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ARTICLES

SYMPOSIUM

"YOU WANT INSURANCE WITH THAT?" USING BEHAVIORAL ECONOMICS TO PROTECT CONSUMERS FROM ADD-ON INSURANCE PRODUCTS

TOM BAKER*
PETER SIEGELMAN*

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Persistently high profits on "insurance" for small value losses sold as an add-on to other products or services (such as extended warranties sold with consumer electronics, loss damage waivers sold with a car rental, and credit life insurance sold with a loan) pose a twofold challenge to the standard economic analysis of insurance. First, expected utility theory teaches that people should not buy insurance for small value losses. Second, the market should not in the long run permit sellers to charge prices that greatly exceed the cost of providing the insurance. Combining the insights of the Gabaix and Laibson shrouded pricing model with the behavioral economics of insurance, this article explains why high profits for add-on insurance persist and describes the negative distributional and welfare consequences of an unregulated market for such insurance. The article explores four potential regulatory responses: enhanced disclosure, a ban on the point of sale offer of add-on insurance, price regulation, and the creation of a new, on-line market. Drawing on theoretical, empirical, and comparative law sources, the article explains why enhanced disclosure will not work, the circumstances under which a point of sale ban is desirable, and why a new, on-line market is preferable to price regulation in circumstances in which a point of sale ban is undesirable.

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I. INTRODUCTION

Informed observers of insurance markets have long marveled at the high prices charged for a wide variety of low value insurance products sold as "add-ons" to consumers buying other products and services. Examples include the extended warranties sold with electronics and home appliances, the credit life insurance and identity theft protection sold with mortgages, auto loans, and credit cards, and the collision damage waivers and short term liability insurance sold with car rentals. Unlike iPhones or Gucci bags, there is nothing obviously cool or distinctive about add-on insurance products. They are just contingent claims on money – often small amounts of money – that, like other forms of insurance, protect consumers from losses that are easy to predict in the aggregate and should, in theory, sell at prices that are close to insurers' predicted costs. Yet sellers are able to charge prices for add-on insurance products that consistently and greatly exceed the cost of providing the insurance, well beyond what is possible in other parts of the consumer insurance market. These excess profits have negative distributional consequences and lead to substantial efficiency losses.

Insurance regulators have long suspected that these high profits reveal that there is something awry in the sale of insurance add-ons. Investigations of credit life insurance in the 1950s,[1] collision damage

[1] *See, e.g.,* Sunderland v. Day, 145 N.E.2d 39, 39 (Ill. 1957) (interpreting Ill. Small Loans Act to forbid a lender from requiring – as was apparently common – that borrower purchase credit life insurance as a condition precedent to the making of a loan); Leland J. Gordon, Book Review, 25 J. INS. 77 (1958) (discussing a finding of the U.S. Senate Subcommittee on Antitrust and Monopoly that significant "abuses in the consumer credit insurance business[,] which included sales of credit insurance far in excess of money loaned, failure to deliver the policy to the borrower, payment of excessive commissions, pyramiding of policies by requiring the borrower to purchase a second policy upon refinancing his loan without cancellation of the first policy, and failure to make a refund of unearned premiums"); NAT'L ASS'N OF INS. COMM'RS, A BACKGROUND STUDY OF THE REGULATION OF CREDIT LIFE AND DISABILITY INSURANCE 39-51 (1970) (chapter entitled "Credit Insurance Abuses"). Interestingly, the volume of scholarly literature on credit life seems to have peaked in the 1960s, and relatively little has been written about it since then; Philip H. Peters, *How Should Credit Life Insurance be Regulated*, 1958 INS. L. J. 529 (1958) (suggesting problems were widespread); William T. Beadles, *Control of Abuses Under Credit Life and Health Insurance*, 26 J. INS. 1 (1959) (detailing a litany of abuses and suggesting regulations to counter them).

waivers in the 1980s,[2] and extended warranties in recent years[3] have documented the excess profits earned on the sale of these insurance products, along with the abusive sales practices that such profits induce. Yet, regulators have struggled to identify how these excess profits are sustained. Indeed, an otherwise impressive study by the Competition Commission of the United Kingdom in 2003 attributes excess profits earned on the sale of extended warranties for consumer electronics to an ill-defined "complex monopoly situation" that the study never really explains.[4] Not surprisingly, the Commission's solution – a set of information forcing measures adopted in 2005 – has not worked.[5]

The conceptual problem for the Competition Commission, state insurance departments, and most other consumer protection agencies that have examined add-on insurance markets can be traced to the economic model they use. The add-on insurance product market quite literally "does not compute" within the standard Insurance Economics 101 framework that

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[2] *See, e.g.,* Iowa Dep't of Ins., *Proposal to the Market Conduct of Consumer Affairs (EX3) Subcommittee re: Proposed Model Statute on Collision Damage Waivers*, 1 NAIC Proc. 173 (1985).

[3] COMPETITION COMM'N, A REPORT ON THE SUPPLY OF EXTENDED WARRANTIES ON DOMESTIC [HOUSEHOLD] ELECTRICAL GOODS WITHIN THE UK, 2003, 1, at 3 *available at* http://webarchive.nationalarchives.gov.uk/+/http://www.competition-commission.org.uk/rep_pub/reports/2003/485xwars.htm#summary. In the US, a 1985 lawsuit by Maine Attorney General James Tierney alleged that retailer Sears, Roebuck used unfair and deceptive trade practices to sell extended warranties. *See* State v. Sears, Roebuck & Co., No. CV-84-133, 1985 LEXIS 239, at *44 (Me. Super. Aug. 29, 1985). These allegedly included: (a) selling coverage that duplicated manufacturers' express warranties that were already included in the purchase price, and (b) after the consumer had made the decision to purchase the product, overstating the need for warranties by exaggerating the probability that a product would fail. *Id*. While noting that extended warranties were "highly profitable" for Sears, *id*. at *51, the court concluded that there were no deceptive trade practices involved because "the State . . . failed to demonstrate that Sears misleads customers when it sells maintenance agreements by making them believe that they must purchase, either through maintenance agreements or through prospective repair costs, what the law gives them for free." *Id*. at *76.

[4] COMPETITION COMM'N, *supra* note 3, at 6.

[5] Recently, the U.K. Office of Fair Trading – which has shown an appreciation for behavioral economics – has taken a fresh look at extended warranties, finding that the extended warranty market remains "unfair and uncompetitive" and proposing a new round of reforms. *See* OFFICE OF FAIR TRADING, EXTENDED WARRANTIES ON DOMESTIC ELECTRICAL GOODS, 2012, 1403 (U.K.), *available at* http://www.oft.gov.uk/shared_oft/markets-work/OFT1403.pdf. For the OFT's interest in behavioral economics, *see, e.g.,* OFFICE OF FAIR TRADING, WHAT DOES BEHAVIORAL ECONOMICS MEAN FOR COMPETITION POLICY?, 2010, 1224 (U.K.), *available at* http://www.oft.gov.uk/shared_oft/economic_research/oft1224.pdf.

has informed insurance regulation, leaving regulators without a reliable guide to action. Regulators' intuition and common sense tell them that consumers are being exploited, but the dominant conceptual framework in their field cannot tell them how or why, or what to do to prevent that exploitation.

When they do try to address the perceived exploitation – as the Competition Commission did for extended warranties in 2005 – regulators understandably lack the confidence to go beyond non-controversial strategies, such as mandatory disclosure or other information-forcing mechanisms. Disclosure rarely improves consumer markets in any context,[6] and, as the Competition Commission experience demonstrates, does not provide meaningful protection to consumers purchasing add-on insurance products. In the end, regulators typically give up. This explains why, for example, many of the credit life insurance abuses identified in the 1950s and rental car insurance abuses identified in the 1980s persist today.[7]

The persistence of large profits in add-on insurance products poses two main conceptual problems for the standard economic analysis employed in insurance regulation. First, according to that analysis, there should not even be a robust market for most of these kinds of insurance products. The expected utility theory that lies at the core of the economic analysis of insurance teaches, unequivocally, that people should not buy insurance for low value losses.[8] The whole point of insurance under expected utility theory is to shift money from states of the world in which people do not need their last dollar very much (their marginal utility of money is low) to states of the world in which they could put that dollar to much better use (their marginal utility of money is high). The amounts of money at stake in most add-on insurance products are simply too small for that difference in marginal utility to explain consumer behavior. Moreover, whatever slight difference there may be in the marginal utility of money between the time a person buys the insurance and the time when she collects on it is more than offset by the transaction costs involved (even leaving aside the excess profits). This is Insurance Economics 101.[9]

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[6] *See* Omri Ben-Shahar & Carl E. Schnieder, *The Failure of Mandated Disclosure,* 159 U. PA. L. REV. 647 (2011).

[7] *See infra* text accompanying note 119.

[8] *See* SCOTT E. HARRINGTON & GREGORY R. NIEHAUS, RISK MANAGEMENT AND INSURANCE 176, 188 (2nd ed. 2004); Matthew Rabin & Richard H. Thaler, *Anomalies: Risk Aversion*, 15 J. ECON. PERSPECTIVES 219 (2001); KENNETH J. ARROW, *The Theory of Risk Aversion*, *in* ESSAYS IN THE THEORY OF RISK BEARING (1971); John W. Pratt, *Risk Aversion in the Small and in the Large*, 32 ECONOMETRICA 122 (1964).

[9] Harrington & Niehaus, *supra* note 8; *infra* text accompanying Figure 1.

Second, even if it did make sense for people to buy add-on insurance products, the market should not in the long run permit sellers to charge prices that greatly exceed the cost of providing the insurance. Excess profits should bring new competitors into the market. Even if most people are not careful shoppers, some are. Their careful shopping should benefit all consumers, as sellers compete for the careful shoppers by reducing prices for the add-on insurance products.[10] This is Microeconomics 101 applied to insurance markets.

As we will explain, the problem is not with economics, per se, but rather with the failure of insurance law and regulation to move beyond Economics 101. Behavioral economic analysis has addressed both of the conceptual problems presented by the 101-level analyses. First, borrowing from psychological research, behavioral economics provides a compelling explanation for why people choose to insure against small losses, even at prices that greatly exceed the cost of providing the insurance.[11] Second, using a simple (in retrospect) equilibrium model, behavioral economics provides a compelling explanation of why prices for add-on insurance so often greatly exceed cost, even when sellers operate in a competitive market for the primary product or service to which the insurance products are add-ons.[12]

Of the two parts to this behavioral economic explanation, the second is decidedly more important for improving insurance law and regulation. The first part simply puts more rigorous science behind what regulators, marketers, and ordinary people already knew: people are willing to pay for "peace of mind" to an extent that goes well beyond what expected utility theory would predict, especially when they are buying a

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[10] *See, e.g.,* Alan Schwartz & Louis L. Wilde, *Intervening in Markets on the Basis of Imperfect Information: A Legal and Economic Analysis*, 127 U. PA. L. REV. 630, 638 (1979) (concluding that "the presence of at least some consumer search in a market creates the possibility of a 'pecuniary externality': persons who search sometimes protect nonsearchers from overreaching firms."). Moreover, in their model, if at least one-third of consumers undertake comparison shopping, the market price will be close to the competitive price in market where all consumers are informed. *Id.* at 655.

[11] *See, e.g.,* Eric Johnson, John Hershey, Jacqueline Meszaros & Howard Kunreuther, *Framing, Probability Distortions and Insurance Decisions*, 7 J. RISK & UNCERTAINTY 35, 42 (1993); Paul J. H. Shoemaker & Howard C. Kunreuther, *An Experimental Study of Insurance Decisions*, 46 J. RISK & INS. 603 (1979). For an extended treatment, see HOWARD C. KUNREUTHER, MARK V. PAULY & STACEY MCMORROW, INSURANCE AND BEHAVIORAL ECONOMICS: IMPROVING DECISIONS IN THE MOST MISUNDERSTOOD INDUSTRY (2013).

[12] *See* Xavier Gabaix & David Laibson, *Shrouded Attributes, Consumer Myopia, and Information Suppression in Competitive Markets*, 121 Q. J. ECON. 505 (2006).

product or service that puts their peace of mind in question. Indeed, taken all by itself, this first part could do more harm than good, at least in relation to the regulation of add-on insurance products. It is a short step from a better understanding of why people like peace of mind insurance to the claim that there is no need to do anything to protect consumers, other than perhaps mandating certain disclosures, because sellers are simply satisfying consumers' legitimate preferences. Some recent writing by highly regarded law and economics scholars points in that direction, using the language of consumer sovereignty.[13]

The second part of the behavioral economic analysis reveals the existence of heretofore unappreciated "situational monopolies"[14] that require – and hence authorize the use of – more powerful regulatory tools than mere disclosure to fix. This second part has not yet been taken into account in the law and economic analysis of insurance. Thus, there is reason to believe that scholars using consumer sovereignty to support a light touch to the regulation of peace of mind insurance products might reconsider their analysis, at least in the context of add-on insurance products.

It is important to emphasize that we are not merely adding together two disparate strands of behavioral economics. The combination of the shrouded pricing/situational monopoly model with the behavioral economics of low-value insurance yields a key insight into the welfare analysis of this market that is not present in either story by itself. As we spell-out in more detail below, the shrouded pricing model explains in general terms how supra-competitive prices for second-stage or supplemental products (e.g., razor blades, toner cartridges for laser printers) can be maintained in equilibrium. In these cases, the second stage product is an appropriate – or even necessary – complement to the first stage product: razor blades and toner cartridges have finite lives, and razors or printers are useless without them. Consumers may have a choice among

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[13] *See, e.g.,* Colin Camerer, Samuel Issacharoff, George Loewenstein, Ted O'Donoghue & Matthew Rabin, *Regulation for Conservatives: Behavioral Economics and the Case for 'Asymmetric Paternalism*,' 151 U. PA. L. REV. 1211 (2003); Daniel Schwarcz, *Regulating Consumer Demand in Insurance Markets*, 3 ERASMUS L. REV. 23 (2010).

[14] The term "situational monopoly" has appeared in the law and economics literature in the analysis of secured transactions and the application of the contract doctrine of duress. *See* Thomas H. Jackson & Anthony T. Kronman, *Secured Financing and Priorities Among Creditors*, 88 YALE L.J. 1143, 1167-71 (1978-1979) on secured financing and the competitive advantage that a creditor with a security interest in after-acquired property enjoys over other lenders and MICHAEL J. TREBILCOCK, THE LIMITS OF FREEDOM OF CONTRACT 78 - 101 (1993) on duress.

competing second-stage products, but they cannot avoid purchasing any second-stage product at all.

That is decidedly *not* the case when the second-stage product is add-on insurance, the purchase of which is irrational to begin with. The option not to buy at all is not only real, it is compelling (at least to rational consumers). That, in turn, means that sellers must undertake efforts to convince customers to buy the add-on insurance product. Moreover, such efforts are highly profitable because of the supra-competitive prices charged for add-ons, which implies that all kinds of hard-sell tactics are virtually compulsory because the marginal return to a dollar spent on inducing a customer to purchase add-on insurance is high.

The efficiency consequences of such hard-sell practices are not trivial. Such tactics are deployed against all buyers (whether they actually purchase the add-on insurance or not), and are properly counted as a waste of customer and seller time, a real welfare loss that is not present in the original shrouding model.[15] In our view, "merely" protecting unsophisticated consumers from tactics that redistribute wealth to sophisticated consumers is a worthy goal in itself, and one that is shared by most insurance regulators. But the shrouded pricing of small-loss insurance has efficiency consequences as well, as we discuss below.

This Article is organized as follows. In Part I we describe three examples of add-on insurance products – extended warranties for consumer products, loss damage waivers for rental cars, and credit life insurance – and discuss the irrationality of purchasing these products under a standard expected utility approach. In Part II we develop a behavioral economic analysis of these products that helps explain why people buy them and, more importantly, why competition fails to reduce their prices to something approaching their cost. In Part III we discuss the implications of this analysis for insurance regulation, exploring four possible strategies: improved disclosure of the terms of add-on insurance products, a ban on the sale of the products as an add-on, price regulation, and the use of information technology to create a robust market at the point of sale. Drawing from recent U.K. experience, we recommend a mixed approach for the three specific products we examine: a ban on the sale of credit life insurance and extended warranties as add-ons and a new, on-line market for car rental insurance that customers can access at the car rental desk.

Ours is a more activist and decidedly old school approach – with a high tech twist for car rental insurance – than forward thinking insurance regulators have entertained in recent years, but there is new science and a

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[15] For example, East Coast readers may reflect on the need to check a box on the Amtrak website indicating that, no, you do not want to buy the $10 travel insurance on a $60 train ticket.

new regulatory environment behind our proposal. The new science is behavioral economics. The new regulatory environment is developing in response to the financial crisis of 2008. In the legislative process leading to the enactment of the Dodd-Frank financial reform statute, state insurance regulators successfully argued for the exemption of insurance products from the jurisdiction of the new Consumer Financial Protection Bureau, on the grounds that state insurance regulation was already looking out for consumers and that state-based regulation allowed for innovation and experimentation. Add-on insurance products present an excellent opportunity to test that claim.

II. THREE EXAMPLES OF ADD-ON INSURANCE

In this part, we analyze three common forms of add-on insurance: extended warranties for consumer products, the loss or collision damage waivers sold with rental cars, and credit life insurance. Extended warranties – and, in most cases, damage waivers – have negative value in expected utility terms because the losses they protect against are small and the price charged for the insurance is high relative to the expected value. Rational expected utility maximizers should not be risk averse at all over such small stakes. Credit life insurance and, in some situations, damage waivers are a bad deal for slightly different reasons: The stakes can sometimes be high, and thus might be worth insuring; just not when the cost is so high relative to the expected value.

A. EXTENDED WARRANTIES FOR CONSUMER PRODUCTS

An extended warranty is an optional contract that provides the purchaser with a longer period of protection from the failure of a specific product than the standard warranty offered by the manufacturer.[16] Extended warranties differ fundamentally from the *manufacturer*'s warranties that are included in the price of a consumer product. Manufacturers' warranties

[16] There are allegations that some major retailers push extended warranties on products such as power tools that already come with manufacturer's lifetime warranties. For example, Home Depot's Ridgid Power tools come with a lifetime warranty from the manufacturer, yet some customers complain that they were nevertheless sold an extended warranty on the item. *See, e.g.,* Scam Man, *Rigid Extended Warranty Scam* **(**Jun. 2, 2012, 2:06 AM), http://www.home depotsucks.org/forum/viewtopic.php?f=1&t=11532#p13442 (last visited Jan. 29, 2013) ("[m]ost of these ridged [sic] products are not eligible for an extended warranty because [sic] they have lifetime service agreement. yet home depot has the cashiers promp [sic] you to buy them. shows you the greed of home depot and that is just one scam they do").

do have the potential to provide substantial value, but not primarily because of their insurance function. Rather, the primary value of a manufacturer's warranty lies in the quality signal it sends. Consumers rationally conclude that the manufacturer would not offer a generous warranty if the product regularly failed within the warranty period and, thus, consumers appropriately prefer a product with a better manufacturer's warranty.[17]

An optional extended warranty, sold at an additional cost, does not signal high quality. Indeed, our personal shopping experience suggests the opposite. We have found that, once we have decided to buy a particular TV/refrigerator/washing machine/sound system at a retail establishment, the sales person who earnestly persuaded us of the high quality of the selected item disappears, and a "customer assistant" arrives with news of other disappointed customers whose very same TV/refrigerator/washing machine/sound system stopped working shortly after they bought them. Because the TV/refrigerator/washing machine/sound system might not actually be as good as it is supposed to be, the customer assistant explains, the store has arranged for an extended warranty that is available, at a small additional charge, to protect us from such disappointment.[18] This extended warranty is pure insurance (and almost pure profit for the store). For example, Business Week reported that extended warranties were responsible for 50% of Best Buy's profits and almost 100% of Circuit City's profits.[19]

Data on extended warranties are difficult to come by. As a result, there is very little empirical social science literature describing their workings, despite the frequent criticism of extended warranties by economists and consumer advocates.[20] One recent estimate put the size of

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[17] *See generally* George Priest, *A Theory of the Consumer Warranty*, 90 YALE L. J. 1297 (1981); Michael Spence, *Consumer Misperceptions, Product Failure and Producer Liability*, 44 REV. ECON. STUD. 561 (1977)..

[18] This practice turns out to be so well documented in the extended warranty context that it has a name, at least in the UK: "double hitting." Retailers "stressed to [the U.K. Competition Commission] the action they take to stop unacceptable selling practices, which they have told [the U.K.C.C.] would alienate customers." COMPETITION COMM'N, *supra* note 3, at 40. The "unacceptable selling practices" include "double hitting," providing "misleading information," and "persisting in trying to sell an EW when the customer has declined the offer." *Id*.

[19] Tao Chen, Ayay Kalra & Baohon Sun, *Why Do Consumers Buy Extended Service Contracts?*, 36 J. CONSUMER RES. 611, 615 (2009) (using 2003 data from a large retailer in an expected utility framework that assumes that demographic and product characteristics affect the purchase of warranties through differences in risk aversion between consumers).

[20] For exceptions, see Pranav Jindal, Risk Preferences and Demand Drivers of Extended Warranties (Dec. 2012) (working paper) (on file with Smeal College of Business, Pennsylvania State University), *available at* http://ssrn.com/abstract=

this market at $16 billion,[21] but that appears to be a largely impressionistic number, with no derivation given. Better estimates are available for the UK – at least, for the consumer electric goods market – thanks to an investigation by the Competition Commission, which found that on total electric goods sales of £15-20 Billion in 2001, "18.5 million E[xtended] W[arrantie]s were supplied . . . .with a total value of nearly £900 million (including a valuation of free EWs), about 5% of total sales."[22] EWs were purchased by about one-third of all consumers who bought an electric good worth more than £50.[23] Extrapolating those figures to the US yields a rough estimate of about $30 billion in electric goods sales in 2010, and about $1.4 billion in extended warranties sold for these types of products.[24] Extended warranties are also sold as add-ons to other products. For example, the website Warranty Week estimated that the market for automobile extended warranties in the US represents another $11.2 billion.[25]

2196033 (using experimental data to decompose demand for extended warranties on washing machines as a function of risk, and loss, aversion); Chen, Kalra & Sun, *supra* note 19. Some economic theorists have modeled the market for extended warranties. *See, e.g.*, Aidan Hollis, *Extended Warranties, Adverse Selection, and Aftermarkets*, 66 J. RISK & INS. 321 (1999) (surveying theoretical literature, and arguing on the basis of an adverse selection model that sellers of primary goods should not be able to exclude third-party extended warranties). At least in some contexts, extended warranties can be used to price-discriminate among consumers, even when buyers are rational, by increasing switching costs. *See* Edward Iacobucci, *A Switching Costs Explanation of Tying and Warranties*, 37 J. LEGAL STUD. 431 (2008).

[21] *See Extended Warranties*, WARRANTY WEEK, Nov. 21, 2006, *available at* http://www.warrantyweek.com/archive/ww20061121.html (suggesting that the total extended warranty market was worth $16 Billion, but not specifying whether this is a stock measure of the value of warranties in force or an annualized flow).

[22] *See* COMPETITION COMM'N, EXTENDED WARRANTIES ON DOMESTIC ELECTRICAL GOODS, 2003, at vol. 1. p. 3 (U.K.). The OFT recently estimated the total value of the same market as about £1 billion. *See* OFFICE OF FAIR TRADING, EXTENDED WARRANTIES ON DOMESTIC ELECTRICAL GOODS, *supra* note 5, at 24.

[23] COMPETITION COMM'N, *supra* note 21, at 4.

[24] *See generally, Bureau of Economic Analysis, Table 2.4.5. Personal Consumption Expenditures by Type of Product (2013), available at* http://www.bea.gov/national/nipaweb/TableView.asp?SelectedTable=70&Freq=Year&FirstYear=2008&LastYear=2009. There is no precise US equivalent to the U.K. definition of household electric goods. We used Bureau of Economic Analysis Table 2.4.5, and included the categories Small Electric Household Appliances, Video & Audio Equipment, and Information Processing Equipment. *See id.*

[25] *Vehicle Service Contract Administrators*, Warranty Week (Sept. 9, 2010), http://www.warrantyweek.com/archive/ww20100909.html.

Extended warranties sold as an add-on to the purchase of a consumer product are, in expected utility terms, the paradigmatic bad insurance deal.[26] They do not provide protection against any level of loss for which insurance at the prevailing price makes sense for a rational, expected-utility-maximizing individual.[27] The reason is simple: a rational consumer cannot be risk-averse for losses that are so "small" relative to her overall wealth. Classical risk-aversion only applies to large losses, those big enough to change the marginal utility of wealth. And for almost anyone buying a $200 CD player or even a $1,000 TV set, the amount of potential loss – the replacement cost of the item in question – is likely to be quite small in relation to assets or lifetime wealth. Even risk-averse consumers should be essentially risk-neutral for small-stakes gambles,[28] and recent survey research suggests that consumers in fact are risk neutral when it comes to extended warranties.[29]

Consider a consumer who purchases a Sony 55" Class Bravia® EX620- Series LED LCD HDTV sold by Sears on line for $1619.99.[30] According to the Sears website, the extended warranty on this item –

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[26] *See, e.g., David M. Cutler & Richard Zeckhauser, Extending the Theory to Meet the Practice of Insurance, in Brookings-Wharton Papers on Financial Services* 1, 25-28 (Robert Liton & Richard Herring eds., 2004); *Schwarcz, supra* note 13*;* Rabin & Thaler*, supra* note 8.

[27] Except, possibly, for a purchaser who knows that she or he will use the product in an unusual manner that poses a high risk of product failure (but which is not considered misuse, voiding the warranty). The ability of such an individual to buy the warranty at the regular price represents a market failure, not a justification for the market. As the OFT observed, some have suggested that extended warranties may make more sense for liquidity constrained consumers, but there is no evidence that the purchase of extended warranties correlates with liquidity constraint. *See* OFFICE OF FAIR TRADING, EXTENDED WARRANTIES ON DOMESTIC ELECTRICAL GOODS, *supra* note 5, at 35.

[28] John W. Pratt, *Risk Aversion in the Small and in the Large*, 32 Econometrica 122, 122 (1964); Kenneth J. Arrow, *The Theory of Risk Aversion,* Essays in The Theory of Risk Bearing, 90, 90-91 (1971); Rabin & Thaler, *supra* note 8..

[29] *See* Jindal, *supra* note 20 (experimentally examining demand for extended warranties on washing machines and concluding that loss aversion, not risk aversion, explained the demand).

[30] *See* SEARS, http://www.sears.com/shc/s/p_10153_12605_05771742000P?blockNo=3&blockType=G3&prdNo=3&i_cntr=1314814734858 (last visited Aug. 31, 2011). Sears does note that the price includes a manufacturer's warranty for "Service & Support: Limited warranty - parts and labor - 1 year." *Id*. (Source shows a 3-yr warranty).

dubbed the "3 Year In-Home Master Protection Agreement" – costs an additional $39.[31]

Table 1 evaluates the cost/benefit calculations for the extended warranty. On reasonable assumptions about frequency and cost of repair, the warranty costs ten times more than its expected monetary value. This calculation is conservative for at least two reasons. First, we ignore discounting, meaning that we treat a dollar paid in the future identically to a dollar paid today (despite the fact that we know that people greatly prefer dollars today over dollars in the future). Second, as Cutler & Zeckhauser point out, electronic goods tend to fall in price and increase in quality over time over time, with the result that the option to repair the product rather than junk it in favor of a better/cheaper model becomes increasingly less valuable.[32]

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[31] No information about any warranty is available on the main web page described above. *See id*. Only after you have "checked out" (clicked the button signifying that you wish to purchase the TV), are you informed about the possibility of an extended warranty. *See id.* This certainly constitutes an example of "shrouded" pricing. Moreover, although you can choose not to buy the extended warranty, the default is that it is included; you have to check a "decline warranty" box to avoid paying for it. *See id*. Here is how Sears describes the warranty:

> Our coverage goes well beyond the original manufacturer's warranty. No extra charge for covered repairs includes all parts and labor. Cosmetic defects are covered for the first 3 years. Schedule service day or night by calling 1-800-4-MY-HOME. Repairs are done by a force of more than 10,000 Authorized Sears Service Technicians, which means someone you can trust will be working on your products. Fast Help by Phone - we call it Rapid Resolution - provides you with non-technical and instructional assistance. Think of it as a talking owner's manual. It also includes rental reimbursement and a 25% discount on the purchase of consumable parts like filters and blades ordered from Sear Parts Direct (1-800-252-1698). An annual Preventive Maintenance check can be scheduled at the customer's request. The No Lemon Guarantee and Product Replacement includes delivery and installation if applicable. Coverage can be renewed and is transferable.

Id. The "5 year in-home master protection Agreement" costs $519 (almost 1/3 the value of the TV set itself). *Id*.

[32] Cutler & Zeckhauser, *supra* note 27.

Table 1: Extended Warranty Calculations	
Assumptions	
TV Lifetime	5 years
Lifetime probability of repair[33]	20%
Annual probability of repair	$1 - (1-.2)^{1/5} = 4.3\%$
Prob. of repair in 2 out-years (not covered by manufacturer's warranty)	$1 - (1-0.43)^2 = 8.5\%$
Cost of Repair[34]	$400
Results	
Expected Value of Warranty	$0.085 \times \$400 = \$34.16$
Cost of 3 year Warranty	$349
Cost/Expected Monetary Value	**≈ 10/1**

B. LOSS DAMAGE WAIVERS (LDWS) IN RENTAL CAR INSURANCE

Insurance against damage to a rented car is a complex maze of overlapping contracts, state-by-state regulation (or lack thereof) and insurance law doctrines (subrogation, primary vs. secondary coverage, etc.). The analytic problems are made worse by the absence of any consistent data on coverage or pricing. Since Collision and Loss Damage Waivers are not considered insurance for purposes of insurance regulation (wrongly in our view), they are regulated separately if at all, and there appear to be no systematic data on terms or prices.[35]

Under both CDWs and LDWs, the car owner (the car rental company) contracts with the renter to waive its right to be reimbursed for certain kinds of losses suffered while the renter has possession of the vehicle. CDWs traditionally covered damage from collision only,[36] while

[33] *Id*. at Table 5.

[34] This is a guess. Doubling the guess would reduce the cost/expected value ratio to 5:1, exactly the same as that for the low deductible in the homeowners' policy that Sydnor investigated. Recall that the risk aversion needed to explain that choice in expected utility terms would imply that the person would be unwilling to pay $1000 for a 50% chance to win $1 trillion.

[35] California, Hawaii, Illinois, Nevada and New York regulate C/LDWs by statute, apart from the ordinary insurance regulation mechanisms.

