RRE may establish a policy of refusing liability payments to claimants who fail to provide the required information.

The case of *Breitkopf v. Krieger*¹²⁶ illustrates how these methods may be used in practice. In *Breitkopf*, the parties entered into a settlement agreement under which they agreed Medicare’s rights had to be protected.¹²⁷ However, a dispute between the parties arose as to whether Medicare or CMS could appear as a payee on the settlement draft.¹²⁸ The claimant demanded a portion of settlement immediately, however, the insurer did not want to disburse the settlement proceeds for fear of the possibility that Medicare would pursue a claim against it if conditional payments were not repaid within 60 days.¹²⁹ The judge ordered half the money be paid to the claimant and the other half be placed in an escrow

¹²² 42 U.S.C. § 1395y(b)(2)(A).

¹²³ *Id.*

¹²⁴ 42 C.F.R. § 411.24(g)(2006).

¹²⁵ *Hart v. U.S. Dept. of Health & Human Servs.*, 676 F. Supp. 2d 846, 852 (D. Ariz. 2009).

¹²⁶ No. 09-1890 (E.D. Pa. Nov. 2, 2009).

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ *Id.*

account to be distributed to Medicare upon determination of the amount of conditional payments that had been made.¹³⁰

Under an agreement where Medicare is listed as an additional payee to the settlement agreement, the plaintiff's or claimant's attorney or the claimant would be required to obtain CMS' endorsement on the check before distributing or depositing the funds. This would provide CMS with the opportunity to recoup any monies owed to it for conditional payments made. Defense counsel and insurance companies should ensure that the naming of Medicare as an additional payee is a material term to the settlement agreement and that the claimant and/or plaintiff is aware of this term. In the recent decision in *Tomlinson v. Landers*,¹³¹ an insurer issued a settlement draft which included CMS as a payee after learning the Plaintiff was a Medicare beneficiary. The court rejected a Defendant's Motion to Enforce a Settlement on the ground that there was no "meeting of the minds" because the parties' settlement agreement did not include naming CMS as a payee.¹³² Under *Tomlinson*, it is essential that insurers and their attorneys include such a term in the settlement agreement.

A. CONSTITUTIONAL ISSUES

A significant Eighth Amendment constitutional issue is raised by the imposition of heavy fines on RREs for non-compliance, particularly in situations where the RRE is unable to obtain the required information from claimants. The Eighth Amendment provides: "Excessive bail shall not be required, *nor excessive fines imposed*, nor cruel and unusual punishments inflicted."¹³³ The Excessive Fines Clause "limits the government's power to extract payments, whether in cash or in kind 'as punishment for some offense.'"¹³⁴ "The touchstone of the constitutional inquiry under the Excessive Fines Clause is the principle of proportionality: The amount of the forfeiture must bear some relationship to the gravity of the offense that it is designed to punish."¹³⁵ In *Bajakian* the Court held a punitive forfeiture is violative of the Excessive Fines Clause if the forfeiture is "grossly

¹³⁰ *Id.*

¹³¹ No. 3:07-cv-1180-J-TEM, 2009 WL 1117399 (M.D. Fla. Apr. 24, 2009).

¹³² *Id.* at *3-5.

¹³³ U.S. CONST. amend. VIII (emphasis added).

¹³⁴ *Austin v. United States*, 509 U.S. 602, 610 (1993).

¹³⁵ *United States v. Bajakian*, 524 U.S. 321, 334 (1998) (Forfeiture of \$357,144 in case, based on "solely a reporting offense" when defendant failed to declare that he was transporting more than \$10,000 in currency out of the country, held constitutionally impermissible).

disproportional to the gravity of the defendant's offense."¹³⁶ Imposing a fine of \$1,000 per day is arguably disproportional to the offense when imposed on an insured or self-insured that is unable to obtain necessary information from the claimant. Here again, shifting the burden of the penalties to the beneficiary would alleviate an issue created by the Section 111 reporting requirements.

B. PROCESS FOR AVOIDING PENALTIES IMPOSED BY CMS

RREs must take care to develop intensive methods for providing claimants with any necessary forms and documenting all communications with the claimant. For example, the RRE should deliver any required forms to the claimant via certified mail; this method will allow the RRE to develop a record of communications with the claimant. If a response is not received on the initial attempt, the RRE should again attempt to deliver the form via the same method and should document each attempt to deliver the form. Instituting these types of comprehensive practices may allow the RRE to bring possible challenges to any fines imposed upon it in relation to those non-cooperative claimants.

C. SITUATIONS WHERE PENALTIES SHOULD BE IMPOSED ON CLAIMANT

As discussed above, there are likely to be situations where a claimant refuses to provide accurate and complete information relating to Medicare beneficiary status, including their HICN and SSN, to an RRE. An RRE should not be held responsible for its non-compliance with the Section 111 reporting requirements where the RRE has made multiple attempts, in good faith, to retrieve the necessary information from the claimant and can show the claimant is acting to hinder recovery of such information and to prevent a determination of the claimant's Medicare beneficiary status. The burden of proof should be placed on the RRE to establish its good faith attempts to collect the necessary information and that the claimant has hindered that collection.

Where a RRE is able meet its burden it should be excused from monetary liability as to that particular claimant. However, Medicare should not be prevented from collecting monetary fines in this circumstance; instead, the penalties which are to be imposed on the RRE should be shifted to the claimant and/or their representative for their interference with

¹³⁶ *Id.*

Medicare's ability to recoup any conditional payments, to ensure its position as secondary payer for future payments and/or to achieve the overall goal of protecting Medicare's future financial interests. Unlike the safe-harbor provisions which have been advocated by some industry professionals, which merely relieve all parties of liability, shifting the burden of financial penalties to the party responsible for non-compliance will serve the overarching goal of the Section 111 reporting requirements. Furthermore, shifting the burden to the claimant may provide an incentive for future claimants to comply with information requests sent by RREs. Therefore, shifting the financial burden will not only protect RREs from unreasonable penalties, but will result in a more effective process for CMS, RREs and claimants.

VI. HELPFUL SOLUTIONS

A. ERRORS & OMISSIONS INSURANCE POLICIES

The insurance industry has begun to offer new products in response to the reporting requirements. For example, American Empire Surplus Lines Insurance Company (hereinafter "American Empire"), a member of the Great American Insurance Group, has launched an errors and omissions (hereinafter "E&O") liability insurance product specifically designed for Medicare statutory compliance.¹³⁷ E&O insurance is "an agreement to indemnify for loss sustained because of a mistake or oversight by the insured."¹³⁸ Essentially, E&O coverage provides protection "in the event that an error or omission . . . has caused financial loss . . ."¹³⁹ In regards to American Empire's new E&O product, Bob Nelson, American Empire's President and Chief Operating Officer stated:

Our new policy, which provides E&O coverage for Medicare Statutory Compliance, is designed to help all entities who choose to self-insure their workers' compensation or third party liability exposures. The new Extension Act legislation has wide-ranging consequences

¹³⁷ Press Release, Am. Empire Surplus Lines Ins., Am. Empire Surplus Lines Ins. Co. Launches E&O Liab. Ins. For Medicare Statutory Compl. (Nov. 9, 2009).

¹³⁸ BLACK'S LAW DICTIONARY (8th ed. 2004).

¹³⁹ Glenda Wertz, *The Ins and Outs of Errors and Omissions Insurance*, INS. J., July 19, 2004, available at <http://www.insurancejournal.com/magazines/west/2004/07/19/features/44745.htm>.

to these employers, who may soon be confronted with demands from Medicare for reimbursement for claims they thought were settled.¹⁴⁰

The use of an errors and omissions policy will be particularly useful for self-insureds, particularly those that are small companies, where their new Section 111 reporting requirements will seem particularly onerous. An errors and omissions policy like the one discussed above will reduce the risk associated with self-insureds by ensuring coverage where any compliance mistakes are made by the self-insured which would otherwise result in the imposition of heavy fines.

RREs should take into consideration numerous factors in determining whether or not to purchase an E&O policy to protect against non-compliance with the reporting requirements. For instance, in the event an RRE uses an agent as discussed above, it is important to discern whether the E&O policy will cover mistakes made by the agent. Further, as with any type of insurance, RREs must consider what this type of E&O policy will cost.

B. MEDICARE SET ASIDE ARRANGEMENTS

The central goal behind the new reporting requirements enacted through MMSEA is to provide Medicare with additional tools by which to seek reimbursements for Medicare claims. Completing CMS-approved set-aside arrangements, commonly referred to as MSAs, will effectively serve this purpose. A Medicare set-aside is “an allocation for future payments under an insurance claims settlement designated exclusively to pay for medical services that would be covered by Medicare if the injury/illness is not covered by a private insurance program.”¹⁴¹ Medicare set-asides are currently required only in workers’ compensation settlements.¹⁴² The widespread use of Medicare set-asides in other settlement agreements will ensure that Medicare’s interests are being reasonably considered by the parties. The advantage of a Medicare set-aside arrangement is that when the set-aside amount has been completely exhausted, Medicare will become

¹⁴⁰ Am. Empire Surplus Lines Ins., *supra* note 137.

¹⁴¹ *A Closer Look: Medicare Set-Aside Arrangements Become an Issue for Risk Managers*, WORKPLACE STRATEGIES (MARSH, Global Offices) 2005, at 1.

¹⁴² *See id.*

the primary payer and will be responsible for all future Medicare-covered expenses related to the injury.¹⁴³

Under the current Medicare set-aside scheme for workers' compensation claims the following requirements must be met:

- (1) The claimant is currently a Medicare beneficiary and the total settlement amount is greater than \$25,000; OR,
- (2) The claimant has a "reasonable expectation" of Medicare enrollment within thirty (30) months of the settlement date and the anticipated total settlement amount for future medical expenses and disability/lost wages over the life or duration of the settlement agreement is expected to be greater than \$25,000.¹⁴⁴

The amount of a set-aside arrangement varies on a case-by-case basis and should be approved by CMS. The approval process would allow CMS to evaluate the extent to which its interests are being considered and advise the parties as to what adjustments, if any, must be made in their computations. In computing the amount to be "set-aside" the parties should consider: "all future medical expenses (including prescription drugs), repayment of any Medicare conditional payments, previously settled portions of a workers' compensation claim, life expectancy, inflation, administrative fees, wages, and attorney fees."¹⁴⁵

There are no current requirements that MSAs be used in the context of non-workers' compensation claims, including personal injury liability claims. However, using MSAs for these types of claims appears to be the most prudent way to protect Medicare's interests for future expenses

¹⁴³ Berdy & Nichols, *supra* note 3, at 397.

¹⁴⁴ *Id.* at 396 (citing Ctrs. for Medicare & Medicaid Servs., Workers Compensation Medicare Set-aside Arrangement, *available at* http://www.cms.hhs.gov/WorkersCompAgencyServices/04_wcsetaside.asp#TopOfPage); *see id.* (A claimant may have a "reasonable expectation" of Medicare enrollment when the individual (1) has applied for Social Security Disability Benefits; (2) has been denied Social Security Disability Benefits but anticipates appealing that decision; (3) is in the process of appealing and/or refiling for Social Security Disability Benefits; (4) is 62 and six months old; or, (5) has an End Stage Renal Disease condition but does not yet qualify for Medicare.).

¹⁴⁵ *Id.* Conditional payments are those payments made by Medicare to a provider for health care services. "Medicare can and will seek reimbursements from GHPs and non-GHPs for conditional payments made if it determines those payments were the responsible of a primary payer." *Id.* at 395.

and to protect RREs against future liability and fines. A system of MSA for personal injury liability claims could closely resemble the system currently in place for workers' compensation claims. If any scenario listed above exists, a set-aside arrangement would be an appropriate option.¹⁴⁶

VII. CONCLUSION

In an attempt to "protect its future financial interests," Medicare has imposed stringent new reporting requirements on liability (including self-insurance), no-fault and workers' compensation insurers. These new reporting requirements present a variety of obstacles which make strict compliance difficult for these entities. Lack of strict compliance can lead to the imposition of stiff monetary penalties on these entities, as well as liability for any other remedies available to CMS. The simplest way to avoid liability is for the RRE to retain reporting duties within itself, not to outsource that responsibility to agents. That is because RREs may not transfer its duty to report, that is, it will always be liable for errors and non-compliance, regardless if it actively participates in the actual reporting process.

Affected entities need to take care to ensure they determine the proper RRE for reporting purposes and that the RRE makes any and all attempts to ensure compliance. Ensuring compliance with the reporting requirements will be particularly difficult because the RRE must rely heavily on the trustworthiness and cooperation of the claimant who for all intents and purposes has little incentive to honor any information requests from the RRE. For this reason, the burden of penalties should be shifted from the RRE who attempts in good faith to the uncooperative claimant who through his or her actions is essentially interfering with Medicare's right to protect their interests.

As CMS works through the implementation of the mandatory reporting requirements, more "alerts" and information are sure to come. Until then, the hurdles and obstacles faced by RREs and their attorneys will remain great. And until then, entities involved in the liability (including self-insurance), no-fault, and workers' compensation insurance industry must be sure to determine their status as an RRE and comply with the current reporting requirements.

¹⁴⁶ *Id.* at 401.

DOWN THE ROAD TO PERDITION: HOW THE FLAWS OF BASEL II LED TO THE COLLAPSE OF BEAR STEARNS AND LEHMAN BROTHERS

John F. Rosato*

“For the last two decades, the Basel Committee keeps coming back to the same basic question: How much bank capital is enough?”¹

- FDIC Chairman, Sheila Bair

I. INTRODUCTION

It is often said that a wise farmer should “never let a fox guard the henhouse.” Echoing such sentiments, the U.S. FDIC Chairman, Sheila Bair, warned, “There are strong reasons for believing that banks left to their own devices would maintain less capital, not more, than would be prudent. . . . In short; regulators can't leave capital decisions totally to the banks. We wouldn't be doing our jobs or serving the public interest if we did.”² Chairman Bair made these comments in response to the proposed U.S. adoption of the 2004 Basel Accord (Basel II), which allows banks to develop statistical models for quantifying their individual capital requirements.³ Despite Chairman Bair's cautionary words, the U.S. Securities and Exchange Commission (SEC) became the first Federal agency to adopt the Basel II framework in late 2004.⁴

Under heavy pressure from broker-dealers such as Lehman Brothers the SEC adopted the Basel II framework through its Consolidated Supervised Entity (CSE) program.⁵ At its inception, the CSE program had

* J.D., University of Connecticut School of Law, 2011; M.B.A., University of Connecticut School of Business, 2011; B.A. in Political Science and History, University of Richmond, 2007. I would like to thank Professor Patricia McCoy for her feedback and assistance.

¹ Sheila Bair, Chairman, Fed. Deposit Ins. Corp., Remarks at the 2007 Risk Management and Allocation Conference (June 25, 2007) (transcript available at Factiva) [hereinafter Sheila Bair, Remarks].

² *Id.*

³ *Id.* (“When will the Americans finish the rule? We are working on it. We want a consensus on appropriate safeguards that will allow our banks to implement Basel II.”).

⁴ See SEC Alternative Net Capital Requirements for Broker-Dealers, 17 C.F.R. § 240 (2009) [hereinafter Alternative Net Capital Rule].

⁵ See Alternative Net Capital Rule, *supra* note 4; Letter from Joseph Polizzotto, Gen. Counsel, Lehman Brothers, Inc., to Jonathan G. Katz, Sec'y, U.S. Sec. & Exch. Comm'n (Mar. 8, 2004), *available at* <http://edgar.sec.gov/rules/proposed/s72103/lehmanbrothers03082004.htm>. [hereinafter Lehman Brothers

seven participants: Bear Stearns, Goldman Sachs, Lehman Brothers, Merrill Lynch, Morgan Stanley, JP Morgan, and Citigroup.⁶ In particular, Lehman Brothers championed the CSE program as generally increasing competitiveness and aligning U.S. regulations with the European Union.⁷ Fundamentally, these broker-dealers assured regulators that despite capital requirements being calculated internally, adequate risk-management policies and advanced statistical modeling would ensure that proper levels of capital would be maintained.

Despite the promise of the CSE, by March of 2008 three of the five participating firms had at least \$30 of debt to every \$1 in assets.⁸ Such ratios are far in excess of the SEC's standard limit of \$15 in debt to every \$1 in assets.⁹ Yet, even in the face of such alarming levels of leverage, the broker-dealers continued to assure the markets that they were in compliance with the CSE standards. On March 11th, three days before the collapse of Bear Stearns, SEC Chairman, Christopher Cox, stated that he had "a good deal of comfort" about the capital cushions being maintained by CSE participants.¹⁰ Despite such assurances, by the end of September 2008 all but two of the original CSE participants had dissolved or been acquired.¹¹ More alarmingly, September 15th, 2008, the day Lehman

Letter] ("Lehman Brothers applauds and supports the Commission in establishing a voluntary alternative method of computing net capital for certain broker-dealers. . .").

⁶ U.S. SEC. & EXCH. COMM'N OFFICE OF INSPECTOR GEN., SEC'S OVERSIGHT OF BEAR STEARNS AND RELATED ENTITIES: THE CONSOLIDATED SUPERVISED ENTITY PROGRAM iv, Report No. 446-A at iv (September, 2008) [hereinafter *OIG Report*].

⁷ See Lehman Brothers Letter, *supra* note 5.

⁸ Ben Protess, *Flawed SEC Program Failed to Rein in Investment Banks*, PROPUBLICA, Oct. 1, 2008, <http://www.propublica.org/article/flawed-sec-program-failed-to-rein-in-investment-banks-101>.

⁹ *OIG Report*, *supra* note 6, at ix.

¹⁰ Boyd Erman, *The Fed Rushes in as Wall Street Teeters*, GLOBE AND MAIL (Toronto), Mar. 12, 2008, at B1.