[36] LDW has been described as a descendant of CDW, which was "A more restrictive in that it waived the renter's responsibility for vehicle damage only when the damage resulted from a collision with another vehicle or object. The broader LDW option relieves the renter from responsibility for damage that results from virtually

LDWs covered, in addition, damage from such things as vandalism or theft. But the terms now appear to be used somewhat loosely.[37] For simplicity's sake, we will refer to all such agreements as LDWs. In essence, what the consumer buys with an LDW is the right to be free from any liability to the rental car company for any damage to the rented vehicle. From the customer's perspective this certainly feels like insurance, whether insurance law treats it as insurance as a technical matter or not.

LDWs are typical add-on insurance products. They are always priced separately from the car rental fee, and are presented to the customer after the baseline rental price has been announced.[38] When shopping on-line, for example, a typical setup is that the customer first inputs his or her rental location and dates. A second screen then allows for a choice of vehicle, and a third screen gives a list of options, including the LDW and other add-ons such as a booster seat or GPS device. In person, the transaction is typically structured much the same way – a baseline price is quoted, and once the renter has agreed to that price, she is then asked if she wants to "decline" the LDW by checking a box or series of boxes.[39]

In part because LDWs are not sold or regulated as insurance, they are apparently only loosely-based on actuarial principles.[40] Rental car companies

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any cause, including vandalism, theft, and glass breakage." DENNIS STUTH, RENTAL CAR DECISIONS: WHAT YOU DON'T KNOW CAN HURT YOU 125 (2005).

[37] For example, Alamo's self-described "Collision Damage Waiver" covers more than just collision damages. In it, Alamo agrees "to contractually waive [renter's] responsibility for all or part of the cost of damage to, loss or theft of the vehicle." See ALAMO, https://www.alamo.com/en_US/car-rental/reservation/start Reservation.html (complete online rental form filling in location as "Bradley Intl Arpt (BDL)", date of trip, renters age as "25 and up," then click "continue." On the next screen select a rental car by clicking "Add" next to one of the rental vehicles. This will then bring you to a screen with available "Add-On" features which include a category called "Protection Products." Under the "Protection Products" category click the words "Collision Damage Waiver.") (last visited Oct. 13, 2013).

[38] "It is a well-established sales principle that an individual is most susceptible to . . . upsell efforts [inducements to purchase add-ons] immediately after making the basic purchase decision." STUTH, *supra* note 37, at 30.

[39] The purchase of the LDW, while optional, is structured as the default transaction, so that the renter has to make an affirmative choice *not* to buy the coverage. The renter is not asked whether she wishes to buy the LDW, but whether she wishes to "decline" it by checking a box to that effect. In that sense, the LDW is more "default-y" than an extended warranty, in which the consumer is asked to "buy," rather than to "decline." On the other hand, the initial quoted price does not include the LDW, which would give the LDW even more of a default structure.

[40] "In contrast to physical damage coverage . . . provided under a personal auto policy, the LDW daily rate is typically not actuarially based." STUTH, *supra* note 37, at 129.

obviously need to charge a rate that covers their average loss, but beyond that, the rate charged for a LDW is highly dependent on competitive factors. It is not uncommon to find most car rental companies charging nearly the same LDW rate in a particular location.[41] It is therefore difficult to arrive at a typical cost for LDWs sold nationwide. Writing in 2005, industry insider Dennis Stuth suggested that rates ranged from $5 to $18 per day.[42] That seems much too low in today's market, however. Using examples from 3 cities and 3 different rental companies for a Toyota Corolla or similar car (see Table 2), we found prices for LDWs were in the range of $22-$28 per day, with an average of roughly $27. Of course, this was a small and non-random sample (we were unable to uncover any systematic data on pricing), but a price of $25 per day seems like a reasonable estimate.

Table 2: LDW & Car Rental Rates at Selected Airport Locations, June 26, 2012

Car	Rental Dates	Location (Airport)	Rental Company	LDW Cost, per day	Car Rental Base Rate Per day
Midsize	6/26 - 7/1	Hartford	Avis	$27.99	$67
Corolla	6/26 - 7/1	Hartford	Hertz	$28.99	$69
Corolla	6/26 - 7/1	Hartford	Alamo	$22.99	$66
Midsize	6/26 - 7/1	Dallas	Avis	$27.99	$40
Corolla	6/26 - 7/1	Dallas	Hertz	$28.99	$39
Corolla	6/26 - 7/1	Dallas	Alamo	$22.99	$31
Midsize	7/3 - 7/8*	Minneapolis	Avis	$27.99	$52
Corolla	6/26 - 7/1	Minneapolis	Hertz	$28.99	$54
Corolla	6/26 - 7/1	Minneapolis	Alamo	$24.99	$56
			Average:	$26.88	$52.56
			Std. Dev.:	$2.38	$12.89

Source: Rental company websites, visited 6/25/2012
*No availability for 6/26-7/1; dates are 7/3-7/8
Memo Item: MSRP for new Corolla = $17,980.

How much *should* someone be willing to pay for a LDW? This is a difficult question to answer because it depends on a great many idiosyncratic factors, including the extent of coverage under the renter's

[41] *Id.*
[42] *Id.*

own personal auto policy [43] and the credit card used to pay for the rental car in question.[44] Some renters are already covered for some or all of the losses covered by a CDW. For them, there is little or no point in buying additional coverage that duplicates what they already have. At most, the LDW will function to reduce their effective deductible to zero.[45]

Suppose, conservatively, that the renter has no prior coverage that would make the LDW unnecessary. The renter would then be buying coverage for an otherwise uncovered loss, at the rate of $25 per day. This works out to roughly $9,000 per year – far too much for a rational risk averse consumer to pay for coverage against harm to the vehicle.

One way to see why the LDW is overpriced is to compare its cost with ordinary automobile insurance. Typical automobile insurance covers vastly more than the LDW does (including, of course, liability to third parties, which could easily run many times the value of the insured vehicle itself), for far less money. For example, the first author's family auto policy, which covers three automobiles (including a 2013 Audi A6) and three adult drivers (one who is under 25), costs about $3,000 per year. Of that total premium, the first party property insurance coverage costs only $1100. By this metric, the LDW looks to be a very bad deal, since it covers less liability at many times the cost.[46]

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[43] Damage to a car rented by the policyholder is not covered under the standard Insurance Services Office PAP form, but some companies in some states do provide such coverage, which would make the C/LDW (almost) completely unnecessary. Even when damage to one's rented car is already covered, there might be a small side benefit to buying an LDW; since the rental company's loss would be waived, the renter would not need to turn to her or his insurer to cover it and would not risk an increased premium for having filed a claim.

[44] Some premium credit cards cover some kinds of losses (usually up to a relatively low limit) when a cardholder uses the card to rent a car.

[45] Even if someone is already covered by his or her own auto policy, STUTH, *supra* note 37, at 129, suggests that there might nevertheless be some reasons to purchase an LDW. These include: (a) Additional drivers: the renter's own insurance might not cover a driver who is nevertheless authorized under the LDW; and (b) Subrogation hassles: When the renter relies on his or her own insurer to cover any losses, the car rental company typically charges the renter for the losses, and then forces the renter to collect from his or her insurer. *See id.* at 130-31. This may involve considerable time and expense that would be saved by purchasing a LDW. Although they are not zero, these benefits seem very small for the typical rental car customer, and we ignore them.

[46] The moral hazard resulting from the LDW might lead rental drivers to behave more dangerously and get into more accidents than they would when driving their own cars. In turn, this might conceivably drive up the cost of the LDW relative to ordinary insurance on an owned vehicle. But it is difficult to imagine that rental drivers are so much more reckless than drivers of their own

A more standard way to think about the attractiveness of a LDW is to compare its cost to its expected payout (as we did in Table 1). Estimating the expected payout of a LDW is complicated, however, absent data on loss amounts and probabilities. Table 3 presents some back-of-the-envelope calculations. We assume that loss amounts are uniformly distributed in various ranges or "bins," and somewhat arbitrarily assign probabilities to each range.

Table 3: Back-of-the-Envelope Estimate for Expected *Annual* Loss, Corolla LDW

Loss Amount	Loss Probability	Expected Loss
$0-$100	52.0%	$26
$101-$500	26.0%	$78
$501-$1,000	13.0%	$98
$1001-$10,000	6.5%	$358
$10,001-$18,000	2.5%	$238
TOTAL	100.0%	$797
Cost of LDW		$9000
Ratio: Cost/Expected Benefit	11.3:1	

Despite its crudity, the estimated expected loss in Table 3 is an order of magnitude smaller than the annual cost of a LDW, even with conservative (i.e., generous) assumptions about loss probabilities. As with the extended warranty, a LDW looks to be a very bad deal for the consumer. Expedia's alternative loss damage waiver plan starts at $9 per day; that's still not worth buying in expected utility terms, but it is less than half the price of the rental car companies' LDW.[47]

However, the calculations here are somewhat more complicated than in the case of the extended warranty. The reason is that although the *expected* loss in this context is, at about $800, arguably quite small, there is

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cars, especially since so many renters have coverage for their own vehicles that largely mimics that of the LDW.

[47] *Car Rental Insurance*, EXPEDIA, http://www.expedia.com/daily/promos/travel_protection_plans/car_rental.asp?opt=1_7 (last visited Oct. 13, 2013). The program was designed and administered for Expedia, Inc.'s clients by Berkely and is underwritten by Stonebridge Casualty Insurance Company. *Id.* In California, Berkely is a service mark of Aon Direct Insurance Administrators; in all other states Berkely is a division of Affinity Insurance Services, Inc. except AIS Affinity Insurance Agency, Inc. in Minnesota and Oklahoma, and AIS Affinity Insurance Agency in New York. *Id.* The website is interactive, but will not give you a quote unless you actually rent a car.

some chance of a much larger loss. If an $18,000 loss represents a non-trivial fraction of lifetime wealth, then risk aversion may come into play, and the cost/benefit analysis needs to take account of the gains from substituting a certain payment for an uncertain loss amount. Such calculations were per se unnecessary in the case of extended warranties covering small losses.

So, could risk aversion be enough to justify the high premiums charged for a LDW? The short answer is "No." We can reframe the issue of whether the LDW is overpriced by asking how much more than the actuarially fair value of the loss a risk averse consumer would be willing to pay as insurance against that loss, given assumptions about her wealth, the probability and size of the loss, and her degree of risk aversion.[48] This "excess premium" can then be compared to the actual premium charged for the LDW. We assume utility has the widely-used Constant Relative Risk Aversion (CRRA) form.[49]

Kenneth Arrow has argued that on theoretical grounds a CRRA coefficient of about 1.0 (logarithmic utility) should be reasonable; a coefficient of 50 is extraordinarily risk averse. Yet as the last row of Table 4 reveals, even an absurdly risk averse individual, with a coefficient of relative risk aversion of 50, should at most be willing to pay only $1,000 more than the fair premium (of $2,000) to insure against a 10% chance of a $20,000 loss. That is, the most such an individual should be willing to pay for insurance against this loss is about $3000, since anything more than this would make going uninsured the more attractive option. For more reasonable levels of risk aversion, the maximum premium is between $2,036 and $2,330. Of course, these are all far less than the roughly $9,000 premium charged for a LDW by rental car companies and less than the $4,300 premium charged through Expedia.

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[48] To do this, we find the expected utility of the consumer who purchases no insurance and faces an uncertain prospect – a gamble. We then determine the certainty equivalent wealth – defined as the wealth (held with certainty) that gives the same utility as the gamble does.

[49] We use the standard CRRA (constant relative risk aversion) utility function of the form $(W) = \frac{W^{1-\rho}}{1-\rho}$, the limit of which, as ρ approaches 1, is *U(W) = ln(W)*. According to Pierre-André Chiappori & Bernard Salanié, *Modeling Competition and Market Equilibrium in Insurance: Empirical Issues*, 98 AM. ECON. REV. 146, 147,(May 2008), "constant relative risk aversion provides a reasonably good approximation of individual attitude toward risk, at least in an expected utility setting." Somewhat arbitrarily, we set wealth equal to $500,000.

Table 4: Maximum Willingness to Pay for a LDW as function of Risk Aversion

Assumptions				
Wealth, W	$500,000			
Probability of Loss, p	10%			
Loss Amount, L	$20,000			
Fair Premium	$2,000			
	Coefficient of Constant Relative Risk Aversion, ρ			
	1*	2	10	50
Certainty Equivalent Wealth[50]	$481,963	$481,925	$481,668	$480,885
Maximum Excess Premium	$36.54	$75.00	$332.00	$1,115.00

*The CRRA utility function is defined as *ln*(W) when ρ = 1.

These results make it all the more surprising that, according to one rental car insurance expert, 19% of renters always bought an LDW and another 19% sometimes did.[51]

C. CREDIT LIFE INSURANCE

Arthur Morris invented the modern version of credit life insurance in the US in 1917.[52] Borrowers purchase credit life insurance to guarantee

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[50] The certainty equivalent wealth is the amount of risk-free wealth that provides the same utility as the *expected* utility resulting from the gamble under consideration. In this context, the gamble consists of wealth of $500,000, a loss of $10,000, a probability of loss of 10%, and utility function characterized by a given degree of risk aversion. Since the individual dislikes risk, he is willing to pay more than the $1,000 expected loss to avoid it. The difference between ($500,0000 minus the certainty equivalent) and $1,000 represents the maximum excess premium the individual would be willing to pay, and this amount rises as risk aversion increases.

[51] STUTH, *supra* note 37, at 132 (quoting a 2002 survey performed by the Progressive group of insurance companies). Of those who bought, 63% said they did so because they wanted extra protection, but 24% said they bought because they weren't sure whether their PAPs covered the loss and 8% said they bought because the agent pressured them into doing so. *Id.*

[52] Arthur J. Morris, *The Origins of Credit Life Insurance*, 1957 INS. L.J. 329, 329; s*ee also* NAT'L ASS'N OF INS. COMM'RS, *supra* note 1, at 2 (noting that Morris' purpose was to allow the extension of credit to workers with no security or collateral). It's worth noting that the practice of buying life insurance to benefit creditors is much older than this. *See generally* GEOFFREY CLARK, BETTING ON

that if they die before repaying a particular outstanding debt (e.g., a mortgage or a car loan), the insurer will repay the lender. Closely related products such as credit health or credit disability work in much the same way, except that they are triggered by an event other than the death of the insured. The volume of credit life insurance sold in the US was about $770 million in 2010; credit accident and health insurance amounted to an additional $875 million.[53] Credit life is typically sold as an add-on to the financing of a primary purchase (a house, car, or other substantial consumer durable), by the entity making (or financing) the original sale – the car dealership, retailer, etc.[54]

The first thing to note about credit life insurance is that it does not *directly* protect the borrower, her estate, or her heirs. The primary beneficiary (in a legal and economic sense) is the *lender*, who is protected

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LIVES (1999) (describing the culture of life insurance in England from 1695 to 1775). Morris's innovation was extending the link between credit and life insurance to a mass market in a context in which the creditor did not require the debtor to purchase the insurance.

[53] NAT'L ASS'N OF INS. COMM'RS, CREDIT LIFE INSURANCE AND CREDIT ACCIDENT & HEALTH INSURANCE EXPERIENCE 2006-2010, 4 (2011). The roughly 30% drop in the volume of net written premiums between 2008 and 2010 presumably reflects the effects of the recession and the decline in overall consumption expenditures. Somewhat surprisingly, however, there has been a clear downward trend in the volume of both credit life and credit accident/health since 2001, with a drop-off of 62% over this period. *Id.* Patricia McCoy points out to us that under the National Bank Act, national banks are authorized to underwrite and sell insurance substitutes called "debt cancellation contracts" and "debt suspension agreements." 12 C.F.R. § 37.1(a) (2013). It is possible that the drop in credit life and credit accident insurance reflects a growth in the market for close substitutes – debt cancellation/suspension contracts. See Barnett, Sivon & Natter, P.C. and McIntyre & Lemon, P.L.L.C., *Debt Cancellation Contracts and Debt Suspension Agreements*, AM. BANKERS ASS'N (May 23, 2012), http://www.aba.com/ABIA/Documents/36a3b8296aef4474b90d3e3f9a8896feGAODebtCancellationCoalitionFinal2810conformed.pdf, for an overview of these contracts from the perspective of the Debt Cancellation Coalition, of which the American Bankers Insurance Association is an ex officio participant.

[54] We lack data for the US, but a UK Competition Commission report suggests that stand-alone sales of Protection Payment Insurance (PPI) "are very small compared to the total number of PPI policies sold by distributors . . . . [T]he stand-alone market accounts for less than 0.5 per cent of total P[ersonal]L[oan]PPI sales, and less than 0.1 per cent of total C[redit]C[ard]PPI sales. . . . [Even at] a little under 9 per cent…, the extent of M[ortgage]PPI policies sold on a stand-alone basis is still very small." *Market Investigation into Payment Protection Insurance*, COMPETITION COMM'N, 56-57 (Jan. 29, 2009), http://www.competition-commission.org.uk/rep_pub/reports/2009/fulltext/542.pdf. We strongly suspect the same is true for the US.

from the risk that the debtor dies before repaying the loan and the estate cannot repay it.[55] It is true, however, that the purchase of credit life insurance does reduce or eliminate the risk of foreclosure if the borrower/insured dies. Some borrowers may want to leave the asset free and clear to their heirs, or may worry that the heirs can't afford the remaining obligations under the loan and would be forced to give up the asset whose purchase the loan originally financed.

Thus, there are circumstances under which credit life insurance may provide benefits for the purchaser. Suppose the wage-earning spouse buys a car for $15,000, financing it with a loan secured by the car. If the borrower dies before the car loan has been repaid and the surviving spouse cannot make the remaining payments, the lender can take back the car; and if the remaining debt is less than the car's resale value, the lender can come after the estate for the rest of what's owed. Thus, there is a risk that one's survivor will have to repay the loan, and this risk does impinge on the utility of the person buying the insurance, thereby providing at least a superficially plausible motivation for buying credit life insurance. Credit life replaces the payments remaining at the time of the borrower's death, eliminating the risk that the deceased's estate will have to make those payments.

Credit life insurance is thus different from extended warranties and many LDWs for two reasons. First, the amounts at stake in credit life insurance can sometimes be large enough relative to overall wealth that a rational consumer might conceivably find insuring these risks attractive. That is generally not the case with extended warranties and LDWs (especially for a renter who has a personal auto policy with collision coverage), where the size of the risks involved is so much smaller. Second, the value of credit life depends not only on the insured's risk aversion, but also on his altruistic concern for the welfare of his beneficiaries, which

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[55] The lender has many other ways of protecting against this risk, of course, beginning with charging a higher interest rate to reflect the risk that the borrower would die before the loan was repaid. Note that the moral hazard problem with higher interest rates – that they induce borrowers to take on riskier projects – does not seem applicable in the context of credit life insurance. *See* Joseph E. Stiglitz & Andrew Weiss, *Credit Rationing in Markets with Imperfect Information*, 71 AM. ECON. REV. 393, 401 (June 1981) (suggesting that when lenders can't observe borrower behavior, higher interest rates will lead buyers to substitute towards riskier projects). Indeed, one plausible explanation for the existence of credit life insurance is that it offers a legal way to charge risky borrowers a higher interest rate, without running afoul of usury laws. Lenders often require collateral as an additional means of protection.

makes it more difficult for an outside observer to be certain when credit life insurance is a bad deal for an individual purchaser.[56]

Under ideal circumstances, credit life offers a way for borrowers to protect their survivors against the risk of having the borrower's estate drained by paying off a loan after the borrower dies. As many have noted, credit life is not a particularly good way to manage this risk – ordinary life insurance, if it is available, is typically both dramatically cheaper and more flexible, since proceeds are not dedicated to repayment of a particular loan.[57] This flexibility is especially valuable when the deceased borrower's estate is insolvent or if the loan is non-recourse. In either case, the debtor's family or other chosen beneficiary, not the creditor, gets the money, surely the result that is more consistent with the altruistic justification for the purchase of life insurance.

Moreover, some versions of credit life are even less defensible. For instance, many subprime mortgages were sold with so-called "Single Premium Credit Life," in which the total premium for the life of the policy is rolled into the initial mortgage. This meant that:

> The borrower then pa[id] interest on this amount for the life of the loan and typically ha[d] not even begun reducing the loan's principal balance by the time the five-year credit life insurance coverage period expire[d]. Consequently, when a borrower move[d] or refinance[d] out of a subprime loan after five years, all of the premiums for the

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[56] That is, credit life – and indeed all life insurance – does not pay the insured, but rather his or her beneficiaries. Their utility matters to the insured, but only indirectly. Thus, although we can place plausible bounds on risk aversion, we cannot as readily put bounds on altruism (as measured by sources outside of insurance demand). For an attempt to do so using insurance data, *see* B. Douglas Bernheim, *How Strong are Bequest Motives? Evidence Based on Estimates of the Demand for Life Insurance and Annuities*, 99 J. POL. ECON. 899, 900 (1991), concluding that "most individuals are in part motivated by a desire to leave bequests."

[57] Many sources note that if it's available, ordinary life insurance is typically a much cheaper way to cover the risk that credit life also insures against. *See, e.g., Credit Insurance*, WIS. DEP'T OF FIN. INSTS., http://www.wdfi.org/ymm/brochures/credit/credit_insurance.htm (last visited Sept. 25, 2013) (suggesting that "credit insurance is expensive in comparison to other forms of insurance" and offering a chart showing that a typical policyholder, age 30 and in good health, could expect to pay $342 per year for $50,000 of credit life insurance, while the same amount of term life – which of course pays cash, and is not restricted to the repayment of a particular debt – would cost only $70, only one-fifth as much).

> terminated insurance [were] . . . stripped directly out of the borrower's home equity.[58]

Financing the entire credit life premium, rather than paying it month-by-month, thus worked out to be a very poor deal for virtually every consumer.

Many other credit life practices have been highly criticized for over 50 years. Among the abuses discussed in a report by the National Association of Insurance Commissioners report in 1970[59] were: excessive coverage (selling coverage for more than the amount borrowed), failure to refund unearned premiums when the debt was paid earlier than required, coercive selling practices, bad faith claims-adjusting, failures to inform the policyholder of coverage,[60] overcharging, and a host of other practices. While regulatory changes beginning in the 1960s attempted to restrict the most blatant of these abuses,[61] their efficacy is unclear, and at least some of these practices continue in some jurisdictions.

Rather than focusing on the worst practices, however, it's better to consider a typical policy. Unfortunately, data on a "typical" product are not easy to come by,[62] but the Wisconsin Department of Financial Institutions furnishes the details of one assertedly representative example.[63] Using this example, supplemented by some actuarial data, we can do a very conservative back-of-the-envelope calculation on the payback from an average credit life insurance policy, as summarized in Table 5.

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[58] ERIC STEIN, QUANTIFYING THE ECONOMIC COSTS OF PREDATORY LENDING 5 (2001), available at http://www.selegal.org/Cost%20of%20Predatory%20Lending.pdf. Under bans from state regulators and pressure from public opinion, the worst of these practices were abandoned by most sub-prime lenders in the mid-2000's.

[59] For an extensive discussion, see NAT'L ASS'N OF INS. COMM'RS, *supra* note 1, at 39-52.

[60] Borrowers were sometimes sold policies bundled with the primary loan, and were not even informed that they were being charged for coverage. In such cases, the estate of a borrower who died would not know to make a claim on the insurer.

[61] NAT'L ASSOC. OF INS. COMM'RS, *supra* note 1, at 52-87.

[62] This in itself is interesting. Much as Daniel Schwarcz found with home insurance, it appears to be very difficult to shop for credit life insurance on-line, *see* Daniel Schwarcz, *Reevaluating Standardized Insurance Policies*, 78 U. CHI. L. REV. 1263 (2011): we were not able to uncover any recent rate quotes or sample policies.

[63] WIS. DEP'T OF FIN. INSTS., *supra* note 57.

Table 5: Hypothetical Credit Life Valuation

Assumptions:	
Male, 35	Sex, Age
$15,000	Amount of car loan
4	Years to repay
$2,917	Interest/finance charges[64]
$265	Cost of credit life
$8,172	Average Balance owed at death, if death occurs[65]
0.00175	Annual probability of death[66]
0.0072	Total probability of death during 4 year life of loan
Results:	
$58.84	*Expected* balance owed at death
$20.98	Expected interest/finance charge[67]
$79.82	Total Expected Payout from Credit Life
	Ratio: Premium Cost/Expected Payout = 3.3:1[68]

Suppose a 35-year-old male in average health borrows $15,000 to purchase a car, with no down payment. According to the Wisconsin Department of Financial Institutions, a typical credit life insurance policy costs the borrower $265. That amount protects an average balance owed –

[64] Wisconsin DFI apparently assumes an effective annual interest rate of 9.4%.

[65] Assumes that if the borrower dies, on average, it will be at month 24, halfway through the life of the loan. (We inflate the value of credit life insurance by not discounting future cash flows to present value. Were this amount to be discounted to its present value – as seems appropriate – it would be 20 percent smaller.)

[66] Source: http://www.ssa.gov/oact/STATS/table4c6.html for annual death probabilities.

[67] Wisconsin DFI apparently assumes that the entire stream of interest payments are protected by credit life, which implies that the appropriate number is $2,917 x 0.0072 = $20.98. But this is clearly conservative. A borrower who dies at month 24 owes only the interest on the remaining balance outstanding, which is roughly one-half of the total interest. (Again, since the interest would have been paid over the 24 months following the borrower's death, the present value of the remaining interest payments, as of the date of death is only $797.80, when discounted at the borrowing rate of 9.4 percent. That amount discounted to the date the loan is signed is only $667).

[68] With appropriate discounting of principal and interest payments insured by credit life, this ratio would be about 5:1.

over the 48-month life of the loan – of $8,170. The average 35-year-old male stands a 0.72% (0.0072) chance of dying before age 39. Even assuming that the entire interest and finance charges would still be owed if the borrower died, the purchase of credit life insurance would prevent an expected monetary loss of only $79.82. Of course, one should not expect that premiums would be equal to the expected payout, since such actuarially-fair pricing could not cover any of the other costs associated with running the insurance company. But at just over three to one, the ratio of expected payout to premium cost is extraordinarily low: not as low as the ten to one ratios for extended and damage waivers but still much too low to result from anything approaching rational behavior. Only someone who assigns astronomically high value to the wealth or consumption of his heirs should find this kind of ratio appealing. Even then, as noted earlier, there are typically much cheaper ways to protect against this kind of risk than through credit life.

Further proof of the problematic nature of credit life comes from data on industry loss ratios, which are calculated by dividing incurred losses by earned premiums.[69] According to state-by-state data compiled by the National Association of Insurance Commissioners (NAIC) in 2009, the loss ratio on credit life insurance averaged 44.1% for the US as a whole in the period 2003-2007.[70] Louisiana, Nebraska, South Dakota and Nevada all had loss ratios below 33%, and even the best states – Virginia, New York and Vermont – had loss ratios of only about 55%. Compared with a loss ratio of over 90% for group life insurance,[71] it's pretty clear that credit life purchasers are not getting a good return for the premiums they pay. These low loss ratios continue, despite the NAIC's proclamation, in 1959, of a resolution that "provided that any loss ratio for credit life insurance

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[69] If a credit life insurer pays out $100 in losses in a given year and collects $150 in premiums, its loss ratio is 2/3. From a consumer's perspective, the higher the loss ratio, the better, other things equal. Low loss ratios suggest that the premiums consumers pay are too high relative to the coverage they receive for incurred losses. (An actuarially-fair product would have a loss ratio of 1, which would of course leave no room to cover expenses.)

[70] This is the weighted five-year aggregated loss ratio, using states' credit life losses as weights and was computed from data in NAT'L ASS'N OF INS. COMM'RS, *supra* note 52. Using a shorter 3-year window does not make a substantial difference. The standard deviation of the loss ratio across states was 8.6%.

[71] The highly profitable nature of credit life is underscored by the virtual absence of any underwriting requirements for such policies. *See, e.g.,* UsLifeCredit Life Ins. Co. v. McAfee, 630 P.2d 450 (Wash. Ct. App. 1981) (failing to ask about policyholder's medical history did not bar recovery by insured's estate, even though policyholder knew she had cancer when she applied for credit life policies).

below 50 percent would be considered to produce an excessive rate,"[72] and despite many attempts to enforce such a minimum over the succeeding 50 years.

To recap: credit life looks to be a bad deal for consumers for several reasons. First, even in principle, it's not clear why borrowers should want it, although a strong bequest motive could explain some of the demand for credit life. Second, there are often substantially cheaper ways of covering the same risks covered by credit life. Third, the worst versions of credit life are virtually certain losers for the insured, and even average policies look to be a bad deal, unless consumers place extraordinarily high value on protecting their heirs. Finally, the very low ratio of claims paid to premiums collected implies that consumers are not getting enough back for their premium dollars, especially as compared to widely available alternatives.

III. THE BEHAVIORAL ECONOMICS OF ADD-ON INSURANCE PRODUCTS

The add-on insurance market poses two challenges to the standard economic analysis of insurance markets. First, the add-on insurance market largely consists of expensive insurance against relatively small losses, a combination that is unequivocally bad for consumers in expected utility terms. Second, sellers are able to sell the insurance at prices that far exceed the cost, notwithstanding what appears to be a robustly competitive market for the product or service to which the insurance is connected.

Extended warranties clearly pose both of these challenges. The damage waiver and credit life insurance situations are a bit more complicated. For a car renter with a personal auto insurance policy that includes collision coverage, a damage waiver functions simply to reduce the collision deductible to zero and, thus, is economically equivalent to an extended warranty – providing high cost insurance for small losses. But a car renter who does not have other collision coverage does face a small risk of a modest loss. Similarly, credit life insurance benefits can easily pay off in amounts that represent real money. These kinds of losses might barely be worth insuring, just not at the prices prevailing in the add-on insurance context.

In this Part we set out the behavioral economic explanation of why consumers like these products and why sellers can charge such high prices for the insurance, even in what appears to be a competitive market. We note that scholars and regulators have been skeptical about credit life for

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[72] NAT'L ASS'N OF INS. COMM'RS, *supra* note 1, at 69.

similar reasons since at least the 1950s,[73] so the behavioral critique is not new in spirit, even if some of the substance is novel.

A. THE APPEAL OF INSURANCE AGAINST SMALL LOSSES

We begin by reviewing why insurance against small losses is generally a bad deal in expected utility terms.[74] The explanation begins by assuming that people are risk averse and that it is this risk aversion that motivates insurance.[75] Risk aversion can be understood as a consequence of the declining marginal utility of money (meaning that people derive less benefit from each additional dollar that they possess). Insurance reduces financial risk by taking money from people, in the form of premiums, during times when the marginal utility of that money is comparatively low (they need it less, because they have more of it) and giving them money, in the form of claim payments, at times when their marginal utility for that money is high (they need it more because they have less of it, owing to the loss). Thus, a rational, risk-averse person should be willing to pay more than the expected value of a future financial loss to prevent that loss from occurring.