¹¹ Robert Schroeder, *Goldman, Morgan to Become Holding Companies: Companies get Access to Fed Lending in Exchange for Oversight*, MARKETWATCH, Sept. 21, 2008, <http://www.marketwatch.com/story/goldman-sachs-morgan-stanley-to-become-bank-holding-companies>. The remaining two firms, Goldman Sachs and Morgan Stanley applied to be bank holding companies, which effectively removed them from SEC oversight. *Id.*

Brothers filed for bankruptcy, surpassed 9/11 as the costliest day in Wall Street's history.¹²

Such events make Chairman Bair's words seem prophetic. The public is still left wondering what happened, and how regulators could have been so wrong? In an attempt to answer these questions, this Note will investigate the flaws of Basel II's capital requirements by examining the collapse of the investment banks Bear Stearns and Lehman Brothers.

Section II will discuss the relevant background and underlying principles of capital regulation. This information will lay the foundation for understanding how the Basel Accords operate. After establishing these basic principles, section III will outline the regulatory frameworks of the Basel I and Basel II accords. Next, section IV will explore how the U.S. Securities and Exchange Commission (SEC) applied the Basel II standards to investment banks and how the SEC rule contributed to the collapse of Bear Stearns and Lehman Brothers. Connected to the collapse of Bear Stearns and Lehman Brothers, section V will explore how the SEC failed to fulfill its regulatory obligations under the Basel II framework and how global regulators can avoid similar mistakes. Finally, this Note will conclude by recommending that global financial regulators reconsider the adoption of the advanced approach in light of the recent financial crisis, and return to a simpler form of regulation.

II. CONCEPTUAL FOUNDATIONS FOR THE REGULATION OF FINANCIAL INSTITUTIONS

A. WHY WE REGULATE INVESTMENT BANKS

In their simplest form, investment banks are financial intermediaries that pool money raised from investors, and invest that money in securities ranging from corporate stocks and bonds to mortgage-backed securities.¹³ However, unlike depositors in a commercial bank, investors in an investment bank are not guaranteed a specific return and can theoretically lose their entire investment in the company.¹⁴ In return for this additional risk, investment banks offer portfolios with a far broader range of investments and thus, rewards, than traditional commercial bank deposits.

¹² Niall Ferguson, *The Descent of Finance*, HARV. BUS. REV., Jul. 1, 2009, <http://hbr.org/2009/07/the-descent-of-finance/ar/1>.

¹³ RICHARD SCOTT CARNELL ET AL., *THE LAW OF BANKING AND FINANCIAL INSTITUTIONS* 555 (Vicki Been et al. eds., 4th ed. 2009).

¹⁴ *Id.*

Some argue that investment banking is nothing more than a for-profit business similar to any other commercial enterprise.¹⁵ As a result, the advocates of this position assert that investment banks should be subject to the same regulatory oversight as any other business.¹⁶ Such oversight is often relaxed or entirely nonexistent. Nonetheless, every nation in the world subjects investment banks to some form of advanced regulatory supervision.¹⁷ What is the reason for such regulation?

In 1911, Justice Rousseau Angelus Burch provided a clairvoyant answer when he described the economic role of banks as being “indispensible agencies through which the industry, trade and commerce of all civilized countries and communities are now carried on.”¹⁸ Though Justice Burch was specifically referring to commercial banks, his logic applies to investment banks as well. At the beginning of 2008, investment banks held assets in excess of \$13 trillion (23% of total U.S. household financial assets).¹⁹ Given investment banks’ prominent role in creating and maintaining wealth, it should be of little surprise that the proper functioning of the investment banking industry is in the interest of every nation. Like the failure of a commercial bank, the failure of an investment bank carries greater significance than the failure of most other commercial enterprises. Not only does an investment bank’s failure destroy the wealth of its investors, it erodes the public’s confidence in the financial system as a whole, which reduces the flow of credit and, thus, commerce.²⁰ Accordingly, in order to preserve the flow of commerce and protect the wealth of households, nations impose regulations that seek to minimize an investment bank’s exposure to a variety of risks.²¹

Today, financial regulatory schemes are based on several primary principles. First, regulators control entry into the banking industry through

¹⁵ PETER WALLISON, WHY DO WE REGULATE BANKS? 2 (Am. Enter. Inst., August, 2005) available at http://www.aei.org/docLib/20050729_18781FSOAUG05_g.pdf.

¹⁶ *Id.*

¹⁷ For list of nations, see INTERNATIONAL MONETARY FUND, REPORTS ON THE OBSERVANCE OF STANDARDS AND CODES, available at <http://www.imf.org/external/np/rosc/rosc.asp?sort=topic#BankingSupervision> (last visited May. 2, 2010) [hereinafter *Observance Standards*].

¹⁸ *Schaake v. Dolley*, 118 P. 80, 84 (Kan. 1911).

¹⁹ CARNELL ET AL., *supra* note 14.

²⁰ *Id.*

²¹ L. Jacobo Rodriguez, *International Banking Regulation: Where’s the Market Discipline in Basel II?*, POLICY ANALYSIS, Oct. 15, 2002, at 3, available at <http://www.cato.org/pubs/pas/pa455.pdf>.

the issuance of licenses and impose penalties on institutions that fall out of compliance with the requirements of entry.²² Second, regulators generally impose capital requirements that force banks to hold minimum levels of money in reserve.²³ Finally, regulators attempt to impose market discipline on the financial industry through the public disclosure of financial information, which permits investors and depositors to assess the risk associated with a particular bank.²⁴ This Note is primarily concerned with the second principle, minimum capital requirements.

B. THE DEFINITION OF CAPITAL

When regulators refer to a bank's capital they are referring to the "financial cushion that depository institutions maintain to shield themselves from unanticipated losses."²⁵ In its simplest terms, capital is the amount by which financial institution's assets exceed the institution's total liabilities.²⁶ Core capital primarily consists of retained earnings and shareholder's equity.²⁷ It is a generally accepted principle of financial regulation that the larger a financial institution's capital, the more likely the institution will be able to repay its investors and avoid failure.²⁸ In addition, forcing financial institutions to hold a minimum level of capital helps incentivize reasonable risk-taking on the part of the company's shareholders.²⁹

²² RESERVE BANK OF INDIA DEPARTMENT OF BANKING SUPERVISION, CORE PRINCIPLES OF EFFECTIVE BANKING SUPERVISION, §§ 1-2 (1999) (Discussing the essential elements of an effective regulatory system and licensing as core principles of banking regulation), available at <http://www.rbi.org.in/upload/publications/pdfs/10115.pdf>.

²³ *Id.* at § 3 (discussing capital requirements as core principles of banking regulation).

²⁴ *Id.* at § 5 (discussing the disclosure of financial statements as a core principle of banking regulation).

²⁵ PATRICIA MCCOY, BANKING LAW MANUAL: FEDERAL PRUDENTIAL REGULATION OF BANKS AND THRIFTS § 6.03 (Matthew Bender & Co. 2009).

²⁶ Capital is the "net worth of a business; that is, the amount by which its assets exceed its liabilities." InvestorWords.com, Capital, <http://www.investorwords.com/694/capital.html> (last visited April 12, 2011).

²⁷ Equity Capital is "[i]nvested money that, in contrast to debt capital, is not repaid to the investors in the normal course of business. It represents the risk capital staked by owners through purchase of the firm's common stock." Businessdictionary.com, Equity Capital, <http://www.bis.org/press/p981027.htm> (last visited Feb. 26, 2011).

²⁸ CARNELL ET AL., *supra* note 13, at 252.

²⁹ MCCOY, *supra* note 25.

The simplest form of capital regulation is called a “debt-to-capital ratio.” For investment banks, the debt-to-capital ratio represents the ratio of total debt to total equity capital. A higher ratio indicates that the investment bank has more risk associated with its portfolio of investments.³⁰ For instance, suppose that an investment bank has \$310 in assets, \$300 in debt, and \$10 in equity capital (\$310 in assets - \$300 in debt). By dividing total debt by total equity capital we arrive at a leverage ratio of 300/10 or 30-to-1. However, this simple measure of an investment bank’s capital adequacy assumes that all assets are equally suited to providing an effective capital cushion. This assumption fails to account for each asset’s level of risk and risk of default. To solve this obvious flaw, financial regulators developed “risk-adjusted” capital standards.³¹

C. RISK-ADJUSTED CAPITAL STANDARDS

To adequately account for each individual asset’s unique risk profile, international financial regulators employ “risk-adjusted capital standards.” This type of capital adequacy standard, pioneered in the 1988 Basel Accord (Basel I), requires that banks hold a level of capital commensurate with an asset’s credit risk.³² For instance, would you rather place your money in a bank that maintains investments in U.S. Treasury bonds or commercial bonds? Naturally, one favors the bank that invests in U.S. Treasury bonds because U.S. sovereign debt is backed by the full faith and credit of the American people. Similarly, banking regulators need to make judgments about the stability and value of a bank’s assets when calculating the appropriate level of capital that should be held. In the above scenario the bank investing in U.S. Treasury bonds would be required to hold no additional capital, while the bank investing in commercial bonds would be required to hold a more capital in reserve.

This discrepancy results from the varying level of confidence that regulators have in the stability of the underlying asset. Since the bank’s investment in Treasury bonds has few risks and a relatively stable value, regulators have a great deal of confidence that such an asset will act as an effective financial cushion to absorb a bank’s unanticipated losses.

³⁰ *Id.*

³¹ See generally BASEL COMMITTEE ON BANKING REGULATIONS AND SUPERVISORY PRACTICES, INTERNATIONAL CONVERGENCE OF CAPITAL MEASUREMENT AND CAPITAL STANDARDS (1988), available at <http://www.bis.org/publ/bcbsc111.pdf?noframes=1> [hereinafter BASEL I].

³² *Id.* at 7-8.

However, the bank's investment in commercial bonds is inherently more risky. Commercial bonds are susceptible to interest rate fluctuations, the creditworthiness of the debtor company, and a host of other issues that threaten their stability and valuation. As a result of this additional uncertainty, regulators have significantly less confidence in the commercial bonds acting as an effective financial cushion. Accordingly, the primary result of employing risk-adjusted capital standards is to force banks with riskier portfolios of assets to hold larger amount of capital in reserve.³³

III. THE DEVELOPMENT OF INTERNATIONAL BANKING REGULATION

A. BASEL I

In 1988, the Basel Committee on Banking Supervision (Basel Committee) completed the Basel I accord, which establishes a framework for measuring capital adequacy for internationally active banks.³⁴ Basel I, which has since been adopted by more than 100 countries, was developed in response to several financial crises during the 1980's.³⁵ The goal of Basel I is to stabilize the global banking system through uniform capital adequacy standards and to reduce regulatory competition by establishing common regulations for all banks.³⁶ Basel I accomplishes these goals by utilizing a risk-adjusted capital framework, focusing on the measurement of a bank's capital adequacy in relation to its credit risk.³⁷ Basel I was later amended to also account for market risk.³⁸ At the heart of Basel I is a three-step process: 1) determining total capital 2) determining risk-weighted assets; and 3) determining the risk-adjusted capital ratio.³⁹

³³ See MCCOY, *supra* note 26.

³⁴ BASEL I, *supra* note 31.

³⁵ RODRIGUEZ, *supra* note 21, at 7.

³⁶ BASEL I, *supra* note 31, at 1 (“[T]he new framework should serve to strengthen the soundness and stability of the international banking system; and...have a high degree of consistency in its application to banks in different countries with a view to diminishing an existing source of competitive inequality among international banks.”).

³⁷ *Id.* at 8.

³⁸ W. Ronald Gard, Article, *George Bailey in the Twenty-First Century: Are we Moving to the Postmodern Era in the International Financial Regulation with Basel II?*, 8 TENN. J. BUS. L. 161, 183 (2006).

³⁹ CARNELL ET AL., *supra* note 13, at 259-65 (discussing three phase process for calculating a bank's capital adequacy).

1. Total Capital: Tier 1 and Tier 2

Since not all forms of capital provide an effective cushion against losses, Basel I divides a bank's total capital into two tiers.⁴⁰ Tier 1 (Core) capital is the preferred form of capital and consists of common equity shares, non-cumulative preferred shares, and holdings in consolidated subsidiaries.⁴¹ Because of its preferred status, regulators require that 50% of a bank's capital requirements be satisfied with Tier 1 assets.⁴² Tier 2 (Supplementary) capital accounts for all other non-preferred forms of capital.⁴³ Tier 2 capital commonly includes hybrid capital instruments, subordinated debt, and general loan-loss reserves.⁴⁴

Using these tiers, Basel I establishes limits and restrictions on the composition of a bank's total capital. Most prominently, Basel I limits Tier 2 capital to 100 percent of Tier 1 capital.⁴⁵ In other words, if a bank has \$500,000 in Tier 1 capital and \$1 million in Tier 2 capital, the bank's total capital can only be \$1 million (\$500,000 in Tier 1 capital and \$500,000 in Tier 2 capital). Additionally, Basel I limits subordinated debt to 50 percent of Tier 1 capital.⁴⁶ For instance, if a bank has Tier 1 assets of \$500,000 and subordinated debt of \$1 million, the bank's total capital cannot exceed \$750,000 (\$500,000 in Tier 1 capital and \$250,000 in subordinated debt). After appropriately sorting a bank's assets and applying the requisite restrictions, a bank's total capital can be determined by simply adding Tier 1 to Tier 2.⁴⁷

2. Risk-Adjusted Assets

Next, Basel I values a bank's "risk-adjusted assets" by dividing a bank's total assets into four broad categories or "buckets."⁴⁸ Each bucket is assigned a specific conversion factor or "risk-weight" that is tied to the

⁴⁰ See BASEL I, *supra* note 31, at 3-7 (discussing the constituent elements of capital).

⁴¹ *Id.* at 14-15.

⁴² *Id.* at 3-4.

⁴³ *Id.* at 4-6.

⁴⁴ *Id.* at 14.

⁴⁵ BASEL I, *supra* note 31, at 14.

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ RODRIGUEZ, *supra* note 21, at 8.

credit risk associated with the assets contained in each category.⁴⁹ Specifically, the four buckets and their associated risk-weights are: 1) cash and government securities-0 percent; 2) interbank claims-20 percent; 3) debt secured by real property-50 percent; and 4) all other obligations, including corporate debt-100 percent.⁵⁰ Once a bank's total assets have been appropriately sorted into the above categories, the dollar value of each category is multiplied by the conversion factor.⁵¹ The resulting dollar amounts represent the risk-weighted asset value for each category. For instance, if a bank has \$100,000 in mortgages (debt secured by real property), the risk-weighted value of those mortgages is \$50,000 (100,000 multiplied by the conversion factor of 50 percent).

In addition, Basel I also provides mechanisms for drawing otherwise off-balance-sheet obligations, such as letters of credit, into total risk-adjusted assets for purposes of capital adequacy.⁵² Once again, off-balance sheet obligations are grouped into the same four buckets, and multiplied the by the conversion factors: 0 percent, 20 percent, 50 percent, and 100 percent.⁵³ By summing the risk-weighted value of categories 1-4 we can calculate a bank's total risk-weighted asset value.

3. Risk-Adjusted Capital Ratio

Finally, Basel I sets the ratio of minimum capital to risk-weighted assets at 8 percent,⁵⁴ of which Tier 1 capital must be at least 4 percent.⁵⁵ For instance, if a bank has total risk-weighted assets of \$100,000, the bank would be required to hold a minimum of \$8,000 in capital (\$100,000 x .08). At least \$4,000 of the \$8,000 capital charge would need to be Tier 1 capital (\$100,000 x .04). However, Basel I assumes that national bank regulators will require banks to operate with capital levels in excess of the 8 percent

⁴⁹ *Id.*

⁵⁰ *Id.* at 8 tbl. 1.

⁵¹ *Id.* at 8.

⁵² BASEL I, *supra* note 31, at 19.

⁵³ *Id.* at 25 ("Once the bank has calculated the credit equivalent amounts, whether according to the current or the original exposure method, they are to be weighted according to the category of counterparty in the same way as the main framework...").

⁵⁴ *Id.* at 13.

⁵⁵ *Id.*

minimum.⁵⁶ Internationally active banks had until 1992 to bring their capital reserves into compliance with this ratio.⁵⁷

4. Criticisms of Basel I

While Basel I represents an elegantly simple way of calculating a bank's risk-adjusted capital, the accord has been plagued by problems.⁵⁸ First, the use of broad risk categories and risk-weights incorrectly assumes that all assets within a single category are equally risky.⁵⁹ For instance, under Basel I the government bonds of Greece are assumed to be equally as risky as the government bonds of the United States.⁶⁰ As the current sovereign-debt crisis in Greece demonstrates, it is not only imprudent, but incorrect to assume that the same level of risk is associated with each individual asset in a particular risk group. Additionally, Basel I's broad-brush risk categories encourage banks to invest in riskier assets within a given risk category.⁶¹ For instance, since all mortgages have a .50 risk-weight,⁶² banks have an incentive to hold riskier (higher paying) mortgages without holding a commensurate amount of additional capital. These limitations were of great concern to global regulators who feared that the Basel I framework had not adequately accounted for the riskiness of a bank's assets.⁶³ As a result, the Basel Committee began work on a revised capital adequacy framework in 1999.⁶⁴

B. BASEL II

In an effort to correct the pitfalls of Basel I, the Basel Committee released a revised capital adequacy framework known as Basel II in 2004.⁶⁵

⁵⁶ *Id.* at 2.

⁵⁷ Gard, *supra* note 38, at 178.

⁵⁸ RODRIGUEZ, *supra* note 21, at 9.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.* at 10.

⁶² *Id.* at 8 tbl. 1.

⁶³ *Id.* at 11.

⁶⁴ See generally BASEL COMMITTEE ON BANKING SUPERVISION, A NEW CAPITAL ADEQUACY FRAMEWORK (June 1999) <http://www.bis.org/publ/bcbs50.htm>; see also MCCOY, *supra* note 26.