In a world of perfect information and no transaction costs, people would completely insure against all risks for which they could purchase fairly-priced insurance. Of course the real world is very different. For present purposes, the key difference is transaction costs. Insurers have to charge customers more than the present value of the expected loss, because insurers have to pay their employees, the rent on their headquarters, and so forth.

Insurance is a good deal in expected utility terms when the additional utility attributable to risk aversion exceeds the transaction costs and profits embedded in the insurance premiums. Other things equal, insurance that protects people from losses that are large in relation to their income and other assets is more valuable than insurance against small losses, because insurance against large losses provides a bigger marginal

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[73] *See* sources cited *supra* note 1.

[74] The uselessness of insurance for small losses is analyzed in detail in the sources cited *supra* note 8.

[75] There might be other motivations for purchasing insurance aside from classical risk aversion. For an extended treatment, *see* HOWARD C. KUNREUTHER ET AL., INSURANCE AND BEHAVIORAL ECONOMICS: IMPROVING DECISIONS IN THE MOST MISUNDERSTOOD INDUSTRY (2013). For a brief survey, *see, e.g.*, TOM BAKER & PETER SIEGELMAN, *Behavioral Economics and Insurance Law: The Importance of Equilibrium Analysis*, *in* OXFORD HANDBOOK OF BEHAVIORAL ECONOMICS AND THE LAW (Doron Teichman & Eyal Zamir eds.) (forthcoming 2014).

utility boost. Conversely, higher transaction costs or profits make insurance less valuable, because less of the premiums go to pay loss costs. Most add-on insurance products are a bad deal on both of these dimensions. The losses covered by add-on insurance tend to be small in relation to consumer assets. Moreover, the extra amount that consumers pay for the risk spreading services provided by add-on insurance is very high in relation to other kinds of insurance.[76]

Consider, as a useful point of comparison, the choice of deductible in homeowners' insurance. Should a consumer choose a policy with a $250 deductible, a $500 deductible, or a $1000 deductible? Choosing a low deductible in a homeowners' insurance policy is, from an expected utility perspective, similar to buying an add-on insurance product that provides a comparable amount of financial protection. (That is, choosing the $250 deductible instead of the $500 deductible is just buying an additional insurance policy that covers losses in the range of $250-$500, at a cost given by the difference between the two coverage plans.) Recent excellent research by Justin Sydnor precisely identifies the cost and expected benefit of different deductibles in the homeowners' insurance context, demonstrating that expected utility theory cannot explain why consumers choose low deductibles.[77] This analysis is directly applicable to add-on insurance products.

Importantly, however, the *institutional context* in which consumers choose the size of their insurance deductible differs significantly from that in which consumers choose whether to buy an add-on insurance product. As we will see, this difference in context nicely sets up the behavioral economic explanation for sustained high profits in add-on insurance (and the absence of such excess profits in low deductible insurance).

Sydnor uses data from a large homeowners' insurer to demonstrate that a substantial majority of consumers choose a deductible that is dramatically too small to be justified by any reasonable level of risk aversion or future expected claims. For example, many consumers choose a $500 deductible, rather than the $1,000 deductible they might have picked instead. The $500 deductible policy costs about $100 more than the $1000 deductible policy. Given typical claiming rates, the average expected monetary benefit from the additional coverage is about $20. This means that consumers pay $100 to receive an expected $20 monetary

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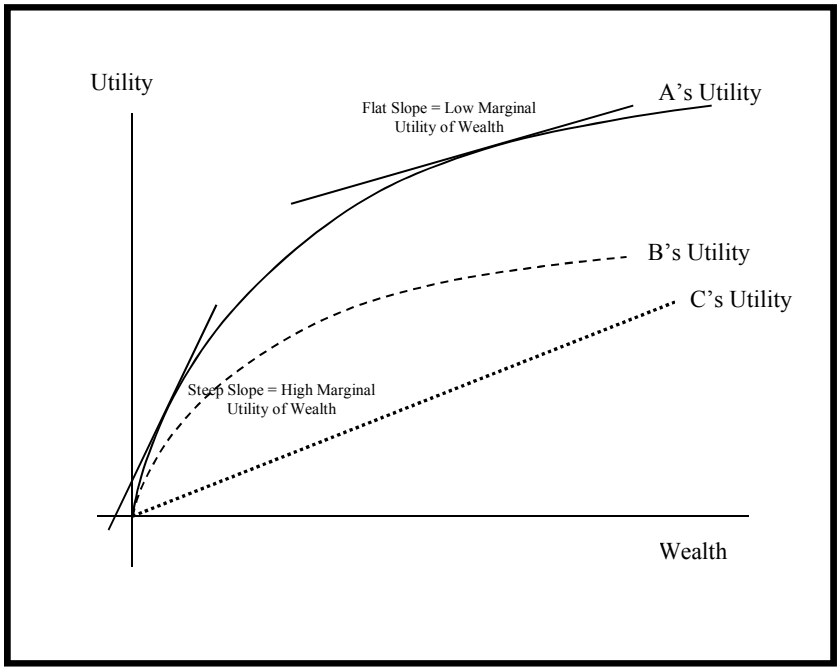
[76] Strictly speaking, not all that extra amount is a "transaction cost" as that term is used in economics. A significant amount is profit. For present purposes, this detail does not matter.

[77] Justin Snydor, *(Over)insuring Modest Risks*, AM. ECON. J.: APPLIED ECON., Oct. 2010, at 177, 178 (showing that among the consumers insured by the company that provided the data, 83% choose a deductible that was too low).

benefit.[78] That is not as bad as the ten to one ratio we found in extended warranties and damage waivers, but it is worse than the three to one ratio in credit life insurance.[79]

To justify the lower deductible on risk aversion grounds, a rational consumer would need to have a utility function that was so astronomically risk-averse that she or he would almost-literally never be able to get out of bed.[80] As we discussed earlier, risk aversion varies across individuals, and depends – somewhat loosely speaking and in very abstract terms – on the curvature of the individual's utility function in wealth/utility space, as illustrated in Figure 1.

Figure 1: Risk Aversion and Risk Neutrality



A highly risk averse person such as A (represented by the solid curve) has a marginal utility of wealth that declines very rapidly as her wealth increases (a highly-bowed utility function in wealth/utility space). Conversely, someone such as person C, who is completely risk neutral, has

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[78] *Id.* at 196.

[79] Recall that using more realistic assumptions produced a 5:1 ratio for credit life insurance, right in line with Sydnor's 5:1 ratio for the low deductible. *See supra* text accompanying note 67.

[80] Rabin and Thaler, *supra* note 8, at 226-27.

a constant marginal utility of wealth (a straight-line utility function represented by the dotted line in Figure 1). Person B (represented by the dashed curve) is more risk averse than C, but less-so than A, since B's marginal utility declines more slowly than A's as wealth increases.

As we explained, economists use a quantitative measure, called the "coefficient of risk aversion" to estimate the curvature of the utility function and hence, to measure an individual's degree of risk aversion.[81] Empirical studies estimate plausible values for the coefficient of relative risk aversion to be in the single digit range, i.e. from 0 (risk neutral) to 9.[82] Buying the lower deductible is a rational economic decision only if one's coefficient of relative risk aversion is implausibly (and astoundingly) high: between 1,840 and 5,064. Someone with a coefficient of relative risk aversion of 5000 would turn down a bet that offered a 50/50 chance of either losing $1,000 or gaining *any amount of money* (including, say $1,000,000,000,0000).[83]

Why do so many people – for example, about 25% of the purchasers of consumer electronics in the UK[84] and 19% of car renters in the US[85] – buy something that is such a bad deal in expected utility terms? Camerer et al. describe one hypothesis in evocative terms. People who buy extended warranties are cognitively challenged "Homer Simpsons," who mistakenly think the warranties are a good deal, perhaps because they overestimate the cost of a repair or the frequency with which products fail and misunderstand the value of insurance against such relatively small losses.[86] We will call this the "mistaken calculator" hypothesis. The

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[81] The coefficient of relative risk aversion is defined as $-WU''(W)/U'(W)$, where U″ is the second derivative of the utility function and U′ is the first derivative, evaluated at some given wealth level W. This is the so-called "Arrow/Pratt" measure of risk aversion. *See* Arrow, *supra* note 8, at 94-95; Pratt, *supra* note 8, at 123, 135-36. Informed readers will realize that we are finessing a conceptually important issue, since risk aversion is measured only at a given point along an individual's utility function.

[82] Syndnor, *supra* note 77 at 178.

[83] *Id*. at 190, Table 3.

[84] *See* U.K. Competition Comm'n, *supra* note 3, at 4; Chen et al., *supra* note 19, at 615 (explaining that 31% of consumers in their data purchased an extended warranty during their observation period at one U.S. retailer and that extended warranties "constitute approximately 33% of all purchase occasions," suggesting that some people bought more than one).

[85] Stuth, *supra* n. 37 at 132.

[86] *See* Camerer et al., *supra* note 13, at 1254 n.144, writes that,

> [I]n a classic Simpsons episode, Homer was having a crayon hammered into his nose to lower his I.Q. (Don't ask.) The writers indicated the lowering of his I.Q. by having Homer make ever

behavioral decision research suggests a second hypothesis, under which consumers buy the warranties as an emotional risk management device that reflects their (irrational but real) aversion to both loss and regret, and their mental accounting.

1. Emotional Risk Management

Behavioral economics offers a variety of potential explanations for preferring low deductibles and other forms of excessive insurance. We begin with regret aversion, which involves the present recognition that we will in the future evaluate our past decisions based on what actually happened, rather than (as in the expected utility analysis) based exclusively on what it was possible for us to know at the moment a decision is made.[87] Michael Braun and Alexander Muermann developed a model for insurance demand that adds regret aversion to the expected utility calculation and conclude that regret aversion leads otherwise rational actors to "hedge their bets" by buying insurance for low value losses.[88]

Regret aversion interacts with "mental accounting" – putting money into different mental categories with different emotional or other values – when people buy insurance against small losses, especially when that purchase is combined with another purchase, sometimes called "reference pricing."[89] The add-on insurance premium is categorized as an

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> stupider statements. The surgeon knew the operation was complete when Homer finally exclaimed: "Extended Warranty! How can I lose?"

Several readers pointed out that there is no need to put "cognitively challenged" in front of "Homer Simpson," but we are aware that not all readers are as familiar with Homer Simpson.

[87] Following a classic article, regret is associated with having made a *choice* that works out badly. In their terms, "compare the sensation of losing £100 as a result of an increase in income tax rates, which you could have done nothing to prevent, with the sensation of losing £100 on a bet on a horse race." Graham Loomes & Robert Sugden, *Regret Theory: An Alternative Theory of Rational Choice Under Uncertainty*, 92 ECON. J. 805, 808 (1982).

[88] *See* Michael Braun & Alexander Muermann, *The Impact of Regret on the Demand for Insurance*, 71 J. RISK & INS. 737 (2004). Although this is not relevant to the present analysis, regret aversion leads people to buy less insurance than they should for severe but infrequent losses.

[89] *See* Pranav Jindal, *supra* note 20 at 6, 16 (providing an explanation and test for "reference pricing" in the extended warranty context); Richard H. Thaler, *Mental Accounting and Consumer Choice*, 4 MARKETING SCIENCE 199 (1985*). See also* Viviana Zelizer, THE SOCIAL MEANING OF MONEY (1995). Our favorite example is Orly Ashenfelter's explanation of how to use mental accounting to

increase in "cost" rather than as a "loss," making the premium payment less painful. By contrast, the financial consequences of the potentially insurable future event are categorized as a loss and over-weighted because of the emotional distress associated with loss.[90]

As Eric Johnson and his collaborators first fully explained in the insurance context in 1993, people experience gains and losses from a reference point. People value the first dollar of a gain the most and each additional dollar of gain less. At the same time, people hate the first dollar of a loss more than any additional dollar. In other words, they have a declining marginal *dis*utility of loss that mirrors their declining marginal utility of gains. That means that people often will pay dearly to avoid a small "loss." In the add-on insurance context, they pay what feels like a small additional cost to avoid the emotional distress associated with a larger future loss.

Behavioral economics offers several other explanations for add-on insurance products. The availability heuristic – judging an event's probability by a particularly vivid example of that event – surely affects the purchase of all three of our examples.[91] The endowment effect – loosely, the tendency of people to prefer what they "have" just because they have it – likely impacts the purchase of extended warranties, and may explain why people buy the warranty once they bought the product, even though they

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drink great wine for nothing: buy cases as an "investment" and then pay nothing when you later drink a bottle.

[90] Johnson et al., *supra* note 11, at 42.

[91] JONATHAN BARON, THINKING AND DECIDING 153 (4th ed. 2007). *See generally* Daniel Kahneman & Amos Tversky, *Availability: A Heuristic for Judging Frequency and Probability*, 4 COGNITIVE PSYCHOLOGY 207 (1973). In the add-on insurance context, the availability heuristic could lead purchases to generalize from the examples of product failure, accidents, or death provided by the salesman to conclude that the likelihood of those events occurring was much larger than they, in fact are. In comments, Tess Wilkinson-Ryan (personal communication) put the point this way:

> Dropping your iPhone, toppling your television, spilling water on your laptop – these are events that are really easy to imagine. Furthermore, when the salesperson asks, "Would you like to pay for insurance against theft, breakage, hardware malfunctions, software malfunctions, lightning strikes, etc.?" it becomes very easy to call to mind ways in which your iPhone might meet its demise.

did not plan to buy the warranty before.[92] The availability of the insurance (which as a general category is something that responsible people buy[93]), together with the salesman's helpful explanation of the benefits and the satisfied people who have bought it, can make purchasing the add-on insurance seem like the right thing to do.[94]

These heuristics work together to make purchasing the insurance feel like the right thing to do. As a result, many consumers are willing to pay a small additional "cost" to protect themselves against the negative emotions associated with a future "loss" that looms larger than it rationally should. While this process could be described in terms of mistakes about probabilities, we think that it is better understood as emotional risk management: paying for peace of mind

2. Tests of the mistaken calculator vs. emotional risk management explanations

A recent article by Marieke Huysentruyt and Daniel Read (H&R) reports the results of survey research into the purchase of extended warranties that provides some support for both the mistaken calculator and the emotional risk management hypotheses, while concluding that emotional risk management offers the better explanation.[95] Using convenience samples that were weighted toward people with a greater immediate need for money and, thus, more disinclined than usual to spend

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[92] Jonathan Baron explains that the endowment effect is a kind of status quo bias, in which "people are unwilling to give up their endowment, which they now 'have,' for what they would otherwise prefer to it." Baron, *supra* note 91, at 297.

[93] *See* TOM BAKER, *Risk, Insurance and the Social Construction of Responsibility*, EMBRACING RISK: THE CHANGING CULTURE OF INSURANCE AND RESPONSIBILITY 33, 38 (Tom Baker & Jonathan Simon eds., 2002).

[94] In comments, Tess Wilkinson-Ryan also offered a useful description of this point:

> [S]ometimes an apparently neutral question or offer actually conveys some normative expectations. This is true for trivial questions like, "Would you like to wash your hands before we eat?" to the more serious: "Would you like to preserve your infant's cord blood?" People are being offered these weird insurance products and don't know what the prudent or responsible choice is. The limited information they have based on the offer is that apparently a market for these products exists.

[95] *See* Marieke Huysentruyt & Daniel Read, *How do People Value Extended Warranties? Evidence from Two Field Surveys*, 40 J. RISK & UNCERTAINTY 197, 215 (2010).

money today to buy future protection, H&R asked people to imagine buying a washing machine. They then asked two sets of questions that were directly related to an extended warranty offered in connection with that purchase. One set of questions elicited their evaluation of the expected financial value of the extended warranty.[96] A second set of questions elicited their assessment of the emotional benefits from purchasing the warranty.[97] They also asked a third, unrelated, set of questions that measured the cognitive capacities of the participants.[98]

The answers to all three sets of questions were correlated with the participants' predicted likelihood of buying the extended warranty. People who placed a higher financial value on the extended warranty were more likely to say they would buy it.[99] People who scored higher on the cognitive tests placed lower (but still inflated) financial values on the extended warranty and, thus, were *less* likely to say they would buy it. People who highly valued the emotional benefits were more likely to say that they would buy it. The first two correlations support the mistaken calculator hypothesis; the third supports the emotional risk management

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[96] These questions inquired into the fair price was for the warranty, the market price for the warranty, how often the washing machine would break down during the extended warranty period, and how much it would cost to repair the machine if it broke down. *Id.* at 203-04.

[97] Using a seven point Likert-scale, they asked participants to agree or disagree with six statements about the warranty:

1. It would give me peace of mind.
2. If I didn't buy it and the washing machine broke down, I would feel a lot of regret.
3. It would be comforting to have the protection of the warranty.
4. Even without the warranty I would not worry about repair costs.
5. I would feel more stress without the warranty.
6. Hopefully I won't need a repair, but I would rather not take the risk.

Id. at 207.

[98] They used the Cognitive Reflection Test discussed in detail in Shane Frederick, *Cognitive Reflection and Decision Making*, 19 J. ECON. PERSPECTIVES 25, 26-29 (2005).

[99] It was the predicted cost of the breakdown that most strongly affected the perceived financial value, rather than the predicted frequency of the breakdown. This is an example of probability neglect. *See* Huysentruyt & Read, *supra* note 95, at 208 (showing how participants generally overestimated the cost of repair and consequently overestimated the actuarial value).

hypothesis. Among these correlations, however, the emotional benefit assessment was by far the strongest.

Notably, the relationship between the emotional benefits reported by the individuals and their responses to the other two sets of questions was independent. In other words, the perceived emotional benefits strongly affected the willingness to buy the extended warranty, without affecting the expected financial value of the warranty. This same result holds true for participants with higher cognitive capacities. Higher cognitive functioning participants were less likely to buy the warranty, but that effect came entirely through their lower estimates of the expected financial value of the warranty, not through their emotional benefit score. Put another way, even the higher cognitive functioning people had heterogeneous assessments of the emotional benefits of an extended warranty, and the differences in those assessments strongly affected their reported willingness to buy the warranty.

Taken as a whole, the H&R result supports the emotional risk management hypothesis more strongly than the mistaken calculator hypothesis as an explanation for the demand for extended warranties. Some people were willing to buy extended warranties because they greatly exaggerated the costs of repairs, but more people – including the cognitively advantaged – were willing to buy the warranties because they highly valued the "peace of mind" the warranties provide. The logical extension of this finding is that, to at least some degree, people already know that the price for extended warranties significantly exceeds the expected cost for the company selling the warranty. People are willing to pay that (high) price because they value the emotional benefits the insurance provides.

A very recent working paper by Pranav Jindal provides some additional support for the emotional risk management explanation.[100] Jindal used conjoint analysis, a survey and statistical technique in which subjects choose among different combinations of features that are presented in a manner that allows the researcher to determine the relative importance of those features to the subjects.[101]

Jindal presented his subjects – executive and full time MBA students – with choices of washers and optional extended warranties.

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[100] *See* Jindal, *supra* note 20.

[101] The idea is similar to hedonic pricing models in economics. In both, the goal is to uncover valuations for individual attributes of a complex product. For example, new car buyers assign different weights to speed, looks, mileage, reliability, and so on, and the methods allow researchers to discern (average) valuations attached to each attribute. *See generally* Paul E. Green & V. Srinivasan, *Conjoint Analysis in Consumer Research: Issues and Outlook*, 5 J. CONS. RES. 103 (1978).

Importantly, he informed these, presumably numerate, subjects about the frequency and cost of the repairs that would be covered by the extended warranties, thereby reducing the likelihood that they would be "mistaken calculators." He varied the choices presented to the subjects along a variety of dimensions, including the price of the washer, the price of the extended warranty, the probability of washer failure, and the cost of the repair. Using the resulting data Jindal then applied logistic regression and Bayesian modeling techniques to evaluate how subjects weighted the different features and to develop different models of the choices.[102]

Consistent with past experience (over half had previously purchased an extended warranty),[103] the subjects frequently chose the extended warranties offered in the surveys. Significantly, they were more likely to choose the warranty if they had already chosen to buy the washing machine than if they were offered the washing machine and warranty as a package, suggesting an endowment effect.[104] As with Sydnor's homeowners insurance, ordinary expected utility analysis did a poor job of explaining the choices, requiring implausibly high levels of risk aversion. Allowing for loss aversion and mental accounting significantly improved Jindal's ability to estimate a model that closely predicted the actual choices.[105]

While the details of Jindal's analysis are complex, the bottom line is that incorporating loss aversion and mental accounting into the model led to a better alignment with choices, and more plausible estimates of risk aversion, than taking a pure expected utility, Economics 101 approach. While Jindal's research cannot rule out the mistaken calculator hypothesis, the fact that there was significant variation in the preferences of his "good calculator" subjects and that this variation can be explained in good measure by differences in loss aversion lends support to the conclusions we reached on the basis of with the H&R results. People who are more loss averse place a higher value on the peace of mind that the warranties provide.

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[102] Consistent with standard practice in Bayesian modeling, Jindal selected a random set of cases to hold out of the models and then used the models to predict the choices made in those cases as a measure of the predictive quality of the models. Jindal, *supra* note 20, at 26.

[103] *Id.* at 15.

[104] *Id.* at 20 ("The two stage choices in the sequential survey could lead to a sense of ownership of the washer in the second stage, which manifests itself in a higher willingness to pay for the warranty"); *Id.* at 22 ("[S]ubjects are slightly more loss averse and have a higher intrinsic preference for warranties in the sequential study").

[105] *Id.* at 35-36.

3. An important equilibrium point

As a result of these behavioral regularities, "Humans" (real people subject to ordinary behavioral biases) sometimes pay a great deal more for their insurance than would "Econs" (imaginary people who always behave as strictly rational expected utility maximizers).[106] Sydnor estimates, for instance, that other things equal, "homeowners could expect to save roughly $4.8 billion per year by holding the highest available deductible"[107] instead of buying more expensive coverage.

As Sydnor points out, however, estimates of this sort can be seriously misleading as a guide for regulation, because they ignore the way markets equilibrate. Indeed, Sydnor concluded that the insurer he studied did not earn excess profits on its low-deductible policies, even though consumers "overpaid" for these policies relative to the expected value of the low deductible. That's because low-deductible consumers had higher claim rates, presumably due to the presence of adverse selection. The low-deductible consumers, who had private information about their own elevated likelihood of making a claim, chose policies that reflected this information. In fact, those with a $500 deductible had about a 50 percent higher claim rate than those with a $1000 deductible, by various measures that controlled for the fact that people with a $1000 deductible cannot make a claim for a $900 loss.[108]

I may be able to get a better view at the ball game if I stand up, but this does not imply that *everyone* can simultaneously get a better view if we all do so. Similarly, Sydnor concludes that "[i]ndividual customers could benefit financially by avoiding over-insuring modest risk. However, if all homeowners changed their behavior, the company would likely need to raise insurance costs or create a new higher deductible in order to separate the more and less risky customers . . . . [I]f all customers had standard risk preferences, the new market equilibrium would not necessarily be welfare-improving for the customers."[109]

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[106] RICHARD H. THALER & CASS R. SUNSTEIN, NUDGE (2008).

[107] Sydnor, *supra* note 77, at 187.

[108] Roughly 3-3.5% for the $500 deductible, vs roughly 2% for the higher deductible. *Id.* at 198. It is important to control for the fact that those with a lower deductible can make claims (e.g., for between $500 and $1000) that those with a higher deductible cannot; thus, it is appropriate to use the rate of claims in excess of the higher deductible for this comparison. Some of the increased claiming may be the result of moral hazard. Teasing out which is a complex matter that was not necessary for Sydnor's purposes. *Cf.* Liran Einav et al., *Selection on Moral Hazard in Health Insurance*, (NBER, Working Paper No. 16969, Apr. 2011), *available at* http://www.nber.org/papers/w16969.

[109] Sydnor, *supra* note 77, at 198.

To this point in the analysis, it is easy to see the appeal of insurance against small losses and, by extension, the appeal of the consumer sovereignty defense of a light touch to the regulation of that insurance. Colin Camerer and colleagues and Daniel Schwarcz follow this line of reasoning in arguing that mistakes can and should be corrected by disclosure, but that if consumers are buying, for example, extended warranties because of loss or regret aversion, or as relief for "anxiety," they should be free to do so, because restricting their ability to make such decisions would leave them (subjectively) worse off.[110]

What the consumer sovereignty defense misses, however, is the institutional context. When insurance is sold as an add-on, the resulting equilibrium can, in effect, *require* the seller to exploit vulnerable consumers in order to compete in the market for the base product to which the add-on insurance is attached. Understood in this way, regulation protecting consumers from sellers pushing add-on insurance also frees up sellers to compete on the basis of what everyone understands to be their core function: selling the base product. We explain this institutional context and the equilibrium effects next, before turning to the distributional and efficiency benefits to be gained from regulating add-on insurance.

B. EXPLAINING THE HIGH PRICES CHARGED FOR ADD-ON INSURANCE

We begin with the "shrouding" model of two-stage or 'tied' purchases developed by Gabaix and Laibson.[111] We summarize that model here, stressing its prediction that when some actors are subject to a plausible behavioral anomaly – an anomaly that is consistent with observed behavior in the add-on insurance market – inefficient and discriminatory

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[110] Camerer et al., *supra* note 13, at 1253-54, noting that consumers purchase what seem to be extravagantly over-priced extended warranties and suggesting that the problem could be solved by disclosing the true frequency of repair because: "[i]f disclosure reduces warranty purchases by reminding consumers of the low chance of product breakage, then purchasing the warranty would have been a mistake rather than a preference. If informed consumers continue to purchase the warranties, then it is quite possible that they have good reason to do so, however unfathomable that decision may seem to an economist."; Schwarcz, *supra* note 13, at 31, "[A]rgues that the insurance demand anomalies . . . can plausibly be explained as sophisticated consumer behavior to manage emotions such as anxiety, regret, and loss aversion. Moreover, the capacity of insurance to address these negative emotions is not necessarily an artifact of manipulative insurance sales or marketing. Rather, it may be a sophisticated and informed strategy on the part of consumers to manage emotions that exist independently of insurers' (and their agents') sales efforts."

[111] Gabaix & Laibson, *supra* note 12, at 505–07.

terms can survive in equilibrium even if a substantial portion of consumers are careful shoppers.[112]

The shrouding model imagines a two-step purchase process of exactly the sort that takes place with add-on insurance products. In the first step, a consumer purchases a base good or service, and then in the second step *optionally* makes a secondary purchase that is somehow tied to the first. Gabaix and Laibson use examples such as a laser printer and replacement cartridges, a hotel room and telephone charges, and a car rental and a pre-paid tank of gas.

In constructing their model, Gabaix and Laibson recognize that consumers are not all alike in their shopping behavior. To simplify, they divide consumers into just two types: "myopes," who don't think about the possibility of future "add-ons" when they make their initial purchase, and "sophisticates," who do. Consumers make the initial purchase in a competitive market, in which the prices charged by all sellers for the base product are completely observable. That first purchase then exposes the buyer to an optional add-on purchase from the same seller, in a market in which the price for the second purchase is unobservable at the time the initial purchase is made (unless one inquires about it). We think it is helpful to think of the second stage purchase as taking place in a "situational monopoly" in which the seller has a captive market for that purchase.[113] As Gabaix and Laibson observe, the second stage price – for the cartridge, the telephone charges, or the add-on insurance – typically is significantly above the marginal cost of providing the good or service. One could presumably buy an extended warranty separately from the primary purchase, but this turns out to be rare in practice,[114] with the result that

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[112] By contrast, models with heterogeneously informed consumers but *no* behavioral anomaly suggest that inefficient pricing is unlikely to survive an equilibrium. Schwartz & Wilde, *supra* note 10, at 638 conclude that "[t]he presence of at least some consumer search in a market creates the possibility of a 'pecuniary externality': persons who search sometimes protect nonsearchers from overreaching firms." Moreover, in their model, if at least one third of consumers undertake comparison shopping, the market price will be close to the competitive price in a market where all consumers are informed. *See id*. at 653. But there are grounds to be skeptical about this dynamic. *See* Ben-Shahar & Snyder, *supra* note 6, at 742-49 (concluding that the empirical history of mandated disclosure has shown that there has been a history of failure in employing mandated disclosure to assist consumers in making choices in the market).

[113] See *supra*, n. 14.

[114] OFFICE OF FAIR TRADING, *supra* note 5, at 87 (indicating that 69% of extended warranties were purchased from the retailer/shop that consumers purchased the insured product from). Patricia McCoy (personal correspondence) points out to us that after she refinanced her own mortgage, she received numerous unsolicited offers for credit life insurance from insurers that were unaffiliated with

most extended warranties are sold at decidedly supra-competitive, monopoly-like prices. Their shrouded pricing model provides an explanation for why.

The explanation begins with the observation that in a competitive market, sellers must earn zero profit on the combination of TV set and extended warranty. Since the second stage monopoly allows the seller to extract supra-competitive prices for the extended warranty, the prices on TV sets must therefore be lower than they would be if they were sold on their own. Suppose now that a firm tries to compete by offering a lower second-stage price – e.g., on extended warranties – than its rival, and by alerting potential customers to the fact that its rivals charge more ("Come buy from us – we charge less for our extended warranties"). Doing so has two consequences. First, it educates the rival's sophisticated consumers that the rival is using high profits on the add-on to subsidize low prices for the TV. The sophisticates will thus prefer to buy the TV from the rival (at the cross-subsidized price) and avoid the rival's high add-on charges. They can do this by substituting a competitively-supplied extended warranty for that offered by the seller or, better yet, by not buying one at all and relying instead on savings or a credit card to replace the product if it breaks. Importantly, however, this advertising will have no effect on the rival's myopic consumers, who aren't paying attention to the second-stage transaction at all.[115] Thus, competitive attempts to unmask a rival's high add-on prices will only succeed in driving sophisticated customers to the rival, and will not do anything for the firm providing the educational information. Hence, there will be no reason for any firm to try to unmask its rivals' high add-on fees, which can then persist in equilibrium.

To bring this point home, try shopping for a rental car using Expedia or other web-based travel sites. All show a "total price" that is the base charge in Gaibaix and Laibson's terms. None show the price for the collision damage waiver or supplemental liability insurance in any easily comparable way. If you spend enough time on the website you can find that information, but nowhere is it combined and presented in a table for

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her lender. She suggests that a separate market is possible (at least for those who do not purchase insurance from the lender at the time of borrowing), but that the disorganized state of the market and the inability of consumers to make comparisons creates a somewhat similar situational monopoly, if perhaps for different reasons.

[115] Consistent with the shrouded pricing model, the U.K. Office of Fair Trading reports that more than half of the people who purchase extended warranties had not considered purchasing an extended warranty before purchasing the covered product. *See* OFFICE OF FAIR TRADING, *supra* note 5, at 36 (only 39% of extended warranty holders agreed that they had intended to take out an extended warranty before purchasing the insured product).

easy comparison. Interestingly, Expedia offers a collision damage waiver that can be used at any car rental agency and that is much less expensive than those sold by the rental car companies.[116] If the market for collision damage waivers was competitive, rental car companies would not be able to charge so much more than Expedia. A "sophisticate" who wants a collision damage waiver will buy it from Expedia and rent the car from the company with the cheapest base charge.

We take some comfort from the fact that the existence of situational monopolies has been understood for a long time. Writing in 1958, Philip H. Peters, a Vice President at John Hancock Life Insurance, diagnosed the problem in credit life insurance as follows:

> [A]buses [of consumers] are possible because *borrowers who take out personal loans or who buy on time are a captive insurance market*. Their lack of knowledge, their need or their diffidence makes them receptive when the lender or dealer suggests that the loan be insured, and they are usually unable to defend themselves against excessive charges or other overreaching. In these circumstances, competition among insurance companies does not protect the borrower. Insurers are competing for the lender's patronage, not the borrower's; the lender is interested in a high premium because his commission or dividend will be higher if the premium is larger.[117] (Emphasis supplied).

The presence of the situational monopoly undercuts the consumer sovereignty defense of a light touch, disclosure-only approach to the regulation of add-on insurance products.[118] Even if consumers are not "mistaken" in purchasing add-on insurance and, instead, are motivated to purchase that insurance by genuine (albeit irrational) fears or anxieties, it does not follow that they should over-pay for the insurance they purchase, as the shrouding model predicts and the evidence we reviewed in Part I shows to be the case. Even if the add-on product meets some real need that

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[116] Expedia, *Frequently Asked Questions*, EXPEDIA CAR RENTAL INSURANCE, http://expediacri.berkelycare.com/product/contact-us/faq.jsf (last visited Sept. 28, 2013); Expedia, Why Should I buy?, EXPEDIA CAR RENTAL INSURANCE, http://expediacri.berkelycare.com/product/home.jsf (last visited Sept. 28, 2013).

[117] Neither Peters nor the U.K. Competition Commission invoke consumer irrationality to explain the absence of competitive pricing in credit life. Peters, *supra* note 1; U.K. COMPETITION COMMISSION, *supra* note 3 at 3-10.

[118] *See* Schwarcz, *supra* note 13, at 39 (interventions monopolizing genuine consumer preferences for the benefit of those consumers are troubling because they undermine welfare economics and consumer sovereignty).

was not the product of seller-created pressure, framing, or advertising, consumers should not have to pay vastly more for such insurance than it costs to provide.

The situational monopoly that Peters identified – and that the shrouded pricing model explains – suggests a market failure that regulation could potentially address, even if insurance is purchased for "legitimate-but-non-standard" reasons such as regret- or loss-aversion. The market failure arises not from consumer motivation per se, but from the way such motivations shape the resultant market equilibrium and reduce the ability of competitive market forces to protect consumers from overpaying.

In this regard, add-on insurance products present a very different case than low deductible homeowner's insurance. People who choose the low deductible homeowners' insurance policies might appear to overpay for their insurance, because the low deductible is over-priced in relation to the expected benefit of the deductible considered in isolation. Yet, as Sydnor's equilibrium analysis reveals, they do not actually overpay for their insurance as a group, because they have higher claim costs. Their preference for the low deductible functions as a sorting device that identifies them as more costly to insure.[119]

Add-on insurance also functions as a sorting device. But that sorting device has little or nothing to do with the cost of providing the add-on insurance. Instead, it sorts consumers according to their foresight and vulnerability to the shrouded pricing dynamic. The people who buy add-on insurance overpay for that insurance, compared to what would be paid in a competitive market, because the shrouded pricing dynamic gives the seller the ability to charge a situational monopoly price. [120] This price provides

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[119] Sydnor's research suggests that the availability of different levels of deductibles in homeowners' insurance facilitate what one of use has called "risk classification by design." *See* Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act,* 159 U. PA. L. REV. 1577, 1588 (2011) (a reduction in plan variation fosters "risk classification by design" which is the creation of separate risk pools as individuals self-select into different health care products according to their self-assessed health risk status). This is, of course, exactly what the famous Rothschild/Stiglitz model shows is the only possible (Nash) equilibrium in a world of asymmetric information. *See* Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information,* 90 Q. J. OF ECON. 629, 633 (1976). The idea is to induce separation (self-selection) by offering a menu of policies such that: (i) both policies earn 0 profit, given who buys them and (ii) the high-deductible policy is cheaper but excludes just enough risk so that the high-risk group prefers the low-deductible policy. *Id.* at 636-37, 646.

[120] Huysentruyt & Read, *supra* note 95, at 217("The central feature of a functioning market is that because providers compete for the business of customers, prices are pushed downward, and consumers can get the best deal with

ample incentive to push people into buying protection that they don't really need or would be much better off buying somewhere else. The extra profits the retailers earn from that insurance reduces the base price that everyone pays for the underlying product or service, meaning that – as in the shrouded pricing model – the people who are vulnerable to the situational monopoly subsidize those who are not.

Moreover, if regret-aversion is the motivation for buying an add-on insurance product, it is not clear that the product in fact increases welfare in the manner that the defenders of consumer sovereignty assert. If there were no extended warranties available, the consumer could not experience regret for having failed to purchase one. Thus, a policy-maker who was convinced that regret-aversion was the reason for consumer purchase of insurance product could ban the insurance with no loss in welfare. This is a case where supply creates its own demand. If we think the demand is welfare-reducing, we can eliminate the supply *and* the demand at the same time.

1. Efficiency Consequences of Add-on Insurance

Ending the redistribution of wealth from myopes to sophisticates is in our minds sufficient justification for regulatory action to eliminate situational monopolies. The justification is strengthened to the extent that the demand for add-on insurance products is seller-induced in the first place. But there are efficiency losses associated with add-on insurance as well, stemming from a key institutional fact that is not captured in Gaibaix and Laibson's model: the retailer's sales efforts.

In the original shrouded pricing story, sellers do not need to *induce* customers to buy the second stage product – if you own a laser printer, you can't use it for long without purchasing replacement toner cartridges. But add-on insurance is qualitatively different, because customers can and often do purchase the primary product (TV set, car rental) without ever needing to buy the insurance. We suspect that relatively few consumers would independently request extended warranties if they were not urged to buy them by sellers (though there may be more people who would continue to buy them in the future having first been persuaded to do so). At a minimum, the sellers are taking advantage of the availability heuristic (by

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the minimum cognitive effort – they do not have to combine breakdown probabilities and repair costs because warranty sellers have done it for them. To a first approximation, all consumers have to do is choose or reject the best deal amongst those available. If a consumer believes that a warranty is worth three times its objective value, but finds that she can buy it for one third of that price, she will buy it and obtain the benefits from knowing she has obtained a bargain as well as the warranty itself.")

highlighting the possibility that the product will fail plus the certainty of death), the endowment effect (by selling the extended warranty in a second step, after the customer has decided to buy), and regret aversion (by causing consumers to imagine a future regret that would not exist absent the over-priced insurance). Quite likely they are doing even more to manipulate buyers, as the U.K. Competition Commission reported.[121] It would be astonishing if they were not, given the truly extraordinary profits that sellers earn on add-on insurance.

Seller efforts to induce consumers to purchase unneeded add-on insurance are a waste of salesperson and consumer time: Simply charging a higher price for the TV set and abandoning the extended warranty altogether would free up resources for more productive uses. A recent story in the New York Times gives a sense of the inefficient practices involved. According to one whistle-blower, Staples (the office products store)

> [h]as in place a set of incentives that make it unpleasant, to put it mildly, for staffers to sell a computer without a whole bunch of accessories, particularly a service plan. Staples . . . has a system called Market Basket that tracks how many dollars' worth of add-ons each staffer sells. [E]ach time you sell a computer, you need to sell, on average, $200 worth of other stuff. And that average is carefully tracked. Sales staffers who aren't meeting their goals are coached, and if that doesn't work . . . there will be disciplinary action that can lead up to termination; underperformers can also end up with lots of night and weekends shifts or even a reduction in scheduled hours.[122]

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[121] Ian Ayres, *Fair Driving: Gender and Race Discrimination in Retail Car Negotiations,* 104 HARV. L. REV. 817, 872 (1991) long ago pointed out that a few "home run" sales (those with extraordinary markups) accounted for a significant proportion of a new car dealers' profits. The pursuit of such large markups plausibly drives much of the hard sell behavior for which car sales are well-known, and an analogous set of incentives operates in the add-on insurance market. *See also* U.K. COMPETITION COMMISSION, *supra* note 3, at app. 2.1 (list of unacceptable practices).

[122] Moreover, store managers who can't keep their storewide "Market Basket" numbers up face "conference calls with district managers" and other discipline. One store manager was told: "'If you can't do the job, you can go sell fries at McDonald's.'" David Segal, *Selling It With Extras, or Not at All,* N.Y. TIMES (Sept. 8, 2012), http://www.nytimes.com/2012/09/09/your-money/sales-incentives-atstap les-draw-complaints-the-haggler.html?pagewanted=1&_r=0&emc=eta1.

As a result, sales personnel seeking to keep their Market Basket average high will actually refuse to sell a computer to a customer who declines to purchase the extended warranty. This practice is common enough to have a name: "Walking the customer," "because consumers are essentially shooed out the door empty-handed" if they want to buy a computer without the warranty.[123] While it is difficult to quantify the time and hassle consumed by such hard-sell tactics, anyone reading the customer complaints about these practices would recognize that they generate considerable frustration.

These last observations suggest a possible role for regulation that would attempt to make extended warranties and other forms of add-on insurance a better deal for consumers by addressing the market failure attributable to the situational monopoly enjoyed by the product retailer.

IV. REGULATORY STRATEGIES

There are four potential regulatory strategies to address the situational monopoly prices charged for add-on insurance: mandating enhanced disclosure, banning the sale of the insurance as an add-on, regulating the price of the insurance, and using information technology to eliminate the situational monopoly. Enhanced disclosure has been tried many times, including in the add-on insurance context, and the evidence shows that disclosure does not work, at least not for add-on insurance products. By contrast, banning the sale of the insurance as an add-on works well, perhaps even too well in some contexts. We recommend banning insurance add-on sales when consumers do not really need to purchase insurance together with the primary product or service, such as extended warranties and credit life insurance. But a ban goes too far when some consumers need to be able to buy the insurance as an add-on. The one example we have identified is when a consumer without a personal auto policy rents a car, but there may be other examples that have not

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[123] David Segal, *A Hard Sell on the Extras, Revisited,* N.Y. TIMES (Dec. 1, 2012), http://www.nytimes.com/2012/12/02/your-money/another-look-at-a-hard-sell -on-extras-at-staples-stores.html?emc=eta1. For another recent example, consider the practice of overbilling for collision damage waivers. Tara Siegel Bernard, *A Quick Electronic Signature at the Car Rental Office, and Then Trouble,* N.Y. TIMES (Apr. 5, 2013), http://www.nytimes.com/2013/04/06/your-money/for-car-renters-signing-on-the-electronic-tablet-may-mean-trouble.html?emc=eta1. According to one source, Dollar Rent a Car charged at least 100 consumers for collision damage waivers that they had explicitly denied to purchase by checking a box on an electronic data entry form. Whether this kind of overbilling represents a deliberate policy or simply a computer glitch, it is clear that the profitability of CDW's drastically reduces the incentives to correct this problem.

occurred to us. Price regulation *could* help protect consumers from the situational monopoly pricing in such situations. We greatly prefer the fourth strategy, however: using information technology to eliminate the situational monopoly. There is some precedent for this approach. The Office of Fair Trading in the UK is in the process of implementing an information technology solution as a result of their investigation into why the Competition Commission's disclosure strategy for extended warranties didn't work. This part briefly describes these four strategies and explains our recommendations among them.

A. ENHANCED DISCLOSURE

Historically, enhanced disclosure has been the preferred free market regulatory strategy, including for add-on insurance.[124] Omri Ben-Shahar and Carl Schneider have recently described in great detail the failure of disclosure as a regulatory strategy.[125] One need not endorse their across-the-board rejection of disclosure to agree with their conclusions in the add-on insurance context. The shrouded pricing model fits the add-on insurance product too well to expect disclosure to work. This conclusion is borne out by the available evidence. A highly regarded U.K. government agency – the Competition Commission – recently tried a well-calibrated enhanced disclosure approach for extended warranties. It failed.

The Competition Commission conducted an investigation of extended warranties sold in connection with consumer electronics, producing an impressive and extensive report that we have relied upon for some of our empirical assertions about extended warranties.[126] The Commission's principle recommendation was to mandate advertising of the extended warranty price along with the price of the covered product, thereby allowing consumers to shop on the basis of the combined price.[127] The Commission also proposed three reforms designed to reduce the likelihood of the customer being pressured into buying the extended warranty: (1) obligating the retailer to provide an offer of an extended warranty that could be accepted at any time during the first 30 days after the purchase (so the consumer could think about it); (2) requiring the warranties to be cancellable with full refund rights for the first 30 days and on a pro rata basis for the life of the warranty; and (3) obligating the retailer to provide an informational booklet at the time of the sale that would explain to the consumer how to get an extended warranty from an

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[124] *See* Camerer, et al., *supra* note 13, at 1254; Schwarcz, *supra* note 13, at 42.

[125] Ben-Shahar & Schneider, *supra* note 6, at 742-43.

[126] *See* U.K. COMPETITION COMMISSION, *supra* note 3, at 15-16 (summary of the study).

[127] *Id.* at 10.

independent third party provider.[128] All four reforms were adopted by regulation, effective April 2005.[129]

Taken together, these reforms reflected the Commission's conclusion at the time that the excess profits from extended warranties resulted from a combination of (a) collusion among retailers to refrain from advertising the extended warranty prices and (b) improper selling practices. Because retailers know that they can make so much money from pressuring customers into buying overpriced extended warranties, the retailers collude to preserve their collective ability to charge excessive prices, or so the Commission seemed to suggest.

We are skeptical that retailers could successfully collude in this manner, however. There are hundreds (maybe even thousands) of retailers offering extended warranties, and it seems highly implausible that they could collusively agree to maintain high prices without chiseling. If making the price of the extended warranty more transparent would actually change the behavior of consumers, such that they would prefer to buy the product from the seller with the cheapest price for both the product and the warranty, then some retailer in the crowded and, to our eyes, intensely competitive consumer electronic product market would at least try competing on that basis.

The behaviorally-informed shrouded pricing model offers a much more compelling story about how supra-competitive pricing could be sustained in equilibrium, without any resort to implausible assumptions about collusion. The shrouding model accepts the behavioral decision research finding that people regularly depart from the rational actor model, focuses on the fact that people are not all the same in this regard, and then incorporates an equilibrium analysis that takes into account the behavior of both buyers and sellers. Thus, at a minimum, it provides a much more compelling explanation for the observed evidence of over-priced extended warranties than does the Competition Commission's story about seller collusion.

Our skepticism is supported by the fact that profits from extended warranties on consumer electronic products in the UK continue to be very high, despite the reforms, and the U.K. Office of Fair Trading still sees the

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[128] A minority of the Commission would have limited point of sale extended warranties to a maximum of one year.

[129] The regulation as adopted allowed for a 45 day cancellation period. *See* COMPETITION COMMISSION, EXTENDED WARRANTIES ON DOMESTIC ELECTRICAL GOODS: A REPORT ON THE SUPPLY OF EXTENDED WARRANTIES ON DOMESTIC ELECTRICAL GOODS WITHIN THE U.K., (December 2003), at 10 (U.K.), *available at* http://www.competitioncommission.org.uk/inquiries/completed/2003/warranty/index/htm; http://www.legislation.gov.uk.uksi/2005/37/contents/made.

market as "unfair and uncompetitive."[130] As the shrouded pricing model would predict, disclosure did not work. The Office of Fair Trading conducted a follow-up investigation that concluded in 2011 that disclosure is not working and recommended, instead, recommended an information technology solution that would eliminate the situational monopoly. British retailers recently accepted that recommendation as an "agreed remedy," perhaps to avoid the ban that we recommend for extended warranties in the add-on context.[131] We discuss this information technology solution below.

1. Why more information is unlikely to be effective

Ben-Shahar and Schneider provide an elegant taxonomy of the reasons why mandatory disclosure regimes almost never provide much protection for those they are designed to benefit. First, regulators can rarely design appropriate disclosure regimes that adequately specify what needs to be disclosed and what constitutes sufficient disclosure. Second, even when they want to comply in good faith – and this is only sometimes the case – disclosers invariably struggle to interpret the disclosure mandate, assemble the required data, and communicate it in meaningful ways. And finally, consumers routinely ignore the information disclosed (i.e., they fail to read contract terms, nutrition labels and so on), fail to understand the terms, even when they are aware of them, and fail to make appropriate use of them, if they're understood.[132] As Ben-Shahar and Schneider put it:

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[130] *See* Rupert Neate, *OFT to look into extended warranties,* THE DAILY TELEGRAPH, Apr. 15, 2011, Bus. Section at p. 3 (reporting that the Office of Fair Trading (OFT) is going to examine the £750M market for extended warranties for electrical goods again; one in four customers purchase extended warranties; and the warranties are still seen by OFT as "unfair and uncompetitive."). Prices of extended warranties have declined at traditional retailers since the reforms, but that appears to be the result of competition from internet retailers and big box stores. *See Evaluating the Impact of the Supply of Extended Warranties on Domestic Electrical Goods Order 2005*, OFFICE OF FAIR TRADING, 5-6, (October 2008), *available at* http://www.oft.gov.uk/shared_oft/reports/Evaluating-OFTs-work/oft1024.pdf.

[131] *Market Review of Domestic Electrical Goods*, OFFICE OF FAIR TRADING (June 27, 2012), http://www.oft.gov.uk/OFTwork/markets-work/othermarketswork/electrical-goods/.

[132] It strikes us as ironic that Camerer, Issacharoff, Loewenstein, O'Donohue and Thaler – all distinguished behavioral economists who have made careers out of demonstrating that most of us are less-than-fully rational most of the time – suggest disclosure as the preferred regulatory solution for dealing with Homer Simpson problems. *See* Camerer, et al., *supra* note 86, at 1254.

> [M]andated disclosure rests on false assumptions: that people want to make all the consequential decisions about their lives, and that they want to do so by assembling all the relevant information, reviewing all the possible outcomes, reviewing all their relevant values, and deciding which choice best promotes their preferences. These assumptions so poorly describe how human beings live that mandated disclosure cannot reliably improve people's decisions.[133]

Consider applying this schema to the disclosure of information regarding, say, extended warranties. One might be tempted to imagine that the first prong – deciding what needs to be disclosed and how – could be satisfied fairly easily (albeit at a non-trivial cost): retailers would need to compile and disclose information on the probability and cost of repair for each item on which a warranty is offered. That is, a consumer purchasing an extended warranty on the Sony TV discussed earlier[134] might be told: "This TV has a 2.5 percent chance of needing a repair during the warranty period, and that repair costs, on average, $400." But characterizing the relevant probability of repair is not straightforward, especially for new products. And cost-of-repair data are also probably difficult to describe and subject to considerable misrepresentation. Moreover, disclosure would have to be regulated as to its timing in the transaction, its precise wording, and so on. These all pose considerable challenges.

As to the second prong – implementing the disclosure regime – since sellers earn substantial profits from the extended warranties, it seems obvious that they would have a strong incentive to manipulate the information disclosed in an effort to make the warranty look more

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[133] Ben-Shahar & Schneider, *supra* note 6, at 705. *Cf.* Andrei Shleifer, *Psychologists at the Gate*, 50 J. ECON. LIT. 1080, 1089 (2012) (reviewing DANIEL KAHNEMAN, THINKING, FAST AND SLOW):

> Faced with bad choices by consumers, such as smoking or undersaving, economists as System 2 thinkers tend to focus on education as a remedy. Show people statistics on deaths from lung cancer, or graphs of consumption drops after retirement, or data on returns on stocks versus bonds, and they will do better. As we have come to realize, such education usually fails. Kahneman's book explains why: System 2 might not really engage until System 1 processes the message. If the message is ignored by System 1, it might never get anywhere.

[134] *See supra* text accompanying notes 30-31.

appealing. One way to do this would be to exaggerate the frequency or cost of repairs (but only, of course, after the consumer has agreed to buy the TV). Another would be to focus on other aspects of the warranty – for example, stressing the hassle-reducing benefits of the warranty ("we'll take care of everything…"). Another would be to exaggerate the length and complexity of the disclosures, and to offer, helpfully, to summarize or skip the disclosure. "Oh, yes, here's another one of those corporate forms for you to pretend to read and sign. I hate those things? Don't you?" Still another would be to threaten to walk customers out the door if they don't buy the insurance after reading the disclosures.[135]

Finally, the third prong – getting consumers to use the information. Suppose that consumers were given the relevant data that would allow them to compare the expected cost of repair (probability of repair × cost of repair) with the cost of the warranty. And suppose this information were displayed prominently and conveyed clearly. Even so, the consumer's decision problem is a difficult one. Consumers presumably differ in their discount rates, and in their degree of risk aversion. We suspect that many would not even know that paying $349 for a warranty that insures against an 8.5 percent chance of a $400 repair is a bad deal, at least not unless the disclosure stated: "Only a fool would purchase this product."[136] Even then we suspect that there are plenty of salespeople who could still get consumers to buy the insurance using the methods we described along with others that we are not devious enough to think up.

B. BANNING ADD-ON SALES OF INSURANCE

The simplest, most straightforward way to protect consumers from situational monopoly prices in the add-on insurance market is to prohibit what the U.K. Competition Commission calls "point of sale purchase" of add-on insurance products.[137] This is the regulatory strategy we endorse for extended warranties, credit life insurance, and any other add-insurance product that could easily be purchased elsewhere, and for which immediate

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[135] See *supra* text accompanying notes 122-123. *See supra* pp. 42-43.

[136] It is well known that many individuals have a very difficult time understanding percentages. *See* Gerd Gigerenzer, *How To Make Cognitive Illusions Disappear: Beyond Heuristics and Biases*, 2 EUR. REV. SOC. PSYCH. 83 (1991).

[137] COMPETITION COMMISSION, MARKET INVESTIGATION INTO PAYMENT PROTECTION INSURANCE, Jan. 29, 2009, at 13 (U.K.). Patricia McCoy (personal communication) points out that Congress or the Comptroller of the Currency would also have to ban debt cancelation/suspension contracts that are very close substitutes for credit life insurance. Otherwise, the possibility for regulatory arbitrage would allow the transactions to continue in a new form.

coverage is not truly necessary. If people really want extended warranties or other kinds of add-on insurance for emotional risk management purposes, they will find that insurance in all the ways that people find other things that they want: on the internet, in the yellow pages, or through a print or direct mail advertisement.

Our proposed ban on retailers' sale of add-on insurance products is similar to, but simpler and stronger than, the complex package of reforms that the U.K. Competition Commission recommended in 2009 for payment protection insurance.[138] Payment protection insurance (PPI) is a commonly purchased form of insurance in the UK that combines credit life insurance with disability and unemployment protection insurance. Where credit life insurance pays the creditor only in the event of the death of the insured, PPI pays the creditor in the event of "involuntary unemployment or incapacity as a result of accident or sickness."[139] The Commission found that the common practice of selling PPI at the point of sale adversely affected competition in the PPI market, disadvantaging, in particular, "providers of stand-alone PPI."[140] The Commission prohibited the purchase of PPI at the point of sale of credit, requiring creditors to wait to sell PPI until seven days after issuing credit and mandating competition enhancing disclosures to consumers and to a regulatory oversight body in connection with the sale of PPI.[141]

We recommend a flat prohibition on the sale of most add-on insurance by product or service retailers. We would not allow them to sell the insurance after some cooling off window, because there are too many ways that retailers can structure the sale of the basic product or service to gain advantage in the insurance purchase even after the cooling off period. The complexity of the measures that the Competition Commission imposed to attempt to reduce this advantage makes our point. A summary

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[138] *Supra* note 137 at 13 (concluding that the best approach to regulating credit life and similar products is to simply prohibit distributors and intermediaries from selling payment protection insurance to their credit customers within seven days of a credit sale).

[139] COMPETITION COMMISSION, PAYMENT PROTECTION INSURANCE MARKET INVESTIGATION ORDER 2011, 2011, at 8 (defining "PPI") (U.K).

[140] *Id*. at 3.

[141] The Commission initially decided to prohibit entirely the purchase of PPI at the point of sale of credit, allowing creditors to sell PPI only seven days after issuing credit and mandating competition enhancing disclosures in connection with the offer of PPI. After an administrative appeal, the Commission relaxed the prohibition slightly, allowing point of sale purchase in connection with certain retail credit arrangements (e.g., with a department store), and allowing creditors to sell PPI to their customers one day after the credit sale in certain limited circumstances. *Id*. at 2.

description of these measures fills one half of the Commission's Notice of making an order, and the measures themselves comprise 80% of the fifty-five page Order. [142] If product or service retailers were to be permitted to sell the insurance after some kind of cooling off period, however, similar pro-competition disclosure and reporting requirements would be necessary.

We would exclude from this prohibition the sale of damage waivers and auto liability protection by rental car companies to customers who do not have their own auto insurance policies. Such customers must have liability protection from somewhere, and they should also be able to purchase auto property damage protection. Because these customers would otherwise remain vulnerable to the shrouded pricing dynamic, however, we recommend that insurance commissioners employ the measures described in subsection 4 to eliminate the situational monopoly.

C. PRICE REGULATION

Price regulation is a well-established approach to the monopoly pricing problem,[143] and has long been used in regulating insurance. Situational monopolies for add-on insurance are not classic monopolies like public utilities, but they present similar opportunities for monopoly pricing. And add-on insurance does bear some resemblance to traditional insurance, so regulating it the way we regulate many other forms of insurance might seem plausible. We do not advocate price regulation for add-on insurance, however, because of the transaction costs involved.

There is a vast literature critiquing price regulation in insurance.[144] Much of that literature concludes that price regulation does not in fact lower insurance prices, because the insurance market would be sufficiently competitive in the absence of such regulation.[145] That is unlikely to be the case here: because of the shrouded pricing dynamic and the resulting

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[142] COMPETITION COMMISSION, *Order*, *supra* note 139, § 2.1 at 8; COMPETITION COMMISSION, *Notice*, *supra* note 139, at 1-4.

[143] For a survey of regulation of monopolies, *see generally* Rick Geddes, *Public Utilities*, ENCYCLOPEDIA OF LAW & ECONOMICS (1999), *available at* http://encyclo.findlaw.com/5940book.pdf.

[144] *See, e.g.,* Scott E. Harrington, *Effects of Prior Approval Regulation in Automobile Insurance, in* DEREGULATING PROPERTY-LIABILITY INSURANCE: RESTORING COMPETITION AND INCREASING MARKET EFFICIENCY 285 (J. David Cummins ed., 2002) (noting that rate regulation fails to reduce average rates in competitive markets); Scott E. Harrington, *Insurance Rate Regulation in the 20th Century,* 19 J. OF INS. REG. 204 (2000) (finding that prior approval rate regulation failed to lower average rate levels or expand coverage availability in competitive markets)..

[145] *E.g.,* Harrington, *supra* note 144, at 216; *Id*. at 309-10.

situational monopoly, competition clearly does not constrain add-on insurance pricing. That does not mean that price regulation is likely to be effective, however.

In theory, prices should be set at a level that gives sellers of add-on insurance a reasonable rate of return. In other words, regulators would ideally set prices at the actuarially fair value plus some markup for overhead, marketing, and profit. But just figuring out the actuarially fair price for extended warranties on a constantly changing array of thousands of different consumer products sold by hundreds of different retailers is a daunting task. Estimating reasonable markups for overhead and marketing costs constitutes another enormous problem, and the result would clearly be subject to manipulation by retailers in obvious ways. Nevertheless, price regulation almost certainly would be better than nothing, just not better than our preferred alternatives.

We prefer, instead, a ban on the sale of add-on insurance by product and service retailers, except in the limited exception described earlier (when a significant number of consumers need immediate coverage). For those situations we prefer eliminating the situational monopoly in the manner we describe next.

D. BUSTING THE SITUATIONAL MONOPOLY

The final strategy is a new regulatory approach made possible by information technology. This strategy would eliminate the situational monopoly by obligating the entity providing the core product or service (e.g., the car rental) to allow the customer to select a desired insurance product through an independently operated website accessed at the point of sale. This website would list the insurance products, features and prices, and allow consumers to use a simple comparison tool. The insurance selection feature of the website would be similar to – but much simpler than – the insurance selection feature of existing health insurance exchange websites.[146] For consumers who did not want the hassle of having to

[146] The website for the Massachusetts health insurance exchange, known as the Massachusetts Connector (which served as the model for the health insurance exchange provisions of the Affordable Care Act), can be accessed at http://www.mahealthconnector.org. The leading private health insurance exchange is ehealth.com. The ehealth.com selection process is much more complicated than the Massachusetts Connector process because ehealth.com cannot provide consumers with a definitive price, due to the fact that health insurance companies are currently authorized to engage in medical underwriting. *See generally* Baker, *supra* note 119 (providing an examination of the distribution of health insurance risk and responsibility under the Affordable Care Act). For research on the complexity of health insurance choice and what to do to make that choice easier,

choose, the website could be programmed to provide a default product based on the consumer answering a few questions, or even without answering any questions other than responding with a "Yes" to "Do you want the standard protection for someone who doesn't have their own auto insurance policy?"[147]

The company providing the core product or service should be permitted to receive a reasonable servicing fee when the customer buys the insurance, but this fee should be based on a formula established by the state insurance commission. The company providing the core product or service should not be permitted to obtain any other material benefit from the purchase of the insurance or from the operator of the independent website.[148] Otherwise, some or all of the situational monopoly profits will continue to flow to the company providing the core product or service. To explain why this is so, we will begin by critiquing a similarly motivated regulatory strategy suggested by Huysentruyt and Read, who conducted the research on extended warranties that we discussed in Part II.

Huysentruyt and Read suggested two reforms for the extended warranty market that attempt to counteract the situational monopoly that results from the shrouded pricing dynamic: (a) requiring retailers to give consumers a choice among extended warranty providers at the point of sale, and (b) allowing retailers to sell only extended warranties that were selected through a competitive bidding process conducted "on behalf of consumers."[149]

Although we agree with H&R's description of the market failure, we are skeptical that their proposals would be effective. Our skepticism is easier to explain for the first proposal: requiring retailers to give consumers a choice. As long as the retailer gets to decide which extended warranties to offer, obligating the retailer to offer consumers a choice will not reduce the situational monopoly prices. If the retailer gets to decide which choices to provide to the consumers, extended warranty providers will have to compete to be selected by the retailer. The way to win that competition is by offering the highest commissions to the retailer, not by offering the

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see Eric Johnson et al., *Can Consumers Make Affordable Care Affordable? The Value of Choice Architecture* (Univ. of Pa. Law Sch. Inst. for Law and Econ., Working Paper No. 13-28, 2012).