⁶⁵ See generally BASEL COMMITTEE ON BANKING SUPERVISION, INTERNATIONAL CONVERGENCE OF CAPITAL MEASUREMENT AND CAPITAL

The new accord is based on three pillars: I) minimum capital requirements for credit risk, market risk, and operation risk; II) Guidelines for effective supervisory review; and III) market discipline through enhanced public disclosures about capital adequacy.⁶⁶ This Note will primarily focus on how Pillars I and II contributed to the collapse of Bear Stearns and Lehman Brothers.

Though Basel II represents a significant departure from Basel I, key elements of Basel I were retained.⁶⁷ For instance, Basel II still utilizes risk-adjusted capital standards, the 8 percent capital ratio, and the classification of capital into Tier 1 and Tier 2.⁶⁸ However, Basel II does introduce significant changes to how the risk may be calculated under Pillar I.⁶⁹ In an effort to correct the “one size fits all” approach of Basel I, Basel II sets up two approaches to calculating a bank’s minimum capital requirement, the “standardized approach” and the “advanced approach.”⁷⁰

1. Pillar I: The Standardized and Advanced Approaches

The standardized approach is best understood as a modified version of the basic risk-adjusted capital requirements in Basel I. The Basel Committee decided to leave this approach intact as an option for banks that may not be able to comply with the significantly more complex advanced approach.⁷¹ Under the standardized approach, the concept of sorting assets into risk categories or “buckets” remains, but the number of buckets is increased.⁷² Additionally, the standardized approach now forces banks to take a standard capital charge to account for market risk.⁷³ Finally, the standardized approach ties the risk-weights assigned to each “bucket” to the external credit-rating of the borrower as issued by companies such as Standard & Poor’s.⁷⁴ By tying the risk-weight to the market-based credit

STANDARDS: A REVISED FRAMEWORK, COMPREHENSIVE VERSION (June 2004)
<http://www.bis.org/publ/bcbs107.pdf?noframes=1> [hereinafter BASEL II].

⁶⁶ *Id.* at 2.

⁶⁷ MCCOY, *supra* note 25 at § 6.03[2].

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ BASEL II, *supra* note 66, at 15, 48; MCCOY, *supra* note 26 at § 6.03[2].

⁷¹ MCCOY, *supra* note 25, at § 6.03[2]a.

⁷² BASEL II, *supra* note 66, at 15, 23 (discussing individual risk categories and associated risk-weights); MCCOY, *supra* note 25, at § 6.03[2]a.

⁷³ MCCOY, *supra* note 25, at § 6.03[2]a.

⁷⁴ BASEL II, *supra* note 65, at 19-27 (discussing the assessment of credit risk using the ratings from “external credit assessment institutions”).

ratings, it is hoped that banks will be less inclined to engage regulatory arbitrage.⁷⁵

By making these modifications, the Basel Committee hoped to correct the problems of Basel I and preserve the basic risk-adjusted capital framework for the banks that chose to utilize it. However, for the largest internationally active banks the Basel Committee developed a far more complex form of capital adequacy standards aimed at providing banks with great flexibility.⁷⁶

The Basel Committee's goal in developing the advanced approach was to give weight to the qualitative differences in banks' [risk management] choices.⁷⁷ The advanced approach permits the largest internationally active banks to estimate their own levels of risk or "risk-weights" by utilizing their own internal value at risk (VaR) statistical models.⁷⁸ The advanced approach is based on the assumptions that banks are better informed about their own risk profiles than regulators, and that banks have a natural incentive to avoid undue losses.⁷⁹ It was hoped that the additional flexibility provided by the advanced approach would help banks realize more consistent profits through improved capital deployment.⁸⁰

i. Understanding the Value at Risk Statistical Model

Value at risk models (VaR) "measure the risk of a portfolio of assets by estimating the probability that a given loss might occur."⁸¹ Put differently, VaR models tell us that there is an X percent probability that a portfolio will lose more than X dollars over a certain period of time.⁸² Under Basel II, banks using the advanced approach are required to develop

⁷⁵ MCCOY, *supra* note 25, at § 6.02[2]a.

⁷⁶ THE FEDERAL RESERVE, CAPITAL STANDARDS FOR BANKS: THE EVOLVING BASEL ACCORD 398 (Sept. 2003) <http://www.federalreserve.gov/pubs/bulletin/2003/0903lead.pdf> [hereinafter *FRB Capital Standards*].

⁷⁷ Gard, *supra* note 38, at 189.

⁷⁸ See BASEL II, *supra* note 65, at 48-112 (discussing the mechanics and requirements of the "internal ratings-based approach").

⁷⁹ MCCOY, *supra* note 26, at § 6.03[2]b.

⁸⁰ Gard, *supra* note 38, at 189-90.

⁸¹ *The Risks of Financial Modeling, VaR and the Economic Meltdown: Hearing before the Subcomm. on Investigations & Oversight, 111th Cong.* 59 (Sept. 2009) (Statement of Richard Bookstaber, Risk Manager, Bridgewater Associates) [hereinafter *Risks of Financial Modeling*].

⁸² *Id.*

VaR models that have a confidence levels of 99 percent, meaning that the model is incorrect only 1 percent of the time.⁸³ To construct a basic VaR model a risk-manager would take the following steps: 1) identify all the assets held in a portfolio; 2) obtain the daily returns for each individual asset for the past 250 trading days (one year); 3) aggregate the returns for each individual asset to obtain the return for the entire portfolio over the past 250 trading days; 4) order the daily portfolio returns from highest to lowest to develop an estimate of the daily value at risk at the 99 percent confidence level, and 5) smooth the results by fitting the returns to the Normal distribution function and incorporating additional risk variables.⁸⁴

However, like all mathematical equations, VaR models have limitations. For instance, a properly constructed VaR model needs to include variables that account for the probability of inherent risks, such as the risk of default.⁸⁵ A failure to input such variables or to input correct probabilities can result in an ineffective model that permits a financial institution to make imprudent investment choices. Additionally, VaR models are dependent upon the assumption that the past trading history for an asset is a reasonable representation of how the asset will trade in the future.⁸⁶ For instance, if the 250 trading day sample only includes a positive trading cycle, a very low probability of decline will be included in the model's predictions. Additionally, since VaR models operate at the 99% confidence level there is still a 1% chance that the model is completely incorrect.⁸⁷ A huge limitation of the VaR model is that it does not tell you whether the 1% represents a catastrophic or minor market event.⁸⁸ Thus, one should not be lulled into a false sense of security by the fact that VaR models employ advanced statistics. The quality and accuracy of VaR models will inevitably vary based on the quality of the inputs and those constructing it.

2. Pillar 2: Supervisory Review

Pillar 2 of the Basel II accord outlines four supervisory principles to guide regulators in participating countries.⁸⁹ The guidelines are meant to

⁸³ See BASEL II, *supra* note 65, at 73.

⁸⁴ *Risks of Financial Modeling*, *supra* note 81.

⁸⁵ *Id.* at 59-60.

⁸⁶ *Id.* at 60.

⁸⁷ Joe Nocera, *Risk Mismanagement*, N.Y. TIMES, Jan. 4, 2009, at MM24.

⁸⁸ *Id.*

⁸⁹ See BASEL II, *supra* note 65, at 158-72 (Discussing the supervisory review process).

ensure that all regulators require that, “banks have adequate capital to support all the risks in their business... [and] to encourage banks to develop and use better risk management techniques in monitoring and managing their risks.”⁹⁰

The four principles are that: 1) banks should have a process for assessing their overall capital in relation to their risk profile and strategy for maintaining their capital levels; 2) regulators should review and evaluate banks’ internal capital adequacy assessments and strategies as well as their ability to monitor and ensure their compliance with regulatory capital ratios. Regulators should take appropriate action if they are not satisfied with the results of this process; 3) regulators should expect banks to operate above the minimum regulatory capital ratios and should have the ability to require banks to hold capital in excess of the minimum; and 4) regulators should seek to intervene at an early stage to prevent capital from falling below the minimum levels required to support the risk characteristics of the particular bank.⁹¹

The principles on supervisory review are an important aspect of achieving the uniform implementation of the accord. Such guidelines are necessary, because Basel II gives each member nation latitude in determining how to implement the framework.⁹² In addition, the added regulatory complexity of Basel II requires adequate supervision in order to compensate for the added flexibility given to banks.⁹³ As the recent financial crisis has shown us, without proper regulatory oversight, risk-models can be approved without proper inspection and banks may be allowed to dip below minimum capital requirements before enforcement action is taken.

C. THE CONSOLIDATED SUPERVISED ENTITY PROGRAM

In 2003, the European Union (EU) issued the Financial Conglomerates Directive, which required that financial conglomerates operating with the EU be supervised by either EU financial regulations or

⁹⁰ *Id.* at 158.

⁹¹ *Id.* at 159-65 (discussing the “four key principles of supervisory review”); Rodriguez, *supra* note 21, at 14.

⁹² *Id.* at 2 (“[T]he framework also allows for a limited degree of national discretion in the way in which each of these options may be applied, to adapt the standards to different conditions of national markets.”).