[147] The website could easily be programmed to randomly assign the customer to the standard product of one of the insurance sellers, on a turn taking basis, on the basis of market share, or any other method that the regulator prescribed.

[148] Note that add-on insurance is "insurance" for regulatory purposes in all states when the entity providing the insurance is different than the entity that provides the core product or service.

[149] Huystentruyt & Read, *supra* note 95, at 216. Note that they discuss the shrouded pricing model.

cheapest price to consumers.[150] Consumers may end up with a choice, but the choice will be among extended warranties sold at or near the situational monopoly price.

Our skepticism about H&R's second proposal – competitive bidding – takes a bit more work to explain. Initially, we shared H&R's intuition that a competitive bidding process would drive out the situational monopoly prices. Our intuition shifted, however, when we realized that a competitive bidding process would only break through the situational monopoly if retailers did not have the ability to influence consumers' choice among extended warranties.

If the retailer can steer the consumer to the warranty paying the higher commission, then a warranty supplier will submit a bid that builds in high commissions (so the retailer steers customers to the supplier's extended warranty). This point is pretty obvious. What is not as obvious is the following: even if all the retailer can do is influence whether the consumer buys a warranty (but not which warranty), warranty suppliers will submit bids that include high commissions.[151] The reason is this: if retailers are able to influence whether the consumers buy the extended warranties (a reasonable assumption in our view), then the retailers, in effect, control access to those consumers who will only buy the warranty if the retailer engages in the effort needed to persuade them to buy it. Even if the consumer who decides to buy a warranty always chooses the lowest priced warranty available, warranty suppliers will have to build into their prices compensation sufficient to motivate the retailer to make the effort needed to persuade the marginal consumer.

It would take a model that we have not created in order to work out all of the relationships among these assumptions in order to develop a thorough understanding of what will emerge from a competitive bidding process for the right to offer extended warranties to consumers.

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[150] This dynamic explains the very high prices for "forced place" auto and homeowners insurance. It also explains the high and discriminatory prices for credit paid by buyers of new cars who finance their purchases through the dealership that is selling them the car. *See, e.g.,* Coleman v. Gen. Motors Acceptance Corp., 296 F.3d 443, 445 (6th Cir. 2002) (class action suit alleging that a car dealership's retail credit pricing system resulted in discrimination against African-American buyers); Ian Ayres, *Market Power and Inequality: A Competitive Conduct Standard for Assessing When Disparate Impacts are Justified*, 95 CAL. L. REV. 669, 692-717 (2007) (analyzing consumer policies in the automobile industry that adversely affect minority purchasers).

[151] Note that heterogeneity in susceptibility to retailers' sales pressure could help to explain the shrouded pricing dynamic, if we assume that people either are unaware of their susceptibility or mistakenly believe that they will be able to resist the pressure this time.

Nevertheless, we are confident that this price will reflect compensation to the retailer for "selling" the extended warranty to consumers who would not buy it if the retailer didn't put forth some costly effort to persuade them.

H&R's proposed reforms should be rejected for the same reasons the retailer's commission must be fixed by regulation and retailers cannot be permitted to obtain any other material benefit from the customer's purchase of the add-on insurance. A retailer who gets a benefit from the purchase of one kind of add-on insurance but not another will have an incentive to steer the customer. And even if the additional benefits are the same for all add-on insurance, those additional benefits will motivate sales practices that induce customers to buy add-on insurance that they do not need.

These reasons also point to a fatal weakness in the consumer sovereignty defense of a light touch, disclosure approach to regulating extended warranties. Recall that the consumer sovereignty challenge was based on research supporting the view that buying extended warranties may in at least some cases represent "sophisticated consumer behavior to manage emotions such as anxiety, regret, and loss aversion" and "a sophisticated and informed strategy on the part of consumers to manage emotions that exist independently of insurers' (and their agents') sales efforts."[152] Yet, as long as we accept that retailers have the capacity to influence the number of consumers who buy the add-on insurance, we can see that the consumer sovereignty justification actually protects (a) sales to people who have to be persuaded, (b) a sales context that provides significant opportunity to exploit behavioral biases, and (c) a product – add-on insurance – that is demonstrably not in the average buyer's financial interest in most situations (even if some buyers can be persuaded that it will make them feel better). Separating the buying from the selling, and the selling from the swindling is almost certainly an impossible task.[153] The U.K. Competition Commission's reforms did not work in this regard, and we doubt that any real world regulator can do a better job.[154] Moreover, the shrouded pricing model demonstrates that, even if consumers value extended warranties for legitimate, if non-standard, reasons, the market can still be distorted in a way that leads them to pay far more than the cost of

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[152] Schwarcz, *supra* note 13, at 31.

[153] *See generally* ARTHUR LEFF, SWINDLING AND SELLING (1976).

[154] *See* LECG, Ltd., *Evaluating the Impact of the Supply of Extended Warranties on Domestic Electrical Goods Order 2005,* OFFICE OF FAIR TRADING 7 (Oct. 2008), *available at* http://www.oft.gov.uk/shared_oft/reports/Evaluating-OFTs-work/oft1024.pdf (finding spotty compliance with the disclosure requirements, misinformation regarding consumer rights, and other sales practices inconsistent with legal requirements).

providing the warranties in question. It is hard to imagine a "sovereign" consumer who would prefer that situation.

The U.K. Office of Fair Trading has recently imposed a similar, situational monopoly-busting reform of the consumer electronic extended warranty market in the UK. Like the Competition Commission's reform of the PPI market, however, the OFT's reform of the extended warranty market contains some loopholes that significantly increase the complexity of the regulatory apparatus.[155] Simpler is better in our view. If our situational monopoly busting reform for auto rental insurance were to be subject to the same kinds of exceptions as the extended warranties in the U.K. context, however, some of same kinds of regulatory complexities would be needed to prevent the re-emergence of situational monopoly pricing.

E. EQUILIBRIUM EFFECTS AND PRICE DISCRIMINATION

Under any of the approaches that would actually work – a ban, price regulation, or busting the situational monopoly – there would be general equilibrium effects of the sort that Justin Sydnor explored in the homeowners' insurance deductible context. The list prices for some products and services would likely increase, Gabaix and Laibson's "sophisticates" would receive smaller subsidies from the "myopes," and core product sellers who depend disproportionately on profits from add-on insurance would suffer in relation to sellers who do not. One result may be to increase the share of internet commerce, as the British experience suggests that traditional retailers depend more on profits from extended warranties than internet sellers.[156] This latter possibility, together with the political clout of the numerous, geographically distributed traditional retail establishments (and their employees and suppliers) may provide the best explanation for why the Competition Commission failed to propose a ban on retailers' sale of extended warranties in 2005, and why the OFT watered down its situational monopoly busting reform of the extended warranty market in 2012.

Some readers – and some of the literature on extended warranties – suggest that the resulting equilibrium might be welfare reducing, if retailers are using the add-on insurance to engage in (welfare-enhancing) price discrimination.[157] The idea is that the excess profits from the add-on

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[155] *See supra* note 5.

[156] *See* OFFICE OF FAIR TRADING, *supra* note 5, at 26.

[157] By extending the size of the market via selective discounts, price discrimination reduces deadweight loss. Suppose a monopolist's profit-maximizing single price for a movie ticket is $8. There are some older customers with reservation prices of $5 who do not find it worthwhile to purchase a ticket at that

insurance allow retailers to lower the price of the core product. This in turn permits some additional sales to customers who would not buy at the higher price that would result if our proposal were adopted. It might ultimately be the case that the loss in welfare to those priced out of the market for TV sets exceeds the gain in welfare to those who no longer buy add-on insurance they don't need (or who buy it at a discount).[158] This is, of course, an empirical question, and different people will have different intuitions about the welfare analysis. Our intuition is that the savings to everyone from not being "nudged," or worse, to buy the add-on insurance, plus the large savings to the people who don't buy or don't overpay for the add-on insurance outweigh the loss in welfare from those priced out of the market by the higher price for the base product or service. But we freely admit that the alternative is possible (albeit unlikely in our view).

This empirical question raises the important normative question of what we think about price discrimination based on heterogeneity in violations of rationality, especially those that encourage sellers to exploit cognitive and other limitations. At least in the realm of insurance, where expected utility theory offers a powerful guide to value and society is already committed to strong consumer protection, we are troubled by such price discrimination, and we expect that insurance regulators are as well.

V. CONCLUSION

We have focused on one kind of insurance that people often buy, even though a reasonably informed, rational person would not buy it (extended warranties) and two other kinds of insurance that makes sense for only some of the people who buy them (rental car damage waivers and credit life insurance) and which are just as over-priced as the first. Many of the behavioral explanations for the gap between expected utility theory and

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price. Since the marginal cost of showing the movie is zero, it is inefficient for the older customers to be priced out of seeing it. So if the monopolist can selectively lower the price for older customers without reducing the price it charges everyone else, then it will earn higher revenue, the older customers will see the movie, and other customers will be unaffected, leaving everyone better off.

[158] For a basic reference, *see* Walter Y. Oi, *A Disneyland Dilemma: Two-Part Tariffs for a Mickey Mouse Monopoly*, 85 Q. J. ECON. 77 (1971) (explaining how charging a flat fee plus a per-unit charge allows for greater extraction of consumer surplus while simultaneously reducing deadweight loss). In the extended warranty context; *see* Jindal, *supra* note 20 (raising this possibility in the context of results that do not allow him to determine whether this is the case); Junhong Chu and Pradeep K. Chintagunta, *Quantifying the Economic Value of Warranties in the U.S. Server Market*, 28 MARKETING SCI. 99 (2009) (analyzing extended warranties as a means of facilitating price discrimination in the U.S. server market and estimating their price discrimination value).

insurance purchasing practice make some sense in terms of emotional risk management. On this view, buying these kinds of insurance comes to look more like a conscious, understandable choice to buy something with real value, and less like a cognitive processing mistake that we should de-bias or ignore. If correct, this emotional risk management explanation could be understood to support a consumer sovereignty justification for these forms of insurance that leads directly to a light touch, disclosure approach to their regulation.

We conclude that this line of reasoning is wrong, at least in the case of these kinds of insurance. It fails to take into account the equilibrium analysis of the shrouded pricing model, the supply-induced nature of demand for these products, and the practical difficulties inherent in the choice/mistake distinction upon which the reasoning depends. Behavioral (and other) research has not been kind to the proposition that disclosure corrects decisional errors.[159] Precisely because consumers who buy add-on insurance are not fully rational, frequency-of-repair statistics and other forms of "de-biasing" education will be difficult for them to process. Behavioral research might help to make disclosure more effective,[160] but we see no reason to be optimistic that disclosure can fully overcome even the most minimal behavioral impediments to appropriate decision-making. This in turn implies that the distinction between mistakes (based on incorrect information) and non-standard preferences as motives for insurance purchases does not provide a solid basis for regulatory policy. Unless we define "mistakes" tautologically (as those decisions that can be altered by disclosure), *effectively* correcting mistakes will often require

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[159] *See generally, e.g.,* Ben-Shahar and Schnieder, *supra* note 6 (general literature on de-biasing, w/spotty results). Nor is financial education likely to improve consumer decision-making. *See*, *e.g.*, Lauren E. Willis, *Against Financial-Literacy Education*, 94 IOWA L. REV. 197 (2008) (arguing that financial education actually leads to worse consumer decisions).

[160] *See, e.g.,* George Loewenstein & Peter Ubel, *Economics Behaving Badly*, N.Y. TIMES (July 15, 2010), http://www.nytimes.com/2010/07/15/opinion/15loewenstein.html, who write:

> Behavioral economics should complement, not substitute for, more substantive economic interventions. If traditional economics suggests that we should have a larger price difference between sugar-free and sugared drinks, behavioral economics could suggest whether consumers would respond better to a subsidy on unsweetened drinks or a tax on sugary drinks. But that's the most it can do. For all of its insights, behavioral economics alone is not a viable alternative to the kinds of far-reaching policies we need to tackle our nation's challenges.

something more than disclosure, and thus entails making it difficult or impossible for consumers to do what they "want."

The shrouding model we have relied on so heavily in this article offers several important insights for the application of behavioral economics to the regulation of consumer products and services more broadly. Most significantly, it shows that behavioral "flaws" don't just influence the consumer's decision about what/how much to buy. These flaws also shape the structure of competition between firms and the resultant market equilibrium. An analysis that focuses only on consumers' deviations from perfect rationality (or non-standard preferences) will miss important properties of this equilibrium. Sadly, there is thus no short-cut from behavioral anomaly directly to policy recommendations: rather, as Justin Syndor's homeowner's insurance analysis also demonstrates, the behavioral anomalies have to be inserted into an overall model of market functioning to predict how policy can influence welfare.

We have proposed a three step regulatory solution to the add-on insurance problem. First, unless there is a compelling case that a significant group of consumers truly needs to purchase the add-on insurance product together with the underlying product or service, the sale of the insurance at the same time as the base product should be banned. Second, if there is a compelling case that a significant number of consumers truly need to purchase the insurance at the same time and place as the base product, then regulators should consider whether it is possible to create a transparent and competitive on-line market for the add-on insurance. If so, then the sellers of the base product should be prohibited from selling the add-on insurance themselves and required to provide a web access point in their establishments or on their web pages that directs the consumers to the on-line market. When a consumer purchases the add-on product at a store or from a product seller's web link, the core product or service seller should receive a standard, state-regulated commission that will fairly compensate the seller for the cost of maintaining the terminal or the web link, without motivating the seller to push the add-on insurance. Finally, if the regulator is not persuaded that it is possible to create a transparent and competitive on-line market, then the regulator should set the prices for the add-on insurance.

RECONCILING THE IRRECONCILABLE CONFLICT IN INSURANCE SEVERABILITY OF INTERESTS CLAUSE INTERPRETATION

JOHNNY PARKER*

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This article explores the inconsistency with which courts interpret severability of interest clauses in insurance policy exclusions. The article explores the severability of interest clauses and discusses the rules that courts employ to interpret such clauses. Specifically, the article outlines three methodologies of contract interpretation used by courts when faced with severability of interest clause controversies and each method's strengths and weakness. The article concludes that behind the different interpretive methods lie two schools of thought amongst the courts, those who follow a "traditional or formalist" approach and those who follow a "functional or reasonable expectations" approach.

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I. INTRODUCTION

Typically, a policy of insurance affords coverage to multiple insureds – those being the named insured, as well as individuals considered to be insureds as a result of their relationship with the named insured. When one or more, but fewer than all, of the insureds being sued actually engaged in conduct excluded from coverage in the policy, a controversy can ensue as to whether an exclusion from coverage, which is clearly applicable to one insured, operates to preclude all insureds – including innocent co-insureds – from coverage under the policy. This issue is further complicated by the inclusion in the policy of a severability of interests clause, which typically provides that the insurance applies separately to each insured.[1] Innocent co-insureds may argue that such a

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[1] The severability of interest clause was first included in insurance policies in 1955, when the National Bureau of Casualty Underwriters and the Mutual Rating Bureau revised the standard provisions and included the clause as a new condition. The provision was designed to correct prior judicial interpretations which construed the term "the insured" to preclude coverage to all insureds when any co-insured was excluded from coverage in the policy. Subsequent revision of the language used in the severability of interest clause sought to express this purpose

severability of interests clause overrides any exclusion to coverage as applied individually to them.

In practical terms, a dispute over a severability of interests clause involves an innocent co-insured who is sued in conjunction with, and as a consequence of, a culpable insured's conduct. The insurance company, upon receipt of a notice of claim from the innocent co-insured, denies coverage under the policy on the basis that because the conduct of a culpable insured is expressly excluded, the claim of the innocent co-insured is similarly excluded from coverage. The innocent co-insured takes the position that regardless of the excluded conduct of another insured, she is nevertheless entitled to coverage because of the presence of a severability of interests clause in the policy.

Severability clause disputes can arise from a myriad of factual situations. For example, in *Co-Operative Ins. Co. v. Bennett*,[2] Michael Jacques allegedly kidnapped his twelve-year-old niece, Brooke Bennett, and transported her to his home in Randolph, Vermont where he "drugged, sexually assaulted, and murdered her."[3] At that time, Michael was married to Denise Woodward, who lived with him in the Randolph house. Denise was not involved in the kidnapping or subsequent events. Nevertheless, Brooke's estate and father sued Denise for having "negligently failed to: (1) supervise minor children while they were in the home, (2) warn the Bennett family of the dangers posed by her husband, and (3) prevent the harm from occurring."[4]

Both Michael and Denise were named insureds on a homeowners' policy issued by Cooperative Insurance Company ("Cooperative"). Denise tendered the claim to Cooperative, which filed a declaratory judgment action against Denise and plaintiffs in the underlying tort action on the grounds that its homeowners' policy excluded from coverage "bodily injury" or "property damage": "(1) which is expected by, directed by, or intended by an 'insured'; (2) that is the result of a criminal act of an 'insured'; or (3) that is the result of an intentional or malicious act by or at the direction of an 'insured.'"[5] The policy also provided that each insured "is a separate 'insured,' but this does not increase 'our' limit."[6]

The issues in *Cooperative* were whether a severability clause creates an ambiguity when read together with an intentional acts exclusion and whether such ambiguity must be resolved in favor of coverage.

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even more clearly. Norman E. Risjord & June M. Austin, "*Who Is 'The Insured'" Revisited*, 28 INS. COUNS. J. 100, 100–101 (1961).

[2] No. 168-8-10 Oecv, 2011 Vt. Super. LEXIS 35 (Apr. 11, 2011), *aff'd sum nom*. Co-Operative Ins. Cos. v. Woodward, 2012 VT 22 (2012).

[3] Co-Operative Ins. Cos., 2011 Vt. Super. LEXIS 35, at * 3.

[4] *Id.* at *4.

[5] *Id.* at *5.

[6] *Id.* at *6.

Defendants—Denise Woodward, along with Brooke Bennett's estate and father—argued that the severability clause created an expectation that the intentional acts exclusion would be applied separately to each insured and that this expectation created an ambiguity when compared with the language of the exclusion.

According to the court, a severability clause does not create an ambiguity in an otherwise clear and unambiguous exclusion for three reasons. First, even though a severability clause may mean that the insurance policy applies separately to each insured, it does not change the fact that the policy contains an exclusion.[7] Consequently, the severability clause "cannot create coverage where none exists."[8] In other words, "the act of applying the policy separately to each insured does not alter or create ambiguity in the substance or sweep of the exclusion."[9] Second, the majority of jurisdictions had adopted the view that "a severability clause does not alter the collective application of an exclusion for intentional, criminal, or fraudulent acts by 'an' or 'any' insured."[10]

Co-Operative Ins. Co. v. Bennett represents one factual extreme - heinous harm to person - on the severability dispute spectrum. The opposite end of the factual spectrum - juvenile vandalism to property - is illustrated by *Chacon v. American Family Mutual Insurance Company.*[11] *Chacon* arose out of the vandalism of an elementary school by the Chacons' ten-year-old son Nicholas and another boy.[12] The vandalism caused damage in excess of $6,000.[13] The school district's insurer paid for the damage and filed suit against the Chacons for reimbursement.[14] Prior to this lawsuit, the Chacons filed a claim relating to the damage caused by Nicholas under their homeowners' policy provided by American Family.[15]

The Chacons were the named insureds in the policy, which defined "insured" to include "your relatives if residents of your household. . . . [or] any other person under the age of 21 in your care or in the care of your resident relatives."[16] The policy further provided that "each person described above is a separate insured under this policy."[17] It also contained a severability clause, which stated "this insurance applies separately to each

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[7] *See id.* at *17.

[8] Co-Operative Ins. Cos., 2011 Vt. Super. LEXIS 35, at *17.

[9] *Id.* at *19 (quoting SECURA Supreme Ins. Co. v. M.S.M., 755 N.W.2d 320, 329 (Minn. Ct. App. 2008).

[10] *Id.* at *17–18 (quoting Minkler v. Safeco Ins. Co. of Am., 232 P.3d 612, 623 (Cal. 2010)).

[11] 788 P.2d 748 (Colo. 1990).

[12] *Id.* at 749.

[13] *Id.*

[14] *Id.*

[15] *Id.*

[16] *Id.* at 750.

[17] *Id.*

insured. This condition will not increase our limit of liability for any one occurrence."[18]

The Chacons' claim, since it resulted from the actions of their son, was within the scope of coverage provided by the policy. Nicholas was also an additional insured under the policy as a minor in their care. American Family, however, argued that coverage was excluded by the intentional acts exclusion which provided that personal liability coverage does "not apply to bodily injury or property damage . . . which is expected or intended by any *insured*."[19]

According to American Family, the exclusion clearly and unambiguously excluded coverage to all insureds when any individual insured caused property damage that was "expected or intended." The Chacons asserted that American Family's position failed to give effect to the severability clause contained in the policy. They argued that the clause created separate insured status for each insured, which required that the exclusion be applied independently to each.

Under the guise of ascertaining the intentions of the parties, the Court engaged in an objective evaluation of what a reasonable person would have understood the contract to mean.[20] The purported advantage of this approach was that it considered and gave effect to all the policy provisions and recognized that an insurance policy is a contract between the parties, which should be enforced in a manner consistent with the intentions expressed therein.[21] Pursuant to this reasoning, the Court concluded that an exclusion containing the term "any insured" clearly and unambiguously expressed an intent to deny coverage to all insureds when damage was intended or expected as a result of the actions of any one of them.[22]

Between these two factual extremes lie a myriad of cases involving every type of insurance policy and factual circumstances imaginable. This article examines the impact of a severability of interests clause on insurance policy exclusions. Its objective is to ascertain and explain the reasoning that makes this area of insurance law seemingly irreconcilable. Section I introduces the severability of interests clause. It uses several factual situations to illustrate and provide a context for severability clause disputes. Section II discusses the rules of insurance contract interpretation. It explores how these rules are employed in the context of severability clause disputes. Section II demonstrates that in the context of severability disputes the rules of contract interpretation are applied in ways which support the recognition of several distinct interpretive methodologies.

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[18] *Id.*
[19] *Id.*
[20] *See id.* at 752.
[21] *Id.*
[22] *Id.*

Section III discusses the interpretive methodologies from the perspective of two competing theories of contract interpretation. Section III explains the strengths and weakness of the various methodologies in the context of these theories. Section IV concludes that the severability of interests clause interpretative landscape has been shaped by two diametrically opposite judicial philosophies, the traditional approach and the functional approach. I argue that the perception that severability clause jurisprudence is irreconcilable is misplaced and that reconciliation in this subject area can be achieved by adherence to the functional or reasonable expectation approach to contract interpretation.

II. SEVERABILITY CLAUSE JURISPRUDENCE

Severability clause jurisprudence has evolved on a variety of fronts. The first is the basic principles used by courts to interpret insurance contracts. All courts agree that the primary objective of insurance policy interpretation is to ascertain and give effect to the intentions of the parties.[23] Except in cases of ambiguity, this process typically begins with the language of the policy.[24] In this context, the words are to be accorded their plain and ordinary meaning and usage,[25] as ascertained from a standard English dictionary.[26] Where possible, an insurance policy should be interpreted in a manner which gives reasonable meaning to all of its provisions.[27] Courts, in ascertaining the intention of the parties, are at liberty to consider the intent and purpose of both the exclusion and

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[23] *See* State Farm Fire & Cas. Co. v. Hooks, 853 N.E.2d 1, 5 (Ill. App. Ct. 2006); T.B. v. Dobson, 868 N.E.2d 831, 836 (Ind. Ct. App. 2007); American Family Mut. Ins. Co. v. Corrigan, 697 N.W.2d 108, 111 (Iowa 2005); Brumley v. Lee, 963 P.2d 1224, 1226 (Kan. 1998); K.M.R. v. Foremost Ins. Grp., 171 S.W.3d 751, 753 (Ky. Ct. App. 2005); Pa. Nat'l Mut. Cas. Ins. Co. v. Bierman, 292 A.2d 674, 677 (Md. Ct. Spec. App. 1972); Travelers Ins. Co. v. American Cas. Co. of Reading, Pa., 441 P.2d 177, 180 (Mont. 1968); Erdo v. Torcon Constr. Co., 645 A.2d 806, 808 (N.J. Super. Ct. App. Div., 1994); Madison Constr Co. v. Harleysville Mut. Ins. Co., 735 A.2d 100, 106 (Pa. 1999).

[24] *See Chacon*, 788 P.2d at 750; *Hooks*, 853 N.E.2d at 5; K.M.R. v. Foremost Ins. Grp., 171 S.W.3d 751, 753 (Ky. Ct. App. 2005); *Erdo*, 645 A.2d 806 at 808.

[25] *See* Essex Ins. Co. v. City of Bakersfield, 154 Cal. App. 4th 696, 7 (Cal. Ct. App. 2007); Farmland Indus. v. Republic Ins. Co., 941 S.W.2d 505, 508 (Mo. 1997).

[26] *See Farmland Indus*, 941 S.W.2d at 508; R.T. Vanderbilt Co. v. Continental Cas. Co., 870 A.2d 1048, 1059 (Conn. 2005).

[27] *See* Cicciarella v. Amica Mut. Ins. Co., 66 F.3d 764, 767 (5th Cir. 1995); Amer. Family Mut. Ins. Co. v. White, 65 P.3d 449, 454 (Ariz. Ct. App. 2003); Valero v. Florida Ins. Guar. Ass'n, Inc., 59 So.3d 1166, 1169 (Fla. Dist. Ct. App.2011); *Hooks*, 853 N.E.2d at 5; *Dobson*, 868 N.E.2d at 836; Benton v. Canal Ins. Co., 130 So.2d 840, 846 (Miss. 1961).

severability clause in the context of the type of policy at issue. Furthermore, in cases of first impression, courts may also be guided in their reasoning by precedents from other jurisdictions.

When an insurer proffers a policy exclusion as a basis for denying coverage, it asserts an affirmative defense for which it has the burden of proof.[28] To prevail, the insurer must prove that the language of the insurance policy is clear and unambiguous.[29] Otherwise, the provision should be construed in favor of coverage.[30]

Application of these rules in the context of severability clause disputes has resulted in three distinct interpretive methods. These interpretive methods share only one common thread. That being that each, in drastically different ways, purports to enforce the intention of the parties to the contract in the context of exclusions couched in terms of "an insured" or "any insured." The differences between the interpretative methodologies are reflected in whether the terms "an insured" and "any insured" are viewed as synonymous or distinct and whether the presence of a severability clause modifies or creates an ambiguity in the exclusion.

While the insurance industry's preference has been to refer to excluded conduct from the perspective of "an" or "any" insured, some insurance companies use different and more specific language to describe what is excluded from coverage. For example, in *Ristine v. Hartford Insurance Co.*, Barbara Ristine and her minor daughter, L., sued David and Carol Purcell, alleging that David had sexually molested L. on repeated occasions while she spent the night at their home.[31] The complaint alleged that Carol was negligent in failing to disclose to the plaintiffs that David was a convicted child molester and in allowing him to be alone with L.[32]

The Purcells notified their homeowners' insurance carrier – The Hartford – of the claim and requested a defense. The Hartford refused the tender on the basis of a policy exclusion excepting from bodily injury or property coverage any claims "[a]rising out of sexual molestation, corporal punishment or physical or mental abuse."[33] The Ristines ultimately settled

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[28] *See* First Specialty Ins. Corp., Inc. v. Flowers, 644 S.E.2d 453, 455 (Ga. Ct. App. 2007); Lucas v. Deville, 385 So.2d 804, 819 (La. Ct. App. 1980); Thommes v. Milwaukee Mut. Ins. Co., 622 N.W.2d 155, 880 (Minn. 2001); Flomerfelt v. Cardiello, 997 A.2d 991, 1004 (N.J. 2010); Madison Constr. Co. v. Harleysville Mut. Ins. Co., 735 A.2d 100, 106 (Pa. 1999); American Family Mut. Ins. Co. v. Purdy, 483 N.W.2d 197, 199 (S.D. 1992).

[29] *See* Madison Constr. Co. v. Harleysville Mut. Ins. Co., 735 A.2d 100, 106 (Pa. 1999); *Cicciarella*, 66 F.3d at 767 (proposing that language is ambiguous when its meaning is uncertain and doubtful or when it is reasonably susceptible of more than one meaning).

[30] *See Cicciarella*, 66 F.3d at 768.

[31] 97 P. 3d 1206, 1207 (Or. Ct. App. 2004).

[32] *Id.*

[33] *Id.*

their lawsuit against Carol Purcell. As a part of the settlement, Carol assigned to them her rights against The Hartford.

The Hartford asserted that the exclusion was unambiguous and that when compared to other exclusions, in policies using the terms "an insured" or "the insured," the language in the policy manifested an intent to exclude all claims arising out of sexual molestation, regardless of who committed the acts.[34] In other words, the exclusion was specifically designed to identify and exclude a particular act, as contrasted with exclusions that identify and exclude on the basis of the actor by using terms such as – "the insured," "an insured" or "any insured." Therefore, all claims arising out of the specified act – sexual molestation – were precluded, without regards to the identity of the actor.

The court agreed with the Hartford that the absence of terminology – such as "the insured," "an insured," or "any insured" – identifying an actor demonstrated that the insurer intended to base the exclusion on the nature of the act, rather than on the identity of the actor.[35] Consequently, even though the severability clause made the provisions of the policy separately applicable to David and Carol, it did not affect the sexual molestation exclusion because it contained no qualifications relative to the identity of the actor.[36]

The impact of a severability clause on an exclusion depends on the interpretive methodology used by the court. For example, in some jurisdictions the terms "an insured" and "any insured" are viewed as synonymous and are not modified by the presence of a severability clause. Thus, all insureds are precluded from coverage because of the excluded conduct of any one insured. I will refer to this as "Methodology No. 1." However, in other jurisdictions which also treat the terms as synonymous, the principle of ambiguity is applied to achieve coverage in light of the inclusion of a severability clause. This approach will be referred to as "Methodology No. 2." A number of jurisdictions reject the conclusion that the terms "an insured" and "any insured" are synonymous when used in an exclusion. Some jurisdictions that follow this view consider the former phrase to be modified by a severability clause while the latter is not ("Methodology No. 3a"). Others reach the same result by construing the phrase "an insured" as ambiguous when read in conjunction with a severability clause while "any insured" is unaffected ("Methodology No. 3b").