⁹³ Erik F. Gerding, *Code, Crash, and Open Source: The Outsourcing of Financial Regulation to Risk Models and the Global Financial Crisis*, 84 WASH. L. REV. 127, 188 (2009).

by a set of substantially equivalent rules.⁹⁴ Given the comprehensive nature of the EU financial regulations, the major U.S. investment banks preferred to be regulated by the SEC.⁹⁵ Unfortunately, the Gramm-Leach-Bliley Act of 1999 created a regulatory void in the U.S. for systemically-important investment bank holding companies.⁹⁶ Nevertheless, major investment banks pressured the SEC to fill the regulatory void in order to avoid the exacting EU regulations.⁹⁷ In response to this pressure, the SEC created a voluntary supervision option for broker-dealers known as the consolidated supervised entity (CSE) program.⁹⁸ The CSE program incorporated the three pillars of Basel II, and allowed the SEC to supervise broker-dealers on a consolidated basis, including their holding companies and affiliates.⁹⁹ The goal of the program was to permit the SEC to monitor the systemic risks to U.S. regulated investment banks posed by their unregulated affiliates.¹⁰⁰

As part of the CSE program, an investment bank could apply to the SEC for an exemption from the Commission's standard net capital rule.¹⁰¹ After obtaining such an exemption and agreeing to consolidated supervision, the investment bank was permitted to compute its required capital using an "alternative method" that complied with the Basel II capital standards.¹⁰² However, unlike Basel II, participating financial institutions would be required to maintain an overall Basel capital ratio of

⁹⁴ Report of Examiner Anton R. Vukas, at 1484, In re Lehman Brothers Holdings, 433 B.R. 133 (Bankr. S.D.N.Y. 2010) (No. 08-13555) *available at* <http://lehmanreport.jenner.com/VOLUME%204.pdf> [hereinafter *Examiner's Report*].

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ See *Lehman Brothers Letter*, *supra* note 5.

⁹⁸ See *Examiner's Report*, *supra* note 94, at 1484-85.

⁹⁹ *OIG Report*, *supra* note 6, at 2-3.

¹⁰⁰ *Id.* at viii ("The regime is intended to allow the Commission to monitor for, and act quickly in response to, financial or operational weakness in a CSE holding company or its unregulated affiliates that might place regulated entities, including US and foreign-registered banks and broker-dealers, or the broader financial system at risk.").

¹⁰¹ *Id.* at 2. Under the standard net capital rule it must meet certain ratios and maintain minimum net capital levels based on the type of securities activities they conduct.

¹⁰² *Id.* at 2-3.

not less than the Federal Reserve's 10 percent well capitalized standard.¹⁰³ Based on the specific risk qualities of its assets, a firm's internal risk modeling could require it to maintain a capital ratio well above the 10 percent minimum.¹⁰⁴

Investment banks such as Bear Stearns and Lehman Brothers favored the adoption of the CSE program, because they believed that their superior risk-management systems would result in lower capital requirements.¹⁰⁵ However, Alan Greenspan aptly pointed out in 2002 that "all risk-management strategies rest on uncertain forecasts and the models underlying the frontier approaches . . . depend on key assumptions that rest on fragmentary or indirect evidence . . . To be sure, even the most sophisticated risk models will never be a complete substitute for experienced judgment."¹⁰⁶ Unfortunately, Mr. Greenspan's concerns were validated on March 14th, 2008, the day Bear Stearns declared bankruptcy.

IV. THE COLLAPSE OF BEAR STEARNS AND LEHMAN BROTHERS

On March 14th, 2008, J.P. Morgan acquired Bear Stearns in a federally orchestrated and assisted effort to save the financial markets from imminent peril.¹⁰⁷ At the time of its acquisition, Bear Stearns had a debt-to-equity ratio of 33 to 1.¹⁰⁸ Similarly, prior to its collapse on September 15th, Lehman Brothers' debt-to-equity ratio reached a high of 32 to 1.¹⁰⁹ Such ratios are in stark contrast to the SEC's standard net-capital rule, which only permits a debt-to-equity ratio of 15 to 1.¹¹⁰ Yet, despite these

¹⁰³ *Id.* at 3 ("The CSEs are required to maintain an overall Basel capital ratio of not less than the Federal Reserve's 10 percent 'well capitalized' standard for bank holding companies.").

¹⁰⁴ BASEL II, *supra* note 66, at 211.

¹⁰⁵ *OIG Report*, *supra* note 6, at 4.

¹⁰⁶ Alan Greenspan, Chairman, Federal Reserve, Remarks at the Conference on Bank Structure and Competition, Chicago, IL. (May 10, 2002) <http://www.federalreserve.gov/boarddocs/speeches/2002/20020510/default.htm>.

¹⁰⁷ See David Ellis & Tami Luhby, *Bear Stearns Bailout Keeps Firm Afloat*, CNNMONEY.COM, March 14, 2008, http://money.cnn.com/2008/03/14/news/companies/jpm_bsc/index.htm?section=money_topstories.

¹⁰⁸ *OIG Report*, *supra* note 6, at 19.

¹⁰⁹ Lehman Brothers Holdings Inc., Quarterly Report (Form 10-Q), 89 (May 31, 2008), available at http://www.rns-pdf.londonstockexchange.com/rns/8436Z_1-2008-7-24.pdf.

¹¹⁰ *OIG Report*, *supra* note 6, at 19.

alarmingly high rates of leverage, Bear Stearns and Lehman Brothers reportedly never fell below the 10 percent capital minimum of the CSE program.¹¹¹ How could these firms have been allowed to reach such high rates of leverage and how could the SEC have maintained confidence in the capital adequacy of these firms? The section below will demonstrate how flaws in VaR modeling, non-compliance with Basel II principles, and failures in SEC oversight helped diminish each firm's capital adequacy and contributed to their collapse.

A. FAILURE OF VAR MODELING (PILLAR I)

As previously discussed, the central innovation of Basel II is the advanced approach for calculating capital adequacy. Essential to the operation of the advanced approach is the VaR statistical model, which allows banks to calculate the risk associated with a particular portfolio of assets. However, as mentioned above, VaR models contain several assumptions that, if not recognized, will result in a distortion of the model's results. Specifically, the models will yield imprecise risk measures, which will adversely affect the level of capital held by the financial institution. It was precisely a lack of attention to the VaR model's assumptions and thus, its limitations, that helped drive Bear Stearns and Lehman Brothers to the brink.

One of the basic assumptions underlying any statistical model is that all of the variables are properly included. In a risk model such as VaR, this means that all of the known assets in a portfolio and their associated risk assumption are included.¹¹² For instance, if a bank were to construct a risk model for a portfolio of mortgage-backed securities, it would be essential that variables such as home prices, interest rate fluctuations, and delinquency rates were included. Such variables represent only the most basic forms of risk associated with mortgage-backed securities and are essential to producing models that yield accurate results. Yet, Bear Stearns' VaR models for mortgage-backed securities failed to adequately account for both the natural fluctuation in home prices and delinquency rates.¹¹³ As a result, in the months leading-up to its collapse, Bear Stearns'

¹¹¹ *Id.* at viii-ix.

¹¹² *Risks of Financial Modeling*, *supra* note 81, at 3.

¹¹³ *OIG Report*, *supra* note 6, at 23.

risk-modeling floundered.¹¹⁴ Because of these inconsistencies, internal memos suggest that the trading-desks began to ignore the advice of risk-managers.¹¹⁵ Internal confidence in risk-modeling was further eroded when Bear Stearns abruptly replaced an experienced risk-manager, which resulted in the further disruption of the company's risk-management structure.¹¹⁶

Additionally, and potentially most critically, VaR models need to have sufficient historical trading and valuation data in order to accurately project future results.¹¹⁷ For instance, if a financial institution's VaR model only contained data during a stable or positive market trend, the model may not accurately forecast potential downswings in valuation. Unfortunately, VaR models at most financial firms included historical trading data that did not adequately capture the volatility of the assets.¹¹⁸ As a result, though the VaR models were operating correctly, they were not accurately projecting the risk of future downturns in asset valuations.

Because of the above and other limitations of VaR models, it is essential that they are adequately "stress-tested."¹¹⁹ Since the VaR models operate at the 99% confidence level, there is still a 1% chance that the model is completely incorrect.¹²⁰ However, a huge limitation of the VaR model is that it doesn't tell you what can happen during the 1% of the time when it is wrong.¹²¹ Thus, to assess whether the 1% represents a catastrophic failure or a small blip, stress testing puts the model through a series of hypothetical stresses to see how it will react. For instance, for a portfolio of corporate bonds a bank might place the VaR model through a test involving a dramatic change in interest rates. Though both Bear

¹¹⁴ Mark Pittman, *Cox's SEC Censors Report on Bear Stearns Collapse*, BLOOMBERG.COM, Oct. 7, 2008, <http://www.bloomberg.com/apps/news?pid=21070001&sid=a6iXuZJG1L44>.

¹¹⁵ *OIG Report*, *supra* note 6, at 22-23.

¹¹⁶ *Id.*

¹¹⁷ *Risks of Financial Modeling*, *supra* note 81, at 3-4.