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[34] *Id.* at 1209.
[35] *See id.*
[36] *Id.*

A. METHODOLOGY NO. 1

Under this methodology, courts construe an insurance policy exclusion that is couched in the words "an insured" or "any insured" to apply to all the insureds and additionally hold that a severability clause has no impact on that exclusion. This conclusion results when courts accord greater weight to the precise language – "an insured" or "any insured" – of the exclusion.[37] Courts following this approach sometimes rule that an absurd or repugnant interpretation should not result from construing the policy to give effect to the severability clause.[38] Under this line of thinking, an absurd or repugnant result would occur when the application of the severability clause would convert the policy purchased into a different type which the insured neither negotiated nor paid for or would otherwise enlarge the obligation originally undertaken by the insurer and permit a windfall to the insured.[39]

The dominant rationale for this approach is that the purpose of the severability clause is to spread protection to the limits of coverage, among all insureds, not to negate bargained-for exclusions.[40] Consequently, a collective effect, pursuant to which the excluded act of one insured precludes coverage for all, is accorded the exclusion if it is "specific" or imposes a joint obligation on the insureds.[41] Some courts construe the use of the terms "an insured" or "any insured" as unambiguously creating a

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[37] *See, e.g.*, Johnson v. Allstate Ins. Co., 687 A.2d 642, 644 (Me. 1997); K.M.R. v. Foremost Ins. Grp., 171 S.W.3d 751 (Ky. Ct. App. 2005); Nat'l Ins. Underwriters v. Lexington Flying Club, Inc., 603 S.W.2d 490 (Ky. Ct. App. 1979); Liberty Mut. Ins. Co. v. State Farm Mut. Auto., 522 S.W.2d 184 (Ky. Ct. App. 1975); Gorzen v. Westfield Ins. Co., 526 N.W.2d 43 (Mich. Ct. App. 1994); Home Owners Ins. Co. v. Selfridge, No. 280112, LEXIS 2504 (Mich. Ct. App. December 18, 2008), McAllister v. Millville Mut. Ins. Co., 640 A.2d 1283 (Pa. Super. 1994): Caroff v. Farmers Ins. Co. of Washington, 261 P.3d 159, 163 (Wash.App. Div. 11999); Co-Operative Ins. Cos. v. Bennett, No. 168-8-10 Oecv, April 11, 2011 Vt. Super. LEXIS 35.

[38] *See* Oaks v. Dupuy, 653 So.2d 165 (La. Ct. App. 1995); Shelter Mut. Ins. Co. v. Haller, 793 S.W.2d 391 (Mo. Ct. App. 1990); B.P. Am., Inc. v. State Auto. Prop. & Cas. Ins. Co., 148 P.3d 832 (Okla. 2005); Transit Cas. Co. v. Hartman's Inc., 239 S.E.2d 894 (Va. 1978).

[39] *See B.P. Am., Inc*. 148 P.3d at 837–39; *Transit Cas. Co*. 239 S.E.2d at 897.

[40] *See* Northwest G.F. Mut. Ins. Co. v. Norgard, 518 N.W.2d 179 (N.D. 1994); Caroff v. Farmers Ins. Co., 261 P.3d 159 (Wash. App. Div. 1 1999).

[41] *See* Allstate Ins. Co. v. Kim, 121 F. Supp. 2d 1301 (D. Haw. 2010); Villa v. Short, 947 A.2d 1217 (N.J. 2008); Northwest G.F. Mut. Ins. Co. v. Norgard, 518 N.W.2d 179 (N.D. 1994); McAllister v. Millville Mut. Ins. Co., 640 A.2d 1283 (Pa. Super. Ct. 1994); Great Cent. Ins. Co. v. Roemmich, 291 N.W.2d 772 (S.D. 1980); Caroff v. Farmers Ins. Co. of Washington, 261 P.3d 159 (Wash.App. Div. 1 1999).

specific exclusion imposing a joint obligation.[42] Apart from this rule, courts otherwise have not articulated what makes an exclusion "specific" as opposed to "general."

This interpretive model was employed in the often cited case of *BP Am., Inc. v. State Auto Prop. & Cas. Ins. Company*. *BP* involved a construction contract between B.P. America, Inc. ("BP") and Doyal W. Rowland Construction, Inc. ("Rowland"). As required under a construction contract, BP obtained $1,000,000 in comprehensive general liability coverage from State Auto and Casualty Company ("Insurer"). Insurer issued two policies, listing Rowland as the named insured and BP as an additional insured. The first policy covered general liability and the second covered automotive liability. While the policies were in force, a multi-car accident occurred involving a dump truck driven by a Rowland employee. Three people died and a fourth sustained serious injuries. Multiple lawsuits were filed. In different combinations, the suits named as defendants the employee, Rowland, BP, and/or Insurer. The personal injury lawsuits settled with Insurer contributing $1,000,000 pursuant to the automotive liability policy. Thereafter, BP filed suit in federal court seeking recovery under the general liability policy. Recognizing that the lawsuit involved issues of first impression, the United States District Court for the Northern District of Oklahoma certified two questions to the Oklahoma Supreme Court:

> 1. "[w]hether, under Oklahoma Law, the term 'any insured' in an 'Auto Exclusion' clause of a commercial general liability policy excludes from coverage all automobile occurrences attributable to any of the insureds?" [and]
> 2. "[w]hether, under Oklahoma Law, the inclusion of both an 'Auto Exclusion' clause and a 'separation of insureds' clause in a commercial general liability policy creates an ambiguity in the contract?"[43]

The Court answered the first certified question in the affirmative. Influenced by the "overwhelming number of courts" which had addressed the issue, the Court concluded that the use of the term "any insured" in an exclusion unambiguously expressed a definite intent to deny coverage to all insureds.[44] According to the Court, insurers are not required to provide coverage in the absence of premium payments – as was the case – except

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[42] *See Allstate Ins. Co*., 121 F. Supp. 2d 1301; *Villa*, 947 A.2d 1217; *Northwest G.F. Mut. Ins. Co.*, 518 N.W.2d 179; *McAllister*, 640 A.2d 1283; *Great Cent. Ins. Co*., 291 N.W.2d 772; *Caroff*, 261 P.3d 159

[43] *B.P. Am., Inc.,* 148 P.3d at 833.

[44] *Id.* at 836.

where public policy demands.[45] Furthermore, a contrary interpretation would "convert a general liability policy—without [automotive] coverage—into an automotive liability policy."[46] The Court further found support for its answer to question one in Oklahoma precedents which construed the phrase "an insured," as used in an exclusion, to preclude coverage to all insureds.[47] In the process, the Court read "an insured" and "any insured" as synonymous.

With respect to the second issue, the insureds argued that, even if the exclusion was clear when read in isolation, the presence of a severability clause in the commercial policy created an ambiguity. That clause provided:

> Except with respect to the Limits of Insurance, and any rights or duties specifically assigned in this Coverage Part to the first Named Insured, this insurance applies:
> a. As if each Named Insured were the only Named Insured; and
> b. Separately as to each insured against whom claim is made or 'suit' is brought.[48]

Insurer contended, however, that to ignore the term "any insured" in the exclusion would be to render an otherwise unambiguous policy provision meaningless.

The Court reasoned that the clear intent of the parties was to preclude coverage for all insureds whenever an exclusion was applicable to "any insured." This intent was reflected not only in the exclusion's use of the phrase "any insured," but also by the fact that the parties negotiated for two different policies providing distinct coverages.[49]

Courts which rely on this interpretive method to conclude that a severability clause has no impact on the collective effect of an exclusion employing the phrase "an insured" or "any insured" typically view the phrases as synonymous.[50] The phrases are viewed as manifesting the intent of the parties to make coverage for all insureds contingent on the actions of

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[45] *Id.* at 837–38.

[46] *Id.* at 839.

[47] *See* Phillips v. Estate of Greenfield, 859 P.2d 1101, 1103 (Okla. 1993) (explaining a homeowner's policy in clear and unambiguous language excludes coverage where an injury arises out of the use of a motor vehicle owned or operated by an insured).

[48] *B.P. Am., Inc.*, 148 P.3d at 839.

[49] *Id.*

[50] Villa v. Short, 947 A.2d 1217, 1223 (N.J. 2008); B.P. Am. Inc., 148 P.3d at 839; McAllister v. Millville Mut. Ins. Co., 640 A.2d 1283, 1288 (Pa. Super. Ct. 1994).

any one insured.[51] These courts also overwhelmingly reject the argument that the language of the severability clause – "this insurance applies. . . [s]eparately as to each insured against whom claim was made"—creates an ambiguity when read in conjunction with exclusions employing either phrase.

Rejection of the ambiguity argument is typically based on one or a combination of two rationales. The first is that the severability clause is located in a different part of the policy from exclusions.[52] Consequently, the insured's sole expectation is for equal coverage.[53] The second rationale is that the use of the indefinite article "an" or "any" before insured in an exclusion clearly signals that the parties understood and intended that the exclusion would be applied collectively to bar all insureds from coverage.[54]

This interpretive method while not novel, is misguided because it ignores the reality that ambiguity in an insurance policy can arise from sources other than ambiguous language, such as inconsistent policy provisions, poor policy organization and inconsistent judicial interpretation.[55] It is also predicated on a legal fiction that a single rule of insurance contract interpretation – language used in a single provision – is dispositive of the intention of the parties. The focus of this line of reasoning is not whether the inclusion of a severability clause is inconsistent with a blanket exclusion, but "whether the contract indicates that the parties intended such a result."[56] The latter formulation allows courts to ignore the language and fundamental purpose of the severability clause. This method is strict in its reliance on a single consideration – language of the exclusion – and harsh in that it places the entire risk of loss on the insured. The most glaring flaw however, is that it provides no incentives for insurance companies to engage in better policy drafting.

B. METHODOLOGY NO. 2

The second interpretive method stands in stark contradiction to the first. It holds that while the terms "an insured" or "any insured" are synonymous, the presence of a severability clause in the policy renders the exclusion ambiguous. This ambiguity derives from the conclusion that the

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[51] *See, e.g.,* Caroff v. Farmers Ins. Co. of Wash., 261 P.3d 159, 161 (Wash. Ct. App. 1999).

[52] *See, e.g.*, Villa, 947 A.2d at 1224.

[53] *Id*. at 1225.

[54] *Id*. at 1223.

[55] *See* Johnny Parker, *The Wacky World of Collision and Comprehensive Coverages: Intentional Injury and Illegal Activity Exclusions*, 79 NEB. L. REV. 75, 101–06 (2000) (stating that ambiguity can arise from inconsistent policy provisions, policy organizations, or ambiguous language).

[56] Chacon v. Am. Family Mut. Ins. Co., 788 P.2d 748, 752 (Colo. Sup. Ct. 1990).

language of the severability clause creates a reasonable expectation that each insured will be separately covered, while the exclusion purports to preclude coverage for all as a result of the excluded act of one. This approach gives meaning and effect to both the severability clause and the exclusion because the culpable insured is excluded from coverage while the innocent co-insured's right to a defense and indemnification is determined separately.

This interpretive model views an exclusion and a severability clause as competing provisions. Where such is the case, the exclusion and the severability clause should be construed to require that the exclusion be applied only against culpable insureds for whom coverage is sought.[57] In other words, the clear language of a severability clause dictates that "coverage as to each insured must be determined separately based on the facts applicable to each such insured."[58]

Under this approach, because a severability clause renders a policy exclusion ambiguous,[59] the term used in the exclusion does not alter this consequence. As observed in *Brumley v. Lee*:

> The words "an" and "any" are inherently indefinite and ambiguous. The two words can and often do have the same meaning. The Random House Dictionary of the English Language 68 (1973) gives many definitions for the word "any." The first definition listed is "one, a, an, or some." Correspondingly, the Random House Dictionary includes the word "any" among its definitions for the word "a" or "an." Hence, the words may have the same meaning. Thus, the word "any" is not materially different from the word "a" or "an," and, contrary to the district court's ruling, Safeco's use of "any" instead of "an" in its policy does not eliminate the ambiguity created by the policy's severability clause.[60]

According to this interpretive model, this rule applies without regard to the type of policy, exclusion or language used therein.[61]

A severability clause, therefore, requires that the policy exclusions be interpreted with respect to the facts and circumstances specific to the

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[57] *See, e.g.*, Brumley v. Lee, 963 P.2d 1224, 1227 (Kan. 1998); Am. Nat'l Fire Ins. Co. v. Estate of Fournelle, 472 N.W.2d 292, 294 (Minn. 1991).

[58] Rose Constr. Co. Inc. v. Gravatt, 642 P.2d 569, 571 (Kan. 1982).

[59] *Brumley*, 963 P.2d at 1228.

[60] *Id.* at 1227–28.

[61] *See, e.g.*, *Rose Constr. Co.*, 642 P.2d 569 (noting that a severability clause modified an exclusion in an automobile policy using the term "an insured").

individual insured seeking coverage.[62] For example, in *American National Fire Insurance Co. v. Fournelle*, the Court entertained the issue of whether a household exclusion in a homeowners' insurance policy containing a severability clause excluded coverage where the named insured killed his two children.[63]

In *Fournelle*, Robert Fournelle and his wife, Joanne Fournelle, separated on January 16, 1985. Robert left the marital residence, while Joanne Fournelle remained in the house with the couple's two sons. After filing for divorce on January 25, 1985, she received temporary custody of the children and temporary possession of the house. Thereafter, Robert lived separate and apart from Joanne and the children.

On March 3, 1985, Robert arrived at the marital residence to visit his sons. He shot and killed the boys, vandalized the house, and then committed suicide. Joanne filed a wrongful death lawsuit against Robert's estate. The estate tendered the defense of the suit to American National pursuant to the Fournelles' homeowners' policy on the marital residence.

The American National homeowners' policy listed both Robert and Joanne as named insureds. The deceased children were not named insureds. The policy's household exclusion provided that coverage "does not apply to: f. bodily injury to you and any insured within the meaning of part a. or b. of Definition 3."[64] Throughout the policy the terms "you" and "your" referred to the named insureds – here, Robert and Joanne. Definition 3, parts a. and b. stated that: "3. 'insured' means you and the following residents of your household: a. your relatives; b. any other person under the age of 21 who is in the care of any person named above."[65] The policy also contained a severability clause.

American National argued that the severability clause was immaterial because the exclusion, by its expressed language, applied to "any insured." Therefore, since the children resided with Joanne – an insured – at the time of their death, they qualified as insureds under the policy as "person[s] under the age of 21 . . . in the care of [a named insured]." The estate countered that the severability clause required that the exclusion be read solely in reference to Robert because he was the only

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[62] *Compare* Secura Supreme Ins. Co. v. M.S.M., 755 N.W.2d 320, 324–25 (Minn. Ct. App. 2008) (holding that a juvenile's attack on a neighbor fell within the meaning of "criminal acts" as used in the policy exclusion regardless of the juvenile's intent), *with* Slavens v. Am. Fire & Cas. Co., No. C7-00-1070, 2001 Minn. App. LEXIS 94, at *5 (Minn. Ct. App. Jan. 30, 2001) (finding that an the intent of the policy was "to exclude coverage when someone who qualifies as 'an insured' under the policy commits an act of sexual molestation – regardless of whether that person is involved in the day care business").

[63] 472 N.W.2d 292, 293 (Minn. 1991).

[64] *Id.*

[65] *Id.*

insured seeking coverage under the policy.

According to the Court, American National's position was inconsistent with both the policy language and the doctrine of severability. Finding the policy's language ambiguous,[66] the Court observed that:

> Severability is a widely recognized doctrine that acknowledges the separate and distinct obligations the insurer undertakes to the various insureds, named and unnamed. The intent of a severability clause is to provide each insured with separate coverage, as if each were separately insured with a distinct policy, subject to the liability limits of the policy. Thus, severability demands that policy exclusions be construed only with reference to the particular insured seeking coverage.[67]

The Court surmised that the insurer must have inserted the severability clause in the policy for some purpose. Furthermore, a reasonable interpretation of the words "this insurance applies separately to each insured" leads to but one conclusion: that each insured must be treated as if he or she was insured separately, applying exclusions individually as to the insured for whom coverage is sought.[68] "There would be no point to a severability clause if it did not provide separately to each named insured."[69] Any other conclusion would render the severability clause meaningless.[70]

This methodology was also employed by the court in *Hilmer v. White.*[71] In *Hilmer*, Benjamin White, then seventeen-years-old, pled guilty to the attempted murder of Casey Hilmer. Benjamin had grabbed the thirteen-year-old Casey while she was jogging, dragged her into the woods, and stabbed her repeatedly in the side and neck.

Casey and her parents sued Benjamin as well as his parents, Lance and Diane White. In the civil suit, the Hilmers claimed that Lance and Diane had been negligent in that they failed to properly supervise their son and entrusted him with a dangerous instrument. The jury returned a verdict for compensatory damages in the amount of $6.5 million. The jury further determined that Lance and Diane were responsible for seventy percent of that amount.

At the time of the attack, the Whites had two homeowners'

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[66] *Id.* at 294.
[67] *Id.* (internal citations omitted).
[68] *Id.* at 294.
[69] *Id.*
[70] *Id.*
[71] No. C-070074, 2007 Ohio App. LEXIS 6288 (Ohio Ct. App. Dec. 28, 2007).

insurance policies and two umbrella policies. One of the homeowners' policies was issued by defendant – appellee Federal Insurance Company ("Federal"). One of the umbrella policies was issued by defendant – appellee Pacific Indemnity Company ("Pacific"). The remaining policies were issued by plaintiff – appellant Safeco Insurance Company ("Safeco").

Shortly after the Hilmers filed their lawsuit, Safeco filed a declaratory judgment action claiming that it owed no duty to defend or indemnify the Whites. Safeco also requested that the trial court determine the priority of coverage between the two policies that it had issued and the two issued by Federal and Pacific. The trial court concluded that the intentional tort exclusions in the Safeco policies were ambiguous because of the severability clause present in each policy. The court also held that Safeco owed coverage on a pro-rata basis with the other two insurance companies. Safeco appealed.

Lance and Diane White were named insureds in the Safeco homeowners' policy. The term "insured" also included relatives who resided in the household. The policy excluded coverage for bodily injury "which is expected or intended by an insured or which is the reasonably foreseeable result of an act or omission intended by an insured."[72] Bodily injury "arising out of an illegal act committed by or at the direction of an insured" was also excluded.[73]

Safeco's umbrella policy named Lance White as an insured. As in the homeowners' policy, the term "insured" included any member of the household.[74] It excluded from coverage "any injury caused by a violation of penal law or ordinance committed by or with the knowledge or consent of any insured"[75] as well as "any act or damage which is expected or intended by any insured, or which is the foreseeable result of an act or omission intended by any insured . . . ."[76] Both the homeowners' policy and the umbrella policy contained a severability provision stating that "[t]his insurance applies separately to each insured . . . ."[77] The appellate court affirmed the trial court and concluded that Safeco's use of the terms "an insured" and "any insured" in its homeowners' and umbrella policies, respectively, caused the exclusions to be ambiguous when read in conjunction with the severability clause found in each.[78]

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[72] *Id.* at *8 (internal quotation marks omitted).

[73] *Id.*

[74] *Id.*

[75] *Id.*

[76] *Id.* at *8–9.

[77] *Id.* at *9.

[78] *Id*. at *11–12; *see also* Ill. Union Ins. Co. v. Shefchuk, 108 Fed. App'x 294 (6th Cir. 2002). The court's conclusion in *Hilmer* has not, however, been consistently followed by other lower courts in Ohio. *See* United Ohio Ins. Co. v. Metzger, No. 12-98-1, 1999 Ohio App. LEXIS 920 (Ohio Ct. App. Feb. 8, 1999). Interestingly, the Ohio Supreme Court has refused to resolve the conflict that exists

This interpretive method is predicated on the maxims that an insurance policy must be read as a whole and, that ambiguity in an insurance contract can arise from inconsistent policy provisions[79] as was the case in *Fournelle* and *Hilmer*, or from ambiguous language as in *Brumley*. As demonstrated by *Hilmer,* the determination that an ambiguity exists as a consequence of inconsistent policy provisions requires little more than an examination of the entire policy and application of the rule of *contra proferentem.* That is, ambiguity will be construed against the drafter and in favor of coverage.

C. METHODOLOGY NO. 3

This interpretive method is the most complex and perplexing of any used to resolve severability clause disputes. While the focus of the inquiry remains the intention of the parties, courts using this approach do not treat "an" or "any" as synonymous. Consequently, these courts reach a different result regarding the effect of a severability clause depending on whether an exclusion refers to the conduct of "an" or "any" insured.[80]

1. Methodology No. 3a

In light of a policy's severability clause, exclusions referring to the conduct of "an" insured have been distinguished from those using the phrase "any" insured and construed to apply separately to each insured such that one insured's excluded activity does not preclude coverage for other insureds who did not participate in the excluded activity.[81] For example, in *United Services Automotive Association v. DeValencia*,[82] an Arizona appellate court found itself confronted with determining a

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among the state appellate courts regarding the issue of whether a severability clause renders an exclusion using the term "an insured" ambiguous. *See* Safeco Ins. Co. of Am. v. White, 913 N.E.2d 426 (Ohio 2009).

[79] *See* Parker, *supra* note 55.

[80] *Compare* Nw. Nat'l Ins. Co. v. Nemetz, 400 N.W.2d 33, 38 (Wis. Ct. App. 1986) (concluding that the "contract [was] ambiguous because the severability clause create[d] a reasonable expectation that each insured's interests [were] separately covered, while the exclusion clause attempt[ed] to exclude coverage for both cause by the act of [an insured]), *with* Taryn E.F. v. Joshua M.C., 505 N.W.2d 418, 422 (Wis. Ct. App. 1993) (finding that "the term 'any insured' unambiguously precludes coverage to all persons covered by the policy if any one of them engages in excludable conduct"), *and* Nationwide Mut. v. Mazur, CV 980489231S, 1999 Conn. Super. LEXIS 1533 (Conn. Super. Ct. June 3, 1999) (finding that a "policy's specific use of the words, 'each' and 'an,' as opposed to the determiner 'any,' demonstrates an intent to provide coverage to the insureds separately").

[81] *See, e.g.,* Litz v. State Farm Fire & Cas. Co., 695 A.2d 566 (Md. 1997).

[82] 949 P.2d 525 (Ariz. Ct. App. 1997).

severability clause's effect on an exclusion from the perspective of a novel factual situation. Therein, Dennis and Debra Gerow provided day care in their home to three minor children of the appellants, the DeValencias. After discovering that their children had been molested by the Gerow's fourteen-year-old son CG, the DeValencias asserted negligent supervision and breach of contract claims against the Gerows.

The Gerows' homeowners' insurer – USAA – filed an action for declaratory judgment in response to the DeValencias' lawsuit, asserting that its policy did not cover their claim. The trial court granted USAA's motion for summary judgment, concluding that there was no coverage under the policy because the business pursuit exclusion precluded liability coverage for acts and omissions "arising out of or in connection with a business engaged in by an insured."[83] The parties agreed that this exclusion was applicable to CG's parents – the Gerows. The DeValencias, however, argued that it was not applicable to CG because of the policy's severability clause, which provided "[t]his insurance applies separately to each insured. This condition will not increase our limit of liability for any one occurrence."[84]

The court concluded that because the exclusion referred to the acts of "an insured," applicability of the exclusion should be determined separately as to each insured. Thus, "to bring CG's acts within the business pursuit exclusion, USAA was obliged to show that he was individually engaged in a business pursuit when he committed the alleged acts."[85]

The court's reasoning and holding in *DeValencia* were subsequently clarified in *Am. Family Mut. Ins. Co. v. White.*[86] Therein, Travis Wilde hit Bryan White in the head with a metal pipe. Travis pled guilty to aggravated assault. White later sued Travis and his parents ("the Wildes"), who filed a claim with their insurance carrier, American Family. American Family filed a declaratory judgment action asserting that all the claims by all insureds were precluded under the "violation of law" exclusion contained in the Wildes' homeowners' policy: "Violation of Law. We will not cover bodily injury or property damage arising out of . . . violation of any criminal law for which any insured is convicted . . . ."[87]

According to the Wildes, because American Family's policy contained a severability of insurance clause identical to that in *DeValencia*, *DeValencia* was controlling, and the applicability of the exclusion had to be determined separately as to each insured. Therefore, because only

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[83] *Id.* at 527 (internal quotation marks omitted).

[84] *Id.*

[85] *Id.*

[86] 65 P.3d 449 (Ariz. Ct. App. 2003).

[87] *Id.* at 452. The policy also contained an "Intentional Injury" exclusion, which like the violation of law exclusion, used the term "any insured." *Id.* at 453 n.2.

Travis was convicted of violating a criminal law, the claims against them remained covered under the policy.[88]

The court rejected this argument and distinguished the exclusionary clause in *DeValencia* from that in the American Family policy purchased by the Wildes. "The exclusionary clause in *DeValencia* applied to 'acts or omissions 'arising out of or in connection with a business engaged in by *an* insured.'"[89] The exclusion at issue in the case at hand applied to "violation of any criminal law for which *any* insured is convicted."[90] While the parties agreed that "any" meant no more than "an," the court, which viewed the matter as a question of law, drew its own conclusion. Deferring to the majority view, it concluded that the phrase "any insured" in an applicable exclusion operates as a bar to coverage for any claim of any insured, even if the policy contains a severability clause.[91]

DeValencia and *White* indirectly or implicitly held that the terms "an insured" or "any insured" when used in an exclusion are neither synonymous nor affected similarly by the presence of a severability clause in the policy. However, in *Nationwide Mut. v. Mazur,*[92] these questions were addressed head on. In *Mazur*, Michael Mazur, a minor, lured Andrew Christmas to a remote area where he assaulted and struck him with such force as to render Andrew unconscious. Michael then proceeded to punch and kick Andrew in the head while he lay helpless and unconscious on the ground. Andrew and his father filed suit against Michael and his mother—Judy Mazur – seeking to recover damages for injuries incurred by Andrew as a result of the assault.

Judy filed a claim under her homeowners' policy provided by Nationwide Mutual ("Nationwide"). Nationwide denied the claim, asserting that it had no duty to defend or indemnify either Michael or Judy because Michael's acts were intentional and expressly excluded in the policy. The relevant exclusion provided in part: "Coverage E Personal Liability . . . [does] not apply to bodily injury . . . . a. caused intentionally by or at the direction of an insured, including willful acts the result of which the insured knows or ought to know will follow from the insured's conduct."[93] Judy contended that because the policy included a severability clause, she, as a separate insured under the policy, was entitled to coverage even if coverage was excluded for Michael.

The court agreed. It construed the inclusion of the severability

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[88] *Id.* at 456.

[89] *Id.* (quoting United Servs. Auto. Ass'n v. DeValencia, 949 P.2d 525, 527 (Ariz. Ct. App. 1997)).

[90] *Id.*

[91] *Id.*

[92] CV 980489231S, 1999 Conn. Super. LEXIS 1533 (Conn. Super. Ct. June 3, 1999).

[93] *Id.* at *25–26.

provision in the policy as recognition on the part of Nationwide that it owed Judy a distinct and separate coverage obligation aside and apart from any obligations it owed Michael. Consequently, whether Michael's conduct was excluded under the policy had no effect on Judy's entitlement to coverage.

Nationwide also argued that the term "an insured" was synonymous with "any insured" in the intentional acts exclusion.[94] The court rejected this assertion and concluded, that the policy's use of the term "each" in the severability clause and "an" in the exclusion demonstrated an intent to provide coverage to the insureds separately. Where the terms "an" or "any" are viewed as distinct, the latter term is often construed to unambiguously deny coverage to all insureds as the result of excluded conduct by any of the persons insured by the policy.[95] The presence of a severability clause generally does not change this result.

In this method, the intent and purpose of the severability clause, which is to limit the scope of the exclusion to the insured seeking coverage, is construed in light of the language – "an insured" – as used in an exclusion. Where the phrase "an insured" is construed as being modified by a severability clause, a narrow construction of the exclusion is implied from the presence of the severability clause in the policy. This means that coverage consists of "what . . . the insured expected to receive and what the insurer agreed to provide, as disclosed by the provisions of the policy . . . ."[96] This approach does not assume that an exclusion is *per se* ambiguous merely because the policy contains a severability clause.[97] Rather, the exclusion is applied to each insured individually for purposes of determining whether there is coverage. The end result is that both the severability clause and the exclusion are given effect.[98] The opposite result occurs where the phrase "any insured" is used.

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[94] *Id.* at *27.

[95] *See* Taryn E.F. v. Joshua M.C., 505 N.W.2d 418, 422 (Wis. Ct. App. 1993); White, 65 P.3d 449; Chacon v. Am. Fam. Mut. Ins. Co., 788 P.2d 748 (Colo. 1990); Am. Fam. Mut. Ins. Co. v. Corrigan, 697 N.W.2d 108 (Iowa 2005); Am. Fam. Mut. Ins. Co. v. Copeland–Williams, 941 S.W.2d 625 (Mo. Ct. App. 1997); Oaks v. Dupuy, 653 So. 2d 165 (La. Ct. App. 1995); *but see,* Am. Fam. Mut. Ins. Co. v. Bower, 752 F. Supp. 2d 957, 971 (N.D. Ind. 2010) (explaining a severability clause renders an exclusion referring to the conduct of any insured ambiguous); W. Am. Ins. Co. v. AV&S, 145 F.3d 1224 (10th Cir. 1998) (explaining a severability clause renders an exclusion referring to the conduct of any insured ambiguous); Worcester Mut. Ins. Co. v. Marnell, 496 N.E.2d 158 (Mass. 1986); Premier Ins. Co. v. Adams, 632 So. 2d 1054 (Fla. Dist. Ct. App. 1994) (noting the term "any insured" modified by the presence of a severability clause).

[96] *See* Covenant Ins. Co. v. Sloat, No. 385786, 2003 Conn. Super. LEXIS 1557, at *20 (Conn. Super. Ct. May 23, 2003).

[97] *See Mazur,* 1999 Conn. Super. LEXIS 1533, at *26–27.

[98] *Sloat,* 2003 Conn. Super. LEXIS 1557, at *34–37.

2. Methodology No. 3b

This methodology is a variant of the one just discussed. It differs only in its reliance on the principle of ambiguity to achieve coverage. It is discussed separately for two reasons. First, only a couple of state Supreme Courts have used the principle of ambiguity to determine the impact of a severability clause on an exclusion referring to the conduct of "an insured" distinct from "any insured." Second, it further demonstrates the general negative treatment that the phrase "an insured," when divorced from "any insured," has received throughout severability of interests clause interpretation.[99] The California Supreme Court's *Minkler v. Safeco Ins. Co.* [100] decision is the most prominent example of this methodology. It illustrates both propositions.

In *Minkler*, the California Supreme Court agreed to answer a question of California insurance law directed to it by the United States Court of Appeals for the Ninth Circuit. The question asked was "[w]here a contract of liability insurance covering multiple insureds contains a severability-of-interest clause . . . , does an exclusion barring coverage for injuries arising out of the intentional acts of 'an insured' bar coverage for claims that one insured negligently failed to prevent the intentional acts of another insured?"[101] *Minkler* involved a lawsuit filed by Scott Minkler against David Schwartz and his mother Betty Schwartz. Scott alleged that David, an adult, had sexually molested him when he was a minor. Some of these acts allegedly occurred in Betty's home and as a result of her negligent supervision.