¹¹⁸ Nocera, *supra* note 87 ("The whole intellectual edifice, however, collapsed in the summer of last year because the data input into the risk-management models generally covered only the past two decades, a period of euphoria. Had instead the models been fitted more appropriately to historic periods of stress, capital requirements would have been much higher and the financial would be in far better shape today.").

¹¹⁹ Romain Berry, *Stress Testing Value-at-Risk*, J.P.MORGAN, http://www.jpmorgan.com/tss/General/Stress_Testing_Value-at-Risk/1159389400084.

¹²⁰ *Id.*

¹²¹ *Id.*

Stearns and Lehman brothers did test their VaR models under certain historical scenarios, (including the 1987 stock market crash in the case of Lehman)¹²² there is evidence that the models were not properly designed. For instance, at Bear Stearns the VaR model for mortgage-backed securities was never tested for a potential collapse in home prices.¹²³ As recent events have shown, such a test would have been critical to highlight potential flaws in how the model was constructed. Similarly, at Lehman Brothers management deliberately excluded risks to its real estate investments from firm wide stress tests.¹²⁴ Thus, Lehman's VaR models were never tested for economic shifts in the real estate market. These examples help demonstrate why adequate stress-testing is needed and why, if not conducted, firms cannot adequately prepare for the catastrophic 1%.

Murphy's Law tells us that "anything that can go wrong will go wrong." Unfortunately, the above represents a perfect example of this concept. The limitations of VaR modeling have been well documented since it was first created by J.P. Morgan in the early 1990's.¹²⁵ Yet, both Bear Stearns and Lehman brothers failed to take notice of these limitations, choosing instead to be lulled into complacency by the sirens song of mathematics. Not only did these firms ignore the flaws contained in VaR modeling, they also failed to take the necessary steps to help mitigate those risks. Thus, as critics of the Basel II advanced approach warned,¹²⁶ Bear Stearns and Lehman Brothers touted the superiority of their risk management systems, while in reality they were woefully unprepared. These inadequacies not only led Bear Stearns and Lehman Brothers to collapse, but led the global financial system down the road to perdition.

B. LACK OF COMPLIANCE WITH BASEL II CAPITAL ADEQUACY STANDARDS (PILLAR I)

Beyond the proper management of VaR models, Bear Stearns and Lehman Brothers demonstrated a troubling record of compliance with CSE and Basel II standards for calculating capital adequacy. The CSE program requires that a participating financial institution "calculate capital adequacy consistent with the international standards adopted by the Basel Committee

¹²² *OIG Report*, *supra* note 6, at 24; *Examiner's Report*, *supra* note 96, at 30.

¹²³ *OIG Report*, *supra* note 6, at 24.

¹²⁴ *Examiner's Report*, *supra* note 96, at 181-82.

¹²⁵ Nocera, *supra* note 87.

¹²⁶ *Sheila Bair Remarks*, *supra* note 1.

on Banking Supervision.”¹²⁷ While both Bear Stearns and Lehman brothers complied with these standards on paper, serious lapses in compliance with the requirements resulted in questionable levels of capital being maintained.

In particular, Bear Stearns exhibited a troublesome pattern where each division of the company maintained separate VaR numbers for each portfolio of assets.¹²⁸ For instance, while the trading desk might have one set of VaR numbers, another division might be working with a completely different set of numbers for the same exact portfolio.¹²⁹ The inconsistency in VaR numbers between divisions undoubtedly diminished the effectiveness of the risk management infrastructure and prevented adequate “enterprise wide” risk assessments from being made. Such a state of affairs is of particular note, because it violated Basel II standards, and would have allowed Bear Stearns to choose the most favorable VaR numbers for calculating its capital charges.¹³⁰ Thus, though one division might have VaR numbers to suggest that the asset presented significant risks, requiring a higher capital charge, the company could chose to disclose a set of VaR numbers that painted a completely different picture. Such behavior is not only risky; it is fraudulent and inconsistent with the spirit of the CSE and Basel II.

Additionally, Bear Stearns failed to comply with Basel II by failing to markdown stressed assets in order to forestall the resulting capital charges.¹³¹ For instance, when the market value of an asset declines, banks are required to “markdown” or reduce the value of the asset as it is recorded on their books. Bear Stearns attempted to avoid the corresponding capital charges by delaying such markdowns. This behavior is particularly incentivized during periods of market turmoil, because the cost of raising new capital can be expensive and can send a negative signal to the market.¹³² Additionally, if a firm were to sell the asset, it might also incur additional capital charges as the value of its assets declined in relation to its debts. Thus, under Basel II, firms have a “perverse incentive to delay markdowns” to avoid additional and potentially costly capital charges.¹³³

¹²⁷ *OIG Report, supra* note 6, at 3.

¹²⁸ *Id.* at 29.

¹²⁹ *Id.*

¹³⁰ *Id.*

¹³¹ *OIG Report, supra* note 6, at 30-31.

¹³² *Id.* at 30.

¹³³ *Id.*

Finally, at Lehman Brothers a series of “Repo 105” transactions resulted in questionable capital charges being made.¹³⁴ A Repo 105 transaction is an accounting maneuver that allows short-term loans to be temporarily classified as a sale.¹³⁵ The cash obtained through these “sales” are then used to pay down debt, allowing the company to appear to reduce its debt-to-equity ratio by temporarily paying down liabilities.¹³⁶ In order to artificially reduce its capital charges and improve its debt-to-equity ratio in late 2007 and early 2008, Lehman Brothers use Repo 105 transactions to temporarily remove debt from its balance sheets.¹³⁷ Prior to its collapse, Lehman Brothers undertook “\$38.6 billion, \$49.1 billion, and \$50.38 billion of Repo 105 transactions at the ends of fourth quarter 2007, first quarter 2008, and second quarter 2008 respectively.”¹³⁸ Such behavior is in direct contravention of Basel II and the CSE program, since it allowed Lehman Brothers to illegitimately reduce its debt-to-equity ratio and corresponding capital charges.

The above series of events only corroborates Chairman Bair’s predictions that banks have a natural tendency to hold less capital rather than more. Instead of choosing to comply with Basel II and CSE standards, Bear Stearns and Lehman Brothers used loopholes and outright tricks to delay the inevitable. Such behavior resulted in the systematic manipulation of capital ratios, and shows a complete disregard for the stability of the financial system. Yet, the above problems with VaR calculations and the deliberate manipulation of capital charges also demonstrate why Basel II and the CSE program contain guidelines for adequate regulatory supervision.

V. FAILURE OF SEC OVERSIGHT (PILLAR II)

Basel II requires that regulators “review and evaluate banks’ internal capital adequacy assessments and strategies as well as their ability to monitor and ensure their compliance with regulatory capital ratios.”¹³⁹ Additionally, Basel II requires that regulators “expect banks to operate above the minimum regulatory capital ratios and should have the ability to

¹³⁴ See *Examiner’s Report*, *supra* note 96, at 732-34.

¹³⁵ *Id.* at 732.

¹³⁶ *Id.* at 733-34.

¹³⁷ *Id.*

¹³⁸ *Id.* at 733 n. 2852.

¹³⁹ BASEL II, *supra* note 67, at 209.

require banks to hold capital in excess of the minimum.”¹⁴⁰ In fact, the CSE program required that participants submit to regular inspections of the internal risk management control systems and gives the SEC the power to require a participant to maintain a capital adequacy ratio of at least 10 percent.¹⁴¹ Yet, despite being aware of many deficiencies in CSE compliance, several documented incidents demonstrate how the SEC failed to use the powers at its disposal to enforce compliance.¹⁴²

So what happened? Was the SEC asleep at the switch? Were the powers given to the agency inadequate? Sadly, the answer seems to be twofold. First, the agency seems to have fallen victim to the same market euphoria and sense of infallibility that plagued the very firms it regulated. Second, the SEC severely understaffed the CSE program, limiting its ability to effectively police participating financial institutions.

One of the major components of Basel II and the CSE is that firms utilizing the advanced approach submit their VaR models to regulators for approval.¹⁴³ Such a review process allows the regulating agency to assess the adequacy of the risk models before approving a firm’s use of the advanced approach.¹⁴⁴ Yet, on several occasions, the SEC approved applications to become part of the CSE program prior to the firm’s VaR models being reviewed.¹⁴⁵ In fact, in the case of Bear Stearns the SEC never issued a formal approval of the firm’s VaR modeling.¹⁴⁶ To make matters worse, internal memoranda reviewed by the inspector general of the SEC suggest that the SEC was aware of the inadequacy of Bear Stearns’ risk management systems, but blindly accepted executives’ assurances that the systems would be updated and corrected.¹⁴⁷ It is unclear what might have been motivating the SEC to not properly review VaR models, but one thing is certain, the failure to do so set the CSE program down an ominous path from the beginning.

¹⁴⁰ *Id.* at 211.

¹⁴¹ *OIG Report*, *supra* note 6, at 3.

¹⁴² *See generally* *OIG Report*, *supra* note 6; *Examiner’s Report*, *supra* note 94.

¹⁴³ *OIG Report*, *supra* note 6, at 40.