Betty was the named insured under a series of policies issued by Safeco Insurance Company ("Safeco"). David was an additional insured in each policy. The policies provided liability coverage to an insured for personal injury or property damages arising out of a covered occurrence. They excluded from coverage any injury that was "expected or intended by an insured or which [was] the foreseeable result of an act or omission intended by an insured . . . ."[102] The policy also contained a severability of interest provision which provided that "[t]his insurance applies separately to each insured."[103] The ultimate question before the Court was whether Betty "was barred from coverage only if her *own* conduct in relation to David's molestation of Scott fell within the policies' exclusion for

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[99] *See* Wilson v. State Farm Mut. Auto. Ins. Co., 540 So. 2d 749 (Ala. 1989)(illustrating how exclusion is ambiguous even in the absence of a severability clause).

[100] 232 P.3d 612 (Cal. 2010).

[101] *Id.* at 616.

[102] *Id.* at 615.

[103] *Id.*

intentional acts."[104]

The *Minkler* Court expressly noted the split of authority surrounding the issue of the impact of a severability clause on a policy exclusion referring to the acts of "an" or "any" insured.[105] It also recognized that California law, in the absence of contrary evidence, viewed exclusions from coverage described in reference to the acts of "an" or "any," as opposed to "the," collectively, so that if one insured committed an excluded act, all insureds were barred from coverage.[106] Nevertheless, the Court concluded that, "an exclusion of coverage for the intentional acts of 'an insured,' read in conjunction with a severability or 'separate insurance' clause like the one at issue . . . creates an ambiguity which must be construed in favor of coverage that a lay policyholder would reasonably expect."[107]

Minkler has several noteworthy aspects. First, the Court's reasoning – which focused on the language of both the severability clause and the exclusion, in light of the reasonable expectation of the insured – is concise and consistent with the rules of insurance contract interpretation. Second, the holding of the court is supported in part by the general, rather than specific, nature of the exclusion. In other words, the use of the term 'an' is insignificant and does not cause an exclusion to be specific in nature. Third, the Court cautioned that its reasoning and holding under the specific circumstances of the case did not mean that a severability clause necessarily affects all exclusions framed in terms of "an" or "any" insured.[108] This cautionary note manifests judicial awareness of the fact-sensitive nature of insurance policy interpretation. In this context, it reflects sensitivity to situations where application of a severability clause would render an absurd result such as converting the policy purchased into a type of policy which was neither negotiated nor paid for.[109]

Courts employing Methodology 3a and 3b, respectively are exercising a policy choice in favor of coverage in limited situations. That choice is reflected in the restricted application of the functional theory of contract interpretation to this methodology. The problem, however, is that the functional approach is neither fully nor consistently applied. For example, in the context of the term "an insured," the philosophy of the reasonable expectation of a lay insured has been fully integrated. However,

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[104] *Id.* at 614.
[105] *Id.*
[106] *Id.* at 617.
[107] *Id.* at 614.
[108] *Id.* at 621–22 n.5.
[109] *See, e.g.,* BP Am. Inc. v. State Auto Prop. & Cas. Ins. Co., 148 P.3d 832 (Okla. 2005); Transit Cas. Co. v. Hartman's, Inc., 239 S.E.2d 894 (Va. 1978); Shelter Mut. Ins. Co. v. Haller, 793 S.W.2d 391 (Mo. App. 1990).

when the exclusion is couched as "any insured," the outcome reflects the functional theory of contract interpretation.

III. RECONCILING THE INTERPRETIVE METHODOLOGIES

While the ultimate legal conclusion reached in a particular case is frequently dictated by individual circumstances, the legal reasoning used by the court is often less transparent. Nevertheless, there is a method to the madness. The interpretive methodologies used to resolve severability disputes indicate that courts are applying principles of contract interpretation in a manner that reflects two competing approaches: (1) the "traditional" or "formalist" approach; (2) the "functional" or "reasonable expectation" approach.[110] These approaches differ in that the "traditional"

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[110] *See* Collins v. Farmers Ins. Co., 822 P.2d 1146, 1159 (Or. 1991) (Unis, J., dissenting). Justice Unis, dissenting, explained the similarities and distinctions between these interpretive approaches:

> Under the "traditional" or "formalist" approach, the court looks to the "four corners" of the insurance policy and interprets it by applying rules applicable to all contracts in general. The insured is held to have read and to have understood the clear language of the policy. Extrinsic evidence relating to the insurance contract may be examined for the purpose of determining the parties' intention to an objective analysis of the "four corners" of the contract. . . . The rationale behind the "formalist" approach is that contracts of insurance rest upon and are controlled by the same principles of law that apply to other contracts, and the parties to an insurance contract may provide such provisions as they deem proper as long as the contract does not contravene law or public policy (citations omitted). . . . The competing approach to insurance contract interpretation—the "functional" or "reasonable expectation" approach – is that the policyholder's reasonable expectations to coverage under the insurance policy should be honored even though those expectations vary from the policy provisions. . . . The "functional" or "reasonable expectation" approach is supported by the notion that insurance contracts are not ordinary contracts negotiated by parties with roughly equal bargaining strength. Rather, they are largely contracts of adhesion, where the insurance company, in preparing a standardized printed form, has the superior bargaining position, and the insured has to accept such a policy on a "take-it-or-leave-it" basis if the insured wants any form of insurance protection. . . . Restatement (Second) of Contracts, § 211 (1981), "[r]epudiates the 'four-corners' ['traditional' or 'formalist'] approach to contract interpretation in the standardized agreement setting and in effect approves a doctrine of 'reasonable expectations.'" . . . A growing number of courts

theory is logically based and precedent-oriented, whereas the "functional" theory is sociologically-based and result-oriented.[111]

According to the "traditional" or "formalist" approach, correct legal decisions are determined by pre-existing legal precedent. Courts reach their decisions by logical deduction which results from applying the facts of a case to a set of pre-existing legal rules. The "traditional" approach is premised entirely on the theory that the law is a science consisting of socially-neutral, logical principles and rules.[112] Pursuant to the "traditional" or "formalist" approach, a severability clause ordinarily will not negate an exclusion unless: (1) the policy is ambiguous; (2) the exclusion is masked by technical or obscure language; or (3) the exclusion is hidden in the policy provisions.[113]

The "functional" or "reasonable expectation" approach posits "that the paramount concern of the law should not be logical consistency . . . but socially desirable consequences."[114] The "functional" approach looks into the future and considers "[w]hat substantive goals, derived from popular wants and interests, are relevant? What rules or other precepts are required to further them?"[115] Thus, the "functional" approach supports a finding of coverage "if (1) the insurer knew or should have known of the insured's expectation; (2) the insurer created or helped to create those expectations; or (3) the insured's expectations are objectively reasonable in light of the

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> use the "functional" approach to protect the "reasonable expectations" of the insured policyholder from possible denial of coverage that might result under the "traditional" or "formalist" contractual analysis of an insurance policy.

Id. at 1159–61 (citations omitted).

[111] Peter Nash Swisher, *Judicial Rationales in Insurance Law: Dusting Off the Formal for the Function*, 52 OHIO ST. L.J. 1037, 1042 (1991).

[112] *Id.* at 1040–41. The formalist approach has been described as:

> It is not the duty of our courts to be leaders in reform … The judge is always confined within the narrow limits of reasonable interpretation. It is not his function or within his power to enlarge or improve the law [since that is the function of the legislature]. His duty is to maintain it, to enforce it, whether it is good or bad, wise or foolish . . . .

id. at 1042 (quoting Elihu Root, *The Importance of an Independent Judicary*, 72 THE INDEPENDENT 704 (1912)).

[113] Johnny Parker, *The Wacky World of Collision and Comprehensive Coverages: Intentional Injury and Illegal Activity Exclusion*, 79 NEB. L. REV. 75, 110 (2000).

[114] Swisher, *supra* note 105, at 1043.

[115] *Id.*

circumstances and facts of the case."[116] "There is no disagreement between the "formalist" and the "functional" approaches whenever the insurance policy is ambiguous or susceptible to two or more reasonable interpretations."[117]

The traditional or formalist[118] articulates the objective of contract interpretation as ascertaining the intention of the parties and, thereafter, inquires as to whether any rational support favoring application of the exclusion exists. Such support is often gleaned from the language of the exclusion to the extent that it can be described as specific (as opposed to general in nature), unambiguous or imposing a joint obligation. The formalistic approach is strict in its adherence to precedents and harsh in that it favors the insurer's interpretation of the policy. This approach also reflects a paternalistic interest in protecting an industry from the consequences of its own ill-advised drafting.

The overarching principle of contract interpretation is to ascertain and give effect to the intention of the parties. While the interpretation of insurance contracts is guided by this principle, it is controlled by somewhat different standards because an insurance contract is often one of adhesion, particularly in personal lines. Adhesion contracts provide insureds with little choice beyond electing among standardized provisions offered to them on a take it or leave it basis. Furthermore, many insureds cannot view their policy language until after tendering payment.[119] Consequently, under the functional approach, insurance policies are construed to provide coverage which a layperson would reasonably expect, given a lay interpretation of the policy language.[120] This construction offsets the greater bargaining position of insurance companies and prevents the use of insurance policies as a wholesale method of controlling applicable law.[121] In contrast, the formalist approach ignores the fact that insurance contracts are contracts of adhesion, typically written to afford greater protection to the insurer.

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[116] Parker, *supra* note 107, at 111.

[117] *See Collins*, 822 P.2d at 1161 (Unis, J., dissenting).

[118] *See, e.g.*, The Ohio Cas. Ins. Co. v. Holcim (US), Inc., 744 F. Supp. 2d 1251 (S.D. Ala. 2010); Md. Cas. Co. v. Am. Fidelity & Cas. Co., 217 F. Supp. 688 (E.D. Tenn. 1963); Am. Family Mut. Ins. Co. v. White, 65 P.3d 449 (Ariz. Ct. App. 2003); BP Am., Inc. v. State Auto Prop. & Cas. Ins. Co., 148 P.3d 832 (Okla. 2005); Coop. Ins. Cos. v. Woodward, 45 A.3d 89 (Vt. 2012).

[119] *See* Daniel Schwarcz, *Transparently Opaque: Understanding the Lack of Transparency in Insurance Consumer Protection*, 61 UCLA L. REV. (forthcoming Jan. 2014), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2130908.

[120] Stordahl v. Gov't Emp. Ins. Co., 564 P.2d 63, 65–66 (Alaska 1977); Lee v. Interinsurance Exch., 57 Cal. Rptr. 2d 798 (Cal. Ct. App. 1986).

[121] Am. Serv. Mut. Ins. Co. v. Bottum, 371 F.2d 6, 12 (8th Cir. 1967).

The functional approach to severability clause interpretation is reflected in every interpretive methodology which holds that a severability of interests provision modifies an exclusion referring to the conduct of 'an' or 'any' insured. [122] However, the functional approach has only been fully incorporated into Methodology No. 2, thus, making it the most insurance consumer oriented. Methodology No. 2 is superior to Methodologies 3a and 3b because it recognizes that an insurance contract is one of adhesion and shifts the entire risk of loss to the drafting party by giving effect to the severability clause regardless of the language used to describe the excluded conduct. Methodologies 3a and 3b use the functional approach to shift the burden of loss to the drafting party by giving effect to the severability clause exclusively in the context of exclusions referring to the conduct of "an insured." Both 3a and 3b use the traditional theory of contract interpretation when an exclusion refers to the conduct of "any insured." Methodology No. 1 is the least favorable to insurance consumers because it relies solely on the traditional theory of contract interpretation, pursuant to which the adhesive nature of insurance contracts is insignificant.

The functional approach considers the policy as a whole and typically employs the principle of ambiguity or reasonable expectation of the insured to construe the severability clause in favor of coverage or as having severed application. The availability of clearer language and alternative provisions are relevant considerations in the context of the functional approach to insurance contract interpretation. The functional approach has become firmly entrenched in insurance law jurisprudence over the past four decades.[123]

The functional approach, unlike its "traditional" counterpart, promotes fairness in policy interpretation by avoiding the recognition of a per se rule of coverage or non-coverage. Rather, the exclusion, in light of the presence of the severability clause, is applied to each insured separately. It also promotes and encourages careful drafting. For if it is

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[122] *See* Am. Fam. Mut. Ins. Co. v. Corrigan, 697 N.W.2d 108 (Iowa 2005); Chacon v. Am. Fam. Mut. Ins. Co., 788 P.2d 748 (Colo. 1990); Am. Family Mut. Ins. Co. v. White, 65 P.3d 449 (Ariz. Ct. App. 2003); Am. Fam. Mut. Ins. Co. v. Copeland Williams, 941 S.W.2d 625 (Mo. Ct. App. 1997); Taryn E.F. v. Joshua M.C., 505 N.W.2d 418 (Wis. Ct. App. 1993). *But see* West Am. Ins. Co. v. AV&S, 145 F.3d 1224 (10th Cir. 1998) (finding severability clause renders an exclusion referring to the conduct of any insured ambiguous); Am. Fam. Mut. Ins. Co. v. Bower, II, 752 F. Supp. 2d 957 (N.D. Ind. 2010) (finding severability clause makes an exclusion referring to the actions of any insured ambiguous); Worcester Mut. Ins. Co. v. Marnell, 496 N.E.2d 158 (Mass. 1986).

[123] The formal articulation of the doctrine is generally traced to Judge, then Professor, Robert Keeton's seminal article, Robert Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARVARD L. REV. 961 (1970). 2 ERIC MILLS HOLMES & MARK RHODES, HOLMES' APPLEMAN ON INSURANCE, 2D 416 (1996).

asked, "why do insurance companies include severability clauses in insurance contracts?," the "functional" answer is that a severability clause objectively conveys the impression of coverage. It appears to be the virtually unanimous opinion of the legal scholars writing on the subject that the purpose of the addition of the severability clause was to provide coverage.[124] Otherwise, the clause is unnecessary.

The problems associated with severability clause interpretation could easily be resolved by employing language which clearly alerts insureds to the absence of coverage. The functional approach imposes such an obligation on insurers. Where insurers fulfill this obligation, their interpretation of the exclusion should be adopted.

For example, in *Northwest G. F. Mut. Ins. Co. v. Norgard,*[125] the insurer used language specifically designed to avoid a severability clause dispute. In *Norgard,* Ray and Jean Norgard purchased a homeowners' policy from Northwest G. F. Mut. Insurance Company ("Northwest"). Jean operated a home day care business for which she purchased additional insurance coverage from Northwest. Under the day care endorsement, Northwest provided coverage for "bodily injury and property damage arising out of home day care services regularly provided by an insured and for which an insured receives monetary or other compensation."[126] It excluded coverage for "bodily injury or property damage arising out of sexual molestation, corporal punishment or physical or mental abuse inflicted upon any person by or at the direction of an insured, an insured's employee or any other person involved in any capacity in the day care enterprise . . . ."[127] Ray was the named insured and all relatives residing in the Norgard household were also insured under the homeowners' policy.

Ray Norgard was accused and convicted of engaging in sexual contact with L.A.A., the Andersons' four-year-old daughter, while the child was under Jean's supervision at day care. The Andersons brought a civil action against both Ray and Jean, accusing the latter of negligence in the supervision and care of the child. The Norgards tendered the claim to Northwest.

Northwest filed a declaratory judgment action seeking to establish that it was not obligated to defend or indemnify either Ray or Jean because the injuries arose out of Ray's sexual molestation, which was specifically excluded from coverage. While the parties agreed that Ray was disqualified from coverage under the sexual molestation exclusion, they disagreed as to whether Jean was entitled to coverage. The Norgards argued that she was because of the severability provision, which provided

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[124] Shelby Mut. Ins. Co. v. Schuitema, 183 So. 2d 571, 573 (Fla. Dist. Ct. 1966).

[125] 518 N.W.2d 179 (N.D. 1994).

[126] *Id.* at 180.

[127] *Id.*

that "this insurance applies separately to each insured . . . ."[128]

In ruling on a motion for summary judgment, the district court judge found that the severability clause and the sexual molestation exclusion, when read together, were ambiguous, thus warranting construction in favor of coverage. Northwest appealed.

On appeal, the Court reversed, holding that the severability clause precluded coverage to Jean. The Court based its conclusion on the unique language of the exclusion, which pertained to the conduct of not only "an insured" but also "an insured's employee or any other person involved in any capacity in the day care enterprise . . . ." This language manifested the clear intent of the parties to preclude coverage when any person connected with the operation of the day care engaged in sexual molestation of one of the children. The language clearly and specifically provided that these risks were outside the scope of the policy.[129]

Where the language of the exclusion is particularly tailored to except from coverage specific acts of specific individuals, it should prevail over a more general provision such as the severability clause. Similarly, the absence of any reference to a specific actor – "an insured" or "any insured" – in an exclusion demonstrates that the parties intended to base the exclusion on the nature of the act, rather than on the identity of the actor.[130] In either instance, the severability clause is subordinate to the exclusion.[131]

Severability disputes could also be avoided by replacing the severability clause with a joint obligation clause in the policy. The latter provides: The terms of this policy impose joint obligations on persons defined as an insured person. This means that responsibilities, acts and failures to act of a person defined as an insured person will be binding upon another person defined as an insured person.

IV. CONCLUSION

The conflict that exists in the law of severability clause interpretation is primarily a consequence of misguided adherence to and use of the traditional or formalistic theory of contract interpretation. This theory has no place in modern day insurance contract interpretation. This proposition is illustrated by the court's analysis in *Maryland Casualty Company v. American Fidelity & Casualty Company.*[132] There, a federal district court was called upon to predict how the Tennessee Supreme Court

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[128] *Id.* at 181.

[129] *Id.* at 183.

[130] *See, e.g.,* Ristine v. Hartford Ins. Co. of the Midwest, 97 P.3d 1206, 1209 (Or. Ct. App. 2004).

[131] *See, e.g.,* Nw. G.F. Mut. Ins. Co. v. Norgard, 518 N.W.2d 179, 183 (N.D. 1994); Ristine v. Hartford Ins. Co., 97 P.3d 1206, 1210 (Or. Ct. App. 2004).

[132] 217 F. Supp. 688 (E.D. Tenn. 1963).

would resolve the question of whether a severability clause affected an employee exclusion contained in an automobile liability policy. The court found both the exclusion and the severability clause to be ambiguous because the language used was susceptible to two reasonable interpretations.[133] Ambiguity was also evidenced by the fact that various courts had arrived at conflicting conclusions as to the meaning of both clauses.[134]

Despite its finding of ambiguity, which should have been resolved in favor of the non-drafting party, the court proceeded to a consideration of prevailing precedents. In that context, the court, despite its express disagreement with the soundness of the conclusions reached, felt constrained to hold that any employee of "the insured" meant any employee of *any* insured. In *Maryland Cas.,* use of the traditional theory of contract interpretation resulted in a restrictive construction of the severability clause which, though acknowledged by the court to be unsound, was nevertheless condoned (possibly because the court felt constrained as a federal court sitting in diversity).

Rigid adherence to the traditional theory of contract interpretation limits the legal system's ability to deal with some of the most problematic and frequently litigated questions of insurance coverage. It unduly limits the analysis of the meaning and function of insurance contracts. For these reasons severability of interests clause interpretation remains the "only known situation where many of the courts persist in erring in *favor* of the insurance companies!"[135]

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[133] *Id.* at 691–692.

[134] *Id.* at 692.

[135] Norman E. Risjord & June M. Austin, "*Who is the 'Insured'" Revisited*, 28 INS. COUNS. J. 100, 101 (1961).

DOES AN INSURED HAVE A DUTY TO MITIGATE DAMAGES WHEN THE INSURER BREACHES?

JAMES M. FISCHER*

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This article explores the uncertainty behind an insured's duty to mitigate losses after the insurer has breached its contract. The article explores the arguments for and against mitigation and concludes that the duty to mitigate should be imposed on insureds who are seeking damages for the insurer's breach of a contractual obligation regardless of the type of insurance policy in question. The failure by the insured to act reasonably post-breach should result in them being held responsible for losses that could have been avoided.

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I. INTRODUCTION

The principle that a plaintiff must make reasonable efforts to mitigate damages is well entrenched in the law of contract and tort,[1] although the origins of the requirement are somewhat obscure.[2] The so-called "duty"[3] to mitigate operates to reduce damages to the extent losses could have been avoided had the plaintiff, post-breach, acted reasonably under the circumstances. When insurers breach their obligation under an

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[1] Sutherland identified the origins of the mitigation principle as being equitable in nature, although it is not clear whether the reference was to equity jurisprudence or to general concerns for fairness. 1 J.G. SUTHERLAND, THE LAW OF DAMAGES §149 (3d ed. 1903).

[2] One scholar traces mitigation principles back to Roman law. Saul Litvinoff, *Damages, Mitigation, and Good Faith,* 73 TUL. L. REV. 1161, 1164 (1998–1999).

[3] The mitigation of damages obligation is discussed in detail in JAMES M. FISCHER, UNDERSTANDING REMEDIES, §13 (2d ed. 2006).

> The plaintiff's obligation should not be understood as arising to the level of a legal duty, such as would create affirmative rights exercisable by the defendant. Rather, a plaintiff's failure to mitigate, when mitigation is reasonable and would operate to reduce the plaintiff's loss, will result in a dollar for dollar reduction in the recovery by the amount not mitigated.

Id.

insurance contract, however, there is substantial uncertainty whether the insured has a duty to mitigate. There are surprisingly few decisions that specifically address this issue. Most that do address the question rather casually. Sometimes, a duty to mitigate is assumed;[4] other times, the duty to mitigate is rejected.[5] This article explores the reasons for this state of affairs. The article concludes that a duty to mitigate should be recognized and imposed on insureds who are seeking damages for insurer breach of an insurance contractual obligation.

A. THE DUTY TO MITIGATE – AN OVERVIEW

A plaintiff's recovery may be reduced if the plaintiff fails to make reasonable efforts, post-breach or post-injury, to lessen damages. These efforts may be positive in the sense that the plaintiff must take affirmative, proactive steps to ameliorate the scope or severity of the loss, for example, submitting to reasonable medical procedures to reduce the injury or to hasten the healing process. Alternatively, the obligation may be negative, in the sense that the plaintiff may be required to cease and desist from incurring further loss, as, for example, a contractor continuing to expend labor and materials, and thereby increasing the loss, after the owner has breached the construction contract.[6] The fundamental justification for the mitigation requirement is that compensation should be tied to causal responsibility for the loss.[7] The plaintiff is seen as the cause of any losses that could have been avoided by post-breach action. The plaintiff is not allowed to sit idle and allow losses to grow and accumulate, but must act reasonably to reduce the quantum of loss caused by defendant's legal wrong.

Mitigation resembles several liability doctrines, such as contributory negligence and comparative fault. The doctrinal line that separates mitigation from contributory negligence and comparative fault is

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[4] *See, e.g*, Campbell v. Norfolk & Deham Mut. Fire Ins. Co., 682 A.2d 933, 936 (R.I. 1996) (per curiam) (holding that insured need not await actual, physical collapse of insured structure before loss will be deemed covered because such a requirement would subvert insured's duty to mitigate damages).

[5] *See, e.g.*, Miller v. Mut. Life Ins. Co. of N.Y., 289 N.W. 399, 402 (Minn. 1939) (holding that disabled insured could not be denied benefits because insured failed to take insulin necessary to control his diabetes, which was his disabling condition under the policy).

[6] RESTATEMENT (SECOND) OF CONTRACTS § 350 cmts. ab (1981).

[7] RESTATEMENT (SECOND) OF TORTS § 918 cmt. c (1979) ("The factors determining whether an injured person has used care to avert the consequences of a tort are in general the same as those that determine whether a person has been guilty of negligent conduct . . . .").

the time of the wrong and resulting injury. Plaintiff's pre-injury activities that contribute to the loss are addressed through liability-based doctrines, such as negligence and comparative fault. Plaintiff's post-injury activities that contribute to the extent or magnitude of the loss are addressed through remedial-based doctrines, such as mitigation.[8] The distinction can be significant because mitigation raises pure loss sharing issues, while contributory negligence does not and comparative fault may not.[9]

The mitigation obligation is subject to several constraints. A plaintiff need only expend reasonable efforts to mitigate damages; the plaintiff need not do what is unreasonable or impractical. A plaintiff, who is financially unable to mitigate, need not do what he cannot do.[10] Mitigation is rarely a complete defense; rather, damages are only reduced by the amount of damages reasonable efforts would have avoided. For example, assume an insured has a duty to mitigate after the insurer breached its duty to defend. If the insured unreasonably failed to accept the claimant's offer to settle the matter for $25,000 and the claimant thereafter recovered $50,000, the insured's general, economic damages would be limited to $25,000 – the amount of damages the insured would have incurred had the insured acted reasonably, after the insurer's breach, by settling with the claimant.

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[8] Kocher v. Getz, 824 N.E.2d 671, 675 (Ind. 2005) ("While a plaintiff's postaccident conduct that constitutes an unreasonable failure to mitigate damages is not to be considered in the assessment of fault, a plaintiff 'may not recover for any item of damage that [the plaintiff] could have avoided through the use of reasonable care.'") (alteration in original) (footnote omitted).

[9] *See* Del Tufo v. Twp. of Old Bridge, 685 A.2d 1267, 1282 (N.J. 1996). In *Del Tufo*, an arrestee died from a cocaine overdose while in police custody. *Id.* at 1267. His estate brought a wrongful death action alleging that the police had negligently delayed securing proper medical care for the decedent. *Id.* Under New Jersey's comparative fault statute, the plaintiff had to show that defendant was more than 50% responsible for the decedent's injuries. *Id.* at 1282. The court held that, on these facts, the trial court should have instructed the jury on comparative fault and the failure to do so constituted prejudicial error since the decedent's voluntary ingestion of cocaine was a substantial contributing factor to his death. *Id.* Because New Jersey's comparative fault statute would bar recovery if the trier of fact found that the decedent was more responsible than defendant for his death from a cocaine overdose, the estate argued on that remand it could receive a mitigation instruction, which would allow for some recovery based on the principles of pure fault. *Id.* Thus, if decedent were found to be 80% responsible for his death, the estate could still recover 20% of his damages, which reflected defendant's share of responsibility. The court held that mitigation principles did not apply and that the decedent's actions should be evaluated under faultbased principles. *Id.*

[10] FISCHER, *supra* note 3, at § 13.2.

B. INSURANCE AND MITIGATION

Courts have been inconsistent in their application of mitigation principles to insurance disputes regardless of the type of insurance involved,[11] although most of the disputes have involved liability insurance. This article considers both breaches of the duty to defend (liability insurance) and breaches of the duty to pay (disability and property insurance). While both duties involve distinct obligations of the insurer, neither duty presents unique issues or concerns pertinent to the mitigation obligation when the insured seeks damages. The basic issue whether the insurer has a duty to mitigate does not turn on whether the insurer has breached the duty to defend or the duty to pay because in each case by seeking damages the insured has monetized the claim. Whether the insured has acted reasonably in seeking to mitigate damages may be influenced by the nature of the duty the insurer breached, but that is a topic for later work. Here the focus is on the existence *vel non* of the duty to mitigate.

1. Liability Insurance

Liability insurance policies commonly provide a defense for insureds when the insured is sued and the insurer may be required to provide indemnification.[12] Insurers do not agree to defend their insureds against all claims and whether the insured is or is not owed a defense under the policy is a fertile ground for litigation between insured and insurers.[13]

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[11] LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE 3D § 168:9 (3d ed. 2005) ("[T]he concept of mitigation of loss in insurance has not developed as cohesively as the doctrine of mitigation of damages in other fields.").

[12] Charles Silver & Kent Syverud, *The Professional Responsibilities of Insurance Defense Counsel*, 45 DUKE L.J. 255, 302 (1995) (demonstrating that insurance law burdens the company with two relevant duties: a duty to defend the insured and a duty to behave reasonably in settlement. The first duty requires the company to provide a lawyer to defend the insured. The second duty requires the company to consider the insured's interests along with its own when exercising its settlement discretion.); *see* James Fischer, *Insurer or Policyholder Control of the Defense and the Duty to Fund Settlements*, 2 NEV. L.J. 1, 32–34 (2002) (discussing separation of insurer's contractual duty to provide a defense from the insurer's contractual right to control the defense).

[13] The insured's duty to defend is triggered by the insured's tender of a third party claim against the insured to the insurer. The tendered claim must be within the coverage promised by the insurer under the terms of the liability insurance policy, although this standard is liberally applied to the insured's benefit. First, the duty to defend is broader than the duty to indemnify and is triggered in many jurisdictions by a claim that raises the potentiality of coverage under the insurance policy. KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION 624 (5th ed.

If the insurer refuses to provide a defense and the insured seeks damages for breach, does the insured, putting aside issues of capability under the precise circumstances of the situation, have a duty to mitigate damages by providing a defense? As one commentator observed, the resolution of this issue is "unclear" as courts are divided – some courts holding that mitigation principles apply, other courts concluding that they do not.[14]

2. Disability Insurance

Disability insurance policies provide payments that substitute for compensation the insured could have earned but for the disability the insured has incurred. Usually the payments are on a monthly basis and continue until the disability is resolved or the policy expires, whichever is earlier. In *Heller v. The Equitable Life Insurance Assurance Soc'y of the U.S.*,[15] the insured, a cardio-vascular surgeon, developed carpal tunnel syndrome, which precluded him from performing surgery. His insurer claimed that he failed to mitigate his losses by submitting to surgery to relieve the condition. The insurer relied on a provision in the insurance policy requiring, as a condition of receiving benefits, that the insured be "under the regular care and attendance of a physician" as requiring the insured to submit to surgery when recommended by an attending physician.

2010). Even if the jurisdiction follows the less liberal "pleading" test, which compares the actual allegations in the claim to the terms of the insurance policy, the test is applied liberally in the insured's favor. Zurich Am. Ins. Co. v. Nokia, Inc., 268 S.W.3d 487, 492 (Tex. 2008). Second, many jurisdictions follow the rule that if the duty to defend exists as to part of the claim, the insurer must defend the entire claim. 3 NEW APPLEMAN ON INSURANCE LAW LIBRARY EDITION § 17.01 (3)(a) (Francis J. Mootz, III, et al. eds., LexisNexis 2012). Third, many jurisdictions impose a high standard for insurer escape when the duty to defend is contested. Montrose Chem. Corp. v. Superior Court, 861 P.2d 1153 (Cal. 1993):

> [I]f the plaintiff's complaint against the insured alleged facts which would not have supported a recovery covered by the policy, it was the duty of the defendant to undertake the defense, *until it could confine the claim to recovery that the policy did not cover* . . . . [T]he insurer may terminate its defense obligation by proving that the underlying claim falls outside the scope of policy coverage, but not by demonstrating that the claim lacks merit, or might have merit only on some theory outside the scope of coverage.

Id. at 1159 (citations omitted) (brackets added) (italics in original).

[14] ALLAN D. WINDT, 1 INSURANCE CLAIMS AND DISPUTES § 4.18 (5th ed. 2007) (collecting decisions).