¹⁴⁴ *Id.* (“The purpose of the inspection is to verify the information provided by the firm and to ‘assess the adequacy of the implementation of the firm’s internal risk management policies and procedures.’”).

¹⁴⁵ *Id.* at 40-41.

¹⁴⁶ *Id.* at 41 (“While [the SEC] believes that Bear Stearns implemented corrective action, [it] never verified Bear Stearns’ assertions that it had resolved this issue. . .”).

¹⁴⁷ *Id.*

In another documented occurrence, the SEC became aware of inconsistencies in the VaR numbers being submitted to the agency by Bear Stearns.¹⁴⁸ As discussed above, Bear Stearns was maintaining multiple sets of VaR calculations for the same portfolios of assets and using the most favorable of these numbers to calculate its capital charges. Bear Stearns officials were unable to account for the inconsistencies, but appear to have assured the inspectors that they were taking corrective action.¹⁴⁹ Nothing in the OIG's report suggests that the SEC pursued these inconsistencies further.

Even after the collapse of Bear Stearns the SEC failed to take prompt corrective action against Lehman Brothers. For instance, in 2008 the SEC became aware that Lehman Brothers had characterized a multi-billion dollar deposit with Citigroup (made as a precondition to continued banking relations) as a liquid cash deposit.¹⁵⁰ Given that the deposit could not be withdrawn without adverse effects upon Lehman's day-to-day business operations, the SEC disagreed with Lehman's characterization.¹⁵¹ However, instead of forcing Lehman Brothers to properly classify the deposit, the SEC took no enforcement action.¹⁵² Instead, the SEC discounted the risk posed by the deposit's mischaracterization and characterized it as an "illiquid asset" for internal calculations only.¹⁵³ As a result, Lehman Brothers was effectively permitted to manipulate its debt-to-equity ratio and corresponding capital charges. Such behavior not only misled the investing public as to Lehman Brothers' financial health, it was a patent violation of the CSE program and Basel II standards.

Finally, in the months leading up to the collapse of Bear Stearns and Lehman Brothers, the SEC seemingly took little notice of the rapidly shrinking capital adequacy ratios and rapidly rising leverage ratios at each firm.¹⁵⁴ In fact, the SEC took no action between 2006 and 2008 as Bear Stearns' capital adequacy ratio fell from 21.4 percent to just 11.1 percent by March 2008.¹⁵⁵ While the CSE program and Basel II require that the agency take prompt corrective action to ensure that a firm operates with levels of capital above the minimum requirements, the SEC allowed Bear Stearns to come dangerously close to the 10 percent capital adequacy

¹⁴⁸ *Id.* at 29.

¹⁴⁹ *Id.*

¹⁵⁰ *Examiner's Report*, *supra* note 96, at 1430-32.

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ *Pittman*, *supra* note 114; *Examiner's Report*, *supra* note 96, at 1508.

¹⁵⁵ *Pittman*, *supra* note 114.

minimum without so much as a written warning. It was not until two weeks before the March 14th collapse of Bear Stearns that the SEC sent a letter recommending that the firm raise additional capital.¹⁵⁶ How could the SEC have been so blind?

The answer to the above question is twofold. First, the SEC was simply caught up in the pro-market that plagued the very firms they regulated. Despite being aware of numerous violations, the SEC simply failed to act. In fact, one commentator described the SEC as succumbing “to the anti-regulation climate of recent years. Too many of its members just did not believe in regulation.”¹⁵⁷ Such comments, in combination with the SEC’s relaxed pursuit of known violations suggest a culture of complacency that bred inaction.

Moreover, an inspector general’s report notes that since its inception, the CSE program had a “small number of staff.”¹⁵⁸ In fact, even in 2008, the CSE program only employed seven inspectors, two in Washington, D.C., and five in the New York regional office.¹⁵⁹ Considering that these inspectors were charged with reviewing dozens, if not hundreds of VaR models per firm, it is hard to believe that adequate inspections occurred. Such a conclusion is buttressed by the fact that in September 2008 the CSE program had not conducted any inspections in 18 months.¹⁶⁰ Even six months after the collapse of Bear Stearns, only three inspections were in progress to “assess the adequacy of the implementation of firms’ internal risk management policies and procedures.”¹⁶¹

The SEC’s failure to adequately comply with Pillar II of the 2004 Basel Accord should be a warning to global regulators. A failure to adequately police the use of the advanced approach will inevitably lead to inadequate levels of capital being maintained. However, adequate supervision requires not only promulgated regulations, but adequate staffing with the necessary expertise to evaluate the complicated VaR models. Most importantly, regulators need to remain skeptical of executive assurances that compliance will be forthcoming. As Basel II requires, agencies need to act swiftly to correct violations of regulations.

¹⁵⁶ *Id.*; J. Robert Brown, *Reforming the SEC: Dodging a Legislative Bullet*, THE RACE TO THE BOTTOM.ORG, Sept. 29, 2009, <http://www.theracetothetbottom.org/the-sec-governance/reforming-the-sec-dodging-a-legislative-bullet.html>.

¹⁵⁷ Norman S. Posner, *Why the SEC Failed: Regulators against Regulation*, 3 BROOK. J. CORP. FIN. & COM. L. 289, 289 (2008).

¹⁵⁸ *OIG Report*, *supra* note 6, at 49.

¹⁵⁹ *Id.*

¹⁶⁰ *Id.* at 49-50.

¹⁶¹ *Id.*

VI. CONCLUSION

The above arguments point in favor of scrapping Basel II's advanced approach, which allows financial institutions to set their capital requirements according to their internal risk modeling. The spectacular failure of the VaR models to predict or adequately protect against the current financial crisis makes entrusting capital regulation to proprietary risk-modeling seem hopelessly misguided. In particular, the dismal record of the SEC's CSE program provides a warning to international regulators to reverse their recent adoption of the Basel II framework. Instead, international regulators should renounce the advanced approach and adopt the intermediate approach proposed by U.S. regulators in 2005 (Basel IA).¹⁶²

Although the Basel Committee could revise the advanced approach to provide further guidance to international regulators (which the committee has already done),¹⁶³ the fundamental limitations and flaws of the advanced approach cannot be overcome. More detailed audit standards would simply increase the cost of both compliance and regulation. Additionally, as recent history has shown us, any updated guidance would require constant revision as the financial sector continued to evolve and develop new products. Moreover, more specific rules would only increase the burden on regulators who are already understaffed, overworked, and inexperienced. Basel II already requires regulators to review numerous risk models for a single institution, not to mention back-testing and stress-testing the very same models. Again, as the SEC experiment has shown, regulators whose resources are stretched have an incentive to be less rigorous.

Yet, even armed with sufficient resources, the advanced approach contains the worst elements of both rules and standards. Basel II gives international regulators a wide measure of discretion in deciding which banks may use the advanced approach and whether the firm's risk management systems satisfy the standards of Basel II. Such opaque and flexible standards make it difficult to compare the compliance of regulators in one nation versus another. This lack of transparency provides an incentive for regulators to forgo regulatory action so as to provide the

¹⁶² See Revised Risk-Based Capital Guidelines, 12 C.F.R. Part 325 (2006) [hereinafter *Basel IA*].

¹⁶³ See, e.g. BASEL COMMITTEE ON BANKING SUPERVISION, REVISIONS TO THE BASEL II MARKET RISK FRAMEWORK (Jan. 2009) available at <http://www.bis.org/publ/bcbs148.pdf?noframes=1>.

banks of their own country a competitive advantage. Though regulators attempted to forgo regulatory action under Basel I, their actions were easily discovered due to the simplicity of the regulatory framework.

Alternatively, Basel IA represents an intermediate approach to financial regulation that combines the best elements of Basel I and Basel II. Fundamentally, Basel IA provides meaningful improvements to the risk sensitivity of Basel I, while imposing minimal increases in regulatory burdens. To increase the risk sensitivity of Basel I, Basel IA significantly increases the number of risk-weight categories.¹⁶⁴ The addition of more risk-weight categories solves Basel I's greatest flaw (the "one-size-fits all" approach) by permitting financial institutions to adjust their capital ratios based on the institution's specific risk profile. Yet, by abandoning Basel II's advanced approach in favor of a standardized method for calculating capital adequacy, Basel IA also reduces the burdens placed on global financial regulators. No longer would regulators be forced to police dozens of firm-specific statistical models that are often complicated and beyond the comprehension of the average regulator. Instead, under Basel IA regulators would be free to calculate capital adequacy using a standardized formula that naturally adjusted to the risk-profile of each financial institution. Because of their simplicity, the regulations included in Basel IA are easier to understand and thus, facilitate compliance by financial institutions and adequate auditing by regulators. Further, the Basel IA standards are also more transparent; it would not only be easier for regulators to audit a financial institution, but would be easier for competitors and regulators in other countries to check whether there is adequate compliance. Finally, Basel IA's simpler rules allow regulators and interested parties to more adequately assess the credit and market risks posed by individual institutions. By adopting the Basel IA framework, global regulators will help to establish a sustainable path to global financial stability.

¹⁶⁴ *Basel IA, supra* note 164.