[15] Heller v. Equitable Life Assurance Soc'y, 833 F.2d 1253 (7th Cir. 1987).

The court rejected the insurer's interpretation of the provision, rejecting the insurer's argument that the insured was obligated to reduce or ameliorate his loss by submitting to surgery absent express language requiring such in the policy.[16] The court even more broadly rejected the argument that the insured had an implied obligation to mitigate his disability if he can do so without reasonable risk or pain.[17] *Heller* is consistent with the general approach in disability insurance disputes to resist imposing a duty to mitigate on the insured, although there is some contrary authority.[18]

3. Property Insurance

Property insurance often has an exclusion to coverage that is triggered if the insured neglects to use "all reasonable means to save and preserve property at and after the time of loss."[19] This language creates an express, contractual obligation to mitigate.[20] Some courts have found a

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> In the absence of a clear, unequivocal and specific contractual requirement that the insured is obligated to undergo surgery to attempt to minimize his disability, we refuse to order the same. To hold otherwise and to impose such a requirement would, in effect, enlarge the terms of the policy beyond those clearly defined in the policy agreed to by the parties. Thus, under the terms of this disability policy, Dr. Heller is not required to undergo surgery for treatment of his carpal tunnel syndrome condition before he receives disability income payments.

Id. at 1257–58 (footnote and citation omitted); *but see infra* note 44 (noting contrary authority as to interpretation of "care and attendance" provision).

[17] "Although we might not choose to follow the same course of conduct and path of reasoning as Dr. Heller, there is no moral, much less legal obligation or compelling reason to second guess an insured's, and in this case Dr. Heller's, decision to forgo surgery." *Id.* at 1259 (footnote omitted).

[18] *Compare* Miller v. Mutual Life Ins. Co. of N.Y., 289 N.W. 399, 402 (Minn. 1939) (rejecting duty to mitigate) *with* Provident Life & Accident Ins. Co. v. Van Gemert, 262 F. Supp. 1047, 1052 (C.D. Cal. 2003) (applying California law and holding that that disability policy's "care and attendance" provision required insured to comply with physician's recommendations that would mitigate disabling condition).

[19] Insurance Service Office Homeowner's Policy (H0 00 03 10 00), Section 1 Exclusions, Exclusion A5.

[20] RUSS & SEGALLA, *supra* note 11, § 149.69 ("Distinct from the question of whether there is coverage for loss when an insured voluntarily removes imperiled goods in order to avoid or reduce his or her loss, the policy of insurance may expressly impose upon him or her such a duty. Such a provision is in effect an

duty on the insured's part to mitigate damages even apart from a contractual obligation to do so. In *Real Asset Management, Inc. v. Lloyd's of London*[21] the court held that Louisiana's general common law duty to mitigate damages applied to an insured who claimed property loss under its property insurance policy. The court reversed an award to the insured. The trial court had excused the insured's failure to comply with the contractual duty to mitigate because the insurer had breached its duty to pay, thus excusing the insured's duties of performance under the insurance contract. The Fifth Circuit Court of Appeals concluded that the insurer's breach did not excuse the insured's failure to mitigate and remanded for a determination of the extent to which the failure to mitigate contributed to the loss claimed by the insured.[22]

C. THE ARGUMENTS AGAINST MITIGATION IN THE INSURANCE CONTEXT

1. Insured's Reasonable Expectations

The most common argument against a mitigation requirement for insurer breach of the contract of insurance, absent an express contractual obligation, is that such a requirement defeats the insured's reasonable expectations under the insurance contract. Here's how Windt puts it in the context of the insurer's duty to defend under a liability insurance policy:

> What is unclear, however, is whether insureds have a duty to defend themselves after their insurers have unjustifiably refused to defend them. Some courts have indicated that they do. The majority, and better, rule, however, is to the contrary. Having contracted to have the insurer defend, the

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exception to the coverage, and in the event of failure to make reasonable efforts to protect the property from peril, the insurer is not liable on its policy") (footnotes omitted).

[21] Real Asset Mgmt., Inc. v. Lloyd's of London, 61 F.3d 1223 (5th Cir. 1995) (applying Louisiana law).

[22] *Id.* at 1229–30 ("We find, however, no legal support for the proposition that an insured's duty to mitigate terminates when the insurer breaches his duty to timely settle a claim. Under Louisiana law it is clear a plaintiff has a duty to do what it can to mitigate losses") (citations and footnote omitted); *see* Jablonsky v. Girard Fire & Marine Ins. Co., 174 A. 689, 691 (N.J. 1934) (noting split in authority whether the insured's violation of the policy requirement that the insured expend reasonable efforts to protect the insured property postloss voids the policy; the court concluded, however, that the better rule is that the insured's failure to protect will only affect the amount of recovery to the extent the insured's failure compounded the loss).

> insured should be able to do nothing more than cooperate with the insurer when a suit encompassed by the policy is filed. The insured did not impliedly covenant to attempt to minimize the insurer's exposure in the event of the insurer breaching its duty to defend, and, for policy reasons, the duty to mitigate damages should not be applicable. Having itself refused to take any action in an effort to minimize its potential exposure in the pending lawsuit, the insurer cannot expect the insured to take such action.[23]

This argument against mitigation appears to consist of two claims. First, mitigation is only required when there is an express contractual obligation to do so, an implied obligation should not be read into the agreement. Second, a mitigation obligation violates public policy, at least in the context of an insurer's breach of the duty to defend. There are, however, difficulties with this mitigation position. If it is against public policy to impose a mitigation obligation on an insured, that public policy applies regardless of the content of the insurance policy. It is a cardinal rule of Insurance Law that the terms of the policy may not violate public policy.[24] To the extent they do, the terms are ignored.[25] Thus, if public policy rejects a duty to mitigate, the inclusion of an express mitigation provision in the insurance policy would not alter that result.

The contention may be that public policy does not bar mitigation *per se*, but does bar implying an obligation to mitigate.[26] That approach avoids logical inconsistency, but does so by neutering public policy of any meaning. As revised, the public policy argument becomes a gloss on the

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[23] WINDT, *supra* note 14, § 4.18 (footnotes omitted).

[24] 16 SAMUEL WILLISTON, A TREATISE ON THE LAW OF CONTRACTS § 49.12 (Richard A. Lord, ed., 4th ed. 2000) ("A contract of insurance, or a clause or provision in it, which is contrary to law or public policy is invalid and unenforceable.") (footnotes omitted).

[25] *See* Welin v. American Family Mut. Ins. Co., 717 N.W.2d 690, 702 (Wis. 2006) (noting that "when an insurance policy violates a statutory provision, the remedy is to enforce the policy as though it conformed to the statutory requirement"); *see also* J.C. Penney Cas. Ins. Co. v. M.K., 804 P.2d 689, 694 (Cal. 1991) (noting that statutory requirements are implied terms of insurance contracts).

[26] There is a conflict in the decisional law as to the extent, if at all, implied statutory requirements may be written over by the contracting parties. *Compare* Julian v. Hartford Underwriters Ins. Co., 110 P.3d 903, 907-08 (Cal. 2005) (noting that the statutory causation test could not be overwritten by contracting parties), *with* State Farm Fire & Cas. Co. v. Bongen, 925 P.2d 1042, 1045 (Alaska 1996) ("[A]n insurer may expressly preclude coverage when damage to an insured's property is caused by both a covered and an excluded risk.").

proper interpretation of insurance contracts, much like the doctrine of *contra proferentum* (construction against the drafter). As so understood, a duty to mitigate should not be implied. This position, however, does not raise a meaningful public policy argument because it does not substantiate why contractual silence as to the mitigation issue supports or creates a "no mitigation" public policy rule.[27]

I may, however, be over-reading Windt's use of the term "implied." Perhaps Windt is arguing that public policy absolutely precludes imposing a duty to mitigate damages on the insured. That position, however, is not substantiated by Windt. More fundamentally, this public policy claim is inconsistent with the judicial willingness, noted earlier, to enforce express mitigation provisions in insurance policies. If a mitigation duty violated public policy, these express provisions would be unenforceable.

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[27] This is not to say that public policy arguments against mitigation are necessarily unsubstantial. Several courts have, for example, concluded that it may violate public policy to impose a duty to mitigate on the United States. In Fed. Deposit Ins. Corp. v. Bierman, 2 F.3d 1424, 1438-41 (7th Cir. 1993), the government had seized control of the assets of a failed banking institution and paid the obligations of the institution pursuant to the deposit insurance guarantee. The government then sued the officers and directors of the institution seeking reimbursement. The directors and officers contended the government had failed to mitigate damages by unreasonably managing the assets it had seized, thereby increasing losses above that which prudent action would have realized. The court agreed with the government that there was no duty to mitigate. Such a duty would conflict with the discretionary function exception on the Federal Tort Claims Act. *See also* Fed. Deposit Ins. Corp. v. Mijalis, 15 F.3d 1314, 1323-25 (5th Cir. 1994) (following Bierman in holding that the FDIC is not required to mitigate damages when it sues former directors and officers in their official capacities to recover losses sustained by insolvent financial institutions):

> We also overrule the third assignment of error in which appellant asserts, in essence, that the rest home had a duty to mitigate damages (that is, to stop the buildup of charges in her mother's account) after appellant had denied any responsibility for the deficiency. First, this claim was not made before the trial court and cannot therefore be raised on appeal. Second, we are not persuaded that the rule requiring mitigation of damages applies against a rest home so as to require it to evict an elderly woman with minimal resources and unknown ability to cope by herself the moment her daughter denies liability for her support.

St. Clare Ctr., Inc. v. Mueller, 517 N.E.2d 236, 239 (Ohio Ct. App. 1986).

Neither the argument of no implied duty, nor the argument of violation of public policy explain why a mitigation requirement is inconsistent with principles of insurance law. It is common to impose a duty to mitigate to contract breaches across the board. Courts have consistently deemed efforts to reduce the harm associated with a breach of obligation, whether that obligation sounds in Contract or Tort, as consistent with public policy.[28] Is there something about insurance contracts and duties arising out of the insured – insurer relationship that warrants a different approach?

One argument is that the insurer has promised a particular performance, e.g. defend the insured, provide monthly payments as long as the insured is disabled, etc., and imposing a mitigation obligation would negate the insurer's promised performance, which the insured has paid consideration (premium) to receive. The problem with this argument is that a mitigation obligation is frequently applied to non-insurance contracts that envision a particular performance – indeed, the purpose of all contracts is to obtain a performance in return for consideration. If a plaintiff contracts for 1000 widgets at a particular price, the defendant's breach does not excuse the plaintiff's duty to mitigate. In fact, the duty to mitigate is so strong, that the cost of the substitute performance (cover) may be seen as a substitute measure of damages.[29] Most contracts provide for reciprocal performances, e.g. buyer buys what seller sells, contractor builds what owner acquires, etc. Each party to the contract renders a performance, even if the performance is no more than the payment of consideration for the other party's performance.

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[28] RESTATEMENT (SECOND) OF CONTRACTS § 350 (1981):

> (1) Except as stated in Subsection (2), damages are not recoverable for loss that the injured party could have avoided without undue risk, burden or humiliation.
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> (2) The injured party is not precluded from recovery by the rule stated in Subsection (1) to the extent that he has made reasonable but unsuccessful efforts to avoid loss.

RESTATEMENT (SECOND) OF TORTS § 918 (1979):

> (1) Except as stated in Subsection (2), one injured by the tort of another is not entitled to recover damages for any harm that he could have avoided by the use of reasonable effort or expenditure after the commission of the tort.
>
> (2) One is not prevented from recovering damages for a particular harm resulting from a tort if the tortfeasor intended the harm or was aware of it and was recklessly disregardful of it, unless the injured person with knowledge of the danger of the harm intentionally or heedlessly failed to protect his own interests.

[29] U.C.C. § 2712 (2011).

The contention that insurance contracts are different does not advance the "no mitigation" argument without identifying how insurance contracts are different from other contracts insofar as a mitigation requirement is concerned. Insurance contracts have some unique characteristics. First, the insured always performs, e.g. pays the premium for the insurance policy. Second, the insurer's performance is conditional on the happening of an insured event, e.g. the insured suffers a covered loss during the policy period. If no such loss occurs, the insurer retains the premium, but never renders a reciprocal performance.[30] These characteristics of the insurance contract do not, however, explain why a duty to mitigate should not be recognized. The conditional nature of the insurer's performance may require protections to assure that the promised performance is provided if the condition occurs;[31] however, the insured's duty to mitigate is distinct from the insurer's duty to perform. The duty to mitigate is based on the tenet that when the non-breaching party fails to exercise due diligence post-loss to ameliorate the loss, the factual cause of the avoidable portion of the loss lies with the non-breaching party.[32] Of course, the non-breaching party may be incapable of exercising due diligence. For example, if the insurer refuses to defend, the insured may lack the resources to retain a lawyer. Mitigation only requires what is reasonable under the circumstances.[33] In the duty to defend context, the insured may not be able to accept a settlement offer because the insured

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[30] RESTATEMENT (FIRST) OF CONTRACTS § 291 (1932) ("An 'aleatory promise' in the Restatement means a promise condition on the happening of a fortuitous event, or an event supposed by the parties to be fortuitous."). For this reason, insurance contracts have sometimes been classified as "aleatory" contracts; *see id*. cmt. a (noting that a fortuitous event may be one that is beyond the power of any human being to control; it may be within the control of third persons; it may be an event in the past if the fact is unknown to the parties; it may be positive or negative or an occurrence or failure to occur); 14 WILLISTON, *supra* note 24, § 43:9 (noting that an aleatory promise is a contract in which one party is under a duty that is conditional on the occurrence of an event).

[31] If a right or duty of an injured party to perform is conditional on a fortuitous event, the injured party cannot treat his remaining duties to render performance as discharged unless he or she manifests his or her intent to do so to the other party before the other party has an adverse change in his or her situation. RESTATEMENT (SECOND) OF CONTRACTS § 379 (1981).

[32] Injured person is required to exercise no more than reasonable judgment or fortitude and is only barred from recovery when it was unreasonable for the injured person to refuse or fail to take action to prevent further loss. RESTATEMENT (SECOND) OF TORTS § 918 cmt. c (1979).

[33] *Cf*. Valencia v. Shell Oil Co., 147 P.2d 558, 561 (Cal. 1944) (noting that the duty to mitigate damages does not require an injured person to do what he or she cannot reasonably afford to do).

lacks the resources to fund the settlement and the offer is conditioned on immediate funding. In this situation no breach of the duty to mitigate would occur. Moreover, the standard of due diligence may be set very low,[34] but obligation and capability should not be conflated or confused. Incapability, while it may excuse the particular instance of a failure to mitigate, is not a substitute for a general duty to mitigate.

Alternatively, it may be argued that a non-breaching party should not, under the guise of a duty to mitigate, be deprived of the essential bargain he struck with the breaching party.[35] For example, if the plaintiff agrees to sell Blackacre to defendant for $10,000 over the property's actual market value ($100,000) and defendant breaches, the duty to mitigate does not require the plaintiff to engage in reasonable efforts to resell the property if the plaintiff only wishes to claim the $10,000 profit he would have made had defendant performed. The law treats the $10,000 profit as fixed at the moment the contract was executed. It might be argued that the insured has similarly bargained for an essential performance that is fixed and immutable at the moment of the insurer's breach, thus, negating a duty to mitigate.

The first problem with this argument is that it doesn't travel very far outside the narrow area of benefit of the bargain. When the benefit of the bargain is spread over time, as in the case of employment contracts,

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[34] *Heller*, 833 F.2d at 1258 n.11 (noting that Illinois law gives substantial deference to a person's personality, beliefs, and fears regarding the desirability of surgery when the defendant contends that the plaintiff failed to mitigate damages by submitting to surgery).

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> This was the argument made and accepted in *Miller*, 289 N.W. at 401:
> In the situation herein involved, the breach of contract was defendant's refusal to continue payments under the policies. It is for an amount equivalent to these unpaid benefits that this action was instituted. In other words, they represent the amount of damages plaintiff has suffered by the breach. They are not in an amount in excess of the actionable breach. There is not involved in this case the question of increasing damage after the breach. What is being demanded is the equivalent to the agreed performance. How then can the doctrine be applicable? By the policies, defendant undertook to pay benefits if and when plaintiff became disabled. It did not require submission to treatment. Plaintiff's refusal to take insulin is not increasing the damage after breach. It is simply a refusal to do what there is not a duty to perform and for which defendant did not demand the obligation to perform.

courts consistently impose a duty to mitigate on the non-breaching party.[36] Moreover, because the essence of an insurance contract is indemnity, not profit, it is difficult to see how the insured could be brought within the narrow exception that permits recovery of bargain benefits without a corresponding duty to mitigate. Insurance contracts may be profitable for insurers, but the whole force of insurance law is that they are not a profit center for insureds.[37] This point is addressed in more detail in Part D of this Article *infra*.

The second problem with the argument is that it misapprehends why the mitigation requirement is not applied to the plaintiff's bargain expectancy. If a mitigation requirement was imposed it would depreciate what belongs to the plaintiff, the expectancy itself. Reconsider the plaintiff who sold property for $110,000, realizing a $10,000 profit (expectancy). When the buyer breaches, the plaintiff retains the property, which is worth $100,000. The difference between what the plaintiff has and what the plaintiff is entitled to have is $10,000.[38] In other words, the plaintiff is entitled to have $110,000; however, because of the buyer's breach the plaintiff has only $100,000; thus, the plaintiff is entitled to $10,000 from the buyer. Should the plaintiff have to resell the property to reduce the damages? Reselling the property would not reduce plaintiff's loss, although it might reduce the amount the buyer will have to pay as damages. The plaintiff has $100,000 in the form of the property. Reselling the property at its market value ($100,000) will not reduce plaintiff's loss. It will simply substitute one asset (cash) for another asset (property), but both assets are of equal value. Imposing a mitigation requirement on the plaintiff would require the plaintiff to find another buyer who would pay an above market price for the property. A reasonable plaintiff can assume that a resale will be at the market price, but a market sale price does not affect the plaintiff's damages. Imposing a mitigation requirement assumes that reasonable efforts on the plaintiff's part would produce another buyer who would overpay for the property. That view is, however, completely

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[36] 3 DAN B. DOBBS, LAW OF REMEDIES § 12.21(2) (2d ed. 1993); FISCHER, *supra* note 3, § 13.2.2.

[37] Besides the basic indemnity principle one can identify a plethora of insurance doctrines that are centered on the proposition that insurance should indemnify against loss, not provide a possibility of gain, for example, insurable interest requirements, subrogation rights, coinsurance requirements. Indeed, a primary argument for distinguishing insurance contracts from gambling contracts is that the prospect of gain only attaches to the latter.

[38] P. S. ATIYAH, THE RISE AND FALL OF FREEDOM OF CONTRACTS 759 (1979); Louis E. Wolcher, *The Accommodation of Regret in Contract Remedies*, 73 IOWA L. REV. 797, 876 (1988). I put aside arguments that the seller should not recover his expectancy.

inconsistent with the theory behind market valuation. If there were other buyers who would pay more than $100,000 for the property, $100,000 does not accurately reflect the property's actual market value. And if the property is actually worth more than $100,000, this necessarily reduces the plaintiff's expectancy. Either way, a mitigation obligation would have no impact on the measure of the plaintiff's loss.

Decisions like *Miller v. Mutual Life Ins. Co. of New York*[39] thus misapprehend when the mitigation principle is applied to a contract expectancy. The contract for widgets creates an expectancy, but the duty to mitigate still applies because the plaintiff has the power post-breach to ameliorate the scope of the loss. It is only in those situations when the plaintiff is entitled to the expectancy and reasonable conduct by the plaintiff, post-breach, will not affect the expectancy that the mitigation principle is set aside.

2. Confusion of the Insured's Legal Position

In an early case, *Noshey v. American Auto. Ins. Co.*,[40] the court excused the non-breaching party (the insured) from a duty to mitigate. Imposing such a requirement the court thought might subject the insured to a claim by the breaching party (the insurer) that it (the insured) had violated terms of the insurance contract in the effort to mitigate, particularly the no-settlement without insurer consent provision.[41] The idea that mitigation does not require a party to undermine its legal right is well settled. A party need not mitigate when doing so would compromise the mitigating party's legal position vis-a-vis that party's adversary. For example, a party need not mitigate when seeking the remedy of specific performance because the duty to mitigate is directly inconsistent with the legal right.[42]

To the extent that the insured faces a credible threat that mitigation efforts may compromise the claim against the insurer, no duty to mitigate should be imposed. An insured who has been denied disability benefits because the insurer contends she is able to work should not be required to

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[39] *See Miller*, 289 N.W. at 402. For further discussion, *see supra* note 35.

[40] Noshey v. Am. Auto. Ins. Co., 68 F.2d 808 (6th Cir. 1934).

[41] *Id.* at 810.

[42] Redman v. Dep't of Educ., 519 P.2d 760, 769 (Alaska 1974) (finding that an employee is not required to accept alternative employment that would compromise her claim to reinstatement); Billetter v. Posell, 211 P.2d 621, 623 (Cal. Ct. App. 1949) (stating that one employed for a definite period of time, at an agreed rate and wrongfully discharged before the expiration of his period of employment may refuse his employer's offer of reinstatement when the acceptance of such an offer would amount to a modification of the original contract or to a waiver of his rights to recover according to its terms).

seek and accept work to mitigate damages.[43] Here, plaintiff's efforts to mitigate damages (work) would compromise the merits of her legal claim that she is entitled to disability benefits because she cannot work. Mitigation adds nothing to the controversy. Either the plaintiff can work – in which case she is not entitled to benefits – or she cannot work – in which case she is entitled to benefits.[44] On the other hand, when no reasonable likelihood exists that mitigation would compromise the insured's legal claim against the insurer, mitigation should not be precluded *per se*. This will often be the case in the context of breach of the duty to defend. The insurer's breach of its duty to defend typically excuses the insured's compliance with other terms and conditions of the policy such as the bar on settlements without the insurer's consent.[45] When the danger of confusing

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[43] Moots v. Bankers Life Co., 707 P.2d 1083, 1086 (Kan. Ct. App. 1985) ("It is well known that severely disabled persons, for reasons of physical and mental health, are frequently encouraged by their physicians to take some type of work as therapy. If insureds were able to follow such valuable medical advice only at the peril of losing their only real means of financial survival, we would create for the already disabled a heavy burden indeed. Further, an opposite result would put all insureds at the absolute mercy of their insurers. In such a situation, the insurer could simply terminate disability benefits, wait until the insured is driven by dire necessity to seek *any* kind of employment, and then justify the termination retrospectively based on the subsequent employment. In a society which values work and applauds extraordinary effort by the handicapped such a result would be anomalous, to say the least.").

[44] This is typically the case with disability insurance because the policies contain a "care and attendance" provision. This provision requires the insured to be under the care and attendance of a physician to receive benefits. Some courts have interpreted this provision as requiring the insured to abide by the physician's recommendations regarding treatment to continue to be eligible to receive benefits. *See Van Gemert*, F. Supp. 2d at 1051 (applying California Law: a disability policy that requires an insured claiming benefits to be "under the care and attendance" of a physician cannot reflect an intent of the parties that the insurer will be obligated to pay benefits even if the insured stubbornly refuses the only appropriate "care" recommended). Other courts, however, have read "care and attendance" provision as not requiring the insured to abide by a physician's recommendation of surgery in order to retain benefits. *See* Tittsworth v. Ohio Nat'l Life Ins. Co., 6 Tenn. App. 206 (1927).

[45] McNicholes v. Subotnik, 12 F.3d 105, 108 (8th Cir. 1993) (applying Minnesota law) ("When an insurer denies coverage, an insured defendant does not breach his duty to cooperate by entering a settlement with the plaintiff that serves the insured's best interests; indeed the defendant is expected to do so."). *See* Ellen Smith Pryor, *Comparative Fault and Insurance Bad Faith*, 72 TEX. L. REV. 1505, 1525 (1994) ("[G]enerally, the insurer's material breach of an express or implied duty will excuse the insured from complying with contractual duties.") (footnote omitted).

and/or compromising the insured's legal claim against the insurer does not reasonably exist, the argument against mitigation is mooted.

3. Lack of Connectivity Between Breach and Avoidable Losses

It has been argued the failure to settle after the insurer's refusal to defend its insured is not connected or sufficiently related to the loss; therefore, it should not be considered as reasonable, required mitigation. For example, one commentator argues:

> Failure to mitigate damages is a contract defense designed to reduce damages because the nonbreaching party failed to make reasonable and required efforts to minimize its losses. It applies against a claim that a liability insurer wrongfully failed or refused to defend, but it includes only conduct going to the provision of a defense, such as the insured's failure to hire a lawyer. It does not include matters not directly related to the provision of a defense. The insured's damages must flow as a result of the duty breached and as a result of the insured's self-protective responses to that breach. Thus, there is no duty under these circumstances to "mitigate damages by effecting a favorable settlement…"[46]

There are necessarily constraints on the scope of the duty to mitigate, but these are normally framed in terms of reasonableness. While it is true the insurer's contractual duty to defend does not, by its terms, include a duty to settle, the issue is the insured's proper response when the insurer breaches its obligation. The breaching party's duties do not define the measure of the non-breaching party's mitigation obligation, which accrues after breach and is responsive to the conditions created by the breach. Moreover, it is contestable that the duty to defend does not include a duty to settle; some courts have concluded that it does.[47] Finally, treating

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[46] DENNIS J. WALL, LITIGATION & PREVENTION OF INSURER BAD FAITH § 5.28 (3d ed. 2011) (footnotes omitted).

[47] Goddard *ex rel.* Estate of Goddard v. Framers Ins. Co. of Oregon, 22 P.3d 1224, 1227 (Or. Ct. App. 2001) ("The duty to defendant includes the duty to settle the case within the policy limits if it would be reasonable to do so."). *But see* Mowry v. Badger State Mut. Cas. Co., 385 N.W.2d 171, 187-88 (Wis. 1986) (Steinmetz, J., concurring) (distinguishing between contractual duties (defend and indemnify) from the extra contractual duty to settle). *See generally* Cindie Keegan McMahon, *Duty of Liability Insurer to Initiate Settlement Negotiations*, 51 A.L.R.

loss mitigation (settlement) as distinct from the breach is hard to square with the reality that the insured is seeking compensation for the breach that is the equivalent to what, in theory, could have been avoided. It is logically inconsistent to contend that the insured's losses are not connected to the breach for mitigation purposes, when measured in terms of avoidable losses (mitigation), but are caused by the breach when measured in terms of damages.

4. Mitigation Deprives the Insured of the Right to Specific Performance of the Insurer's Contractual Obligations

It is commonly recognized that no mitigation requirement attaches to a specific performance claim because a mitigation requirement is mutually exclusive to the claim.[48] If the plaintiff must mitigate, the plaintiff will lose the right to claim the defendant's contracted for performance. Although specific performance is not a perfect fit to the usual insurer breach claim, the thinking underlying the specific performance exception appears to underlie much of the reluctance to recognize a mitigation obligation when the insured seeks damages for insurer breach.

Jerry and Richmond identify a number of courts that have held, in the context of a breach of the duty to defend, that the duty to defend is excused because it is foreseeable that the non-breaching party (the insured) will not mitigate damages.[49] Jerry and Richmond note that under this rationale these courts excuse the duty to mitigate only for general damages; the duty to mitigate is imposed as to consequential damages. When the insurer breaches the duty to defend, the courts following this approach permit recovery up to policy limits (general damages) without imposing a mitigation requirement, but do impose such a requirement to the extent the insured seeks an excess-of-limits recovery (consequential damages).[50]

5th 701 (1997) (noting split in authority whether duty to defendant includes the duty to settle).

[48] Ash Park, LLC v. Alexander & Bishop, Ltd., 783 N.W.2d 294, 311 (Wis. 2010) (declining to impose a duty to mitigate on a seller who requests interest in addition to specific performance because recognizing such a duty would create practical that would effectively negate the availability of specific performance); *see* Thomas S. Ulen, *The Efficiency of Specific Performance: Toward a Unified Theory of Contract Remedies*, 83 MICH. L. REV. 341, 390 (1984) ("With specific performance there is no such obligation to mitigate, nor is it easy to see how such an obligation could be imposed under that contract remedy."); *see supra* note 42.

[49] ROBERT H. JERRY, II & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW §111(i) (5th ed. 2012).

[50] This same rationale appears in duty to pay cases. *See Miller*, 289 N.W. at 402. For further discussion, *see supra* note 35.

Jerry and Richmond rightly question whether the distinction can be squared with the test of foreseeability the courts purport to apply:

> The logic apparently underlying this rule is that it is foreseeable at the time of contracting that the insured will be unable to provide her own defense if the insurer fails to do so. The logic underlying recovery for the default judgment up to the policy limits but not in excess thereof is not as apparent. Insureds understandably argue that the entire amount of the judgment is the consequence of the insurer's breach, not just the portion within the policy limits.[51]

Jerry and Richmond are correct that the distinction drawn by courts is less than supportable under a foreseeability test; however, the limitation of the duty to mitigate to consequential damages is understandable when viewed through the lens of specific performance. If the gist of the action is to require the insurer to perform its contractual obligations, e.g., provide/pay for a defense and indemnify the insured up to policy limits, imposing a mitigation requirement can be seen as detracting from the insurer's contracted-for performance.

The specific performance argument is essentially the same as the "reasonable expectations" argument discussed earlier.[52] The "no mitigation" position lacks traction here as it did there. The fact is that the plaintiff is rarely suing for specific performance, which is equitable relief, or for temporary equitable relief, e.g., a preliminary injunction. The insured is seeking compensation for the harm incurred by the insurer's breach of its obligation. Confusion arises because the insurer's obligation is partially phrased in terms of an obligation to provide and pay for a defense and indemnify the insured. When the insured seeks monetary compensation for the insurer's breach of a duty to pay, it is easy to see how this may be equated to a performance like remedy. That equating, however, is neither accurate nor helpful. The insured does not seek an equitable remedy when suing the insurer for damages. The ability of the plaintiff to be fully made whole by an award of damages militates against a finding that specific performance is an appropriate remedy. The insured's claim against the insurer is no different from a seller's claim against a buyer. In both cases the claims are for money damages resulting from a contract. In neither case, absent a showing of irreparable injury, does the claim seek the actual performance due under the contract. Rather, in both

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[51] JERRY & RICHMOND, *supra* note 49, at 828.

[52] *See supra* notes 23-39 and accompanying text.

cases, the claim seeks compensation for losses caused by the defendant's breach.

It may be argued that, in the duty to defend context, insureds contract for a specific performance that only insurers can provide. Insurers are sophisticated, repeat players in the defense of civil actions. Insurers also employ experienced attorneys, at discount prices, to defend insureds. Insureds for the most part cannot duplicate these advantages that insurers bring to civil litigation defense. This argument, while factually accurate in its assertions regarding insurer capabilities is misplaced when it comes to the issue of the insured's duty to mitigate.[53]

The no mitigation position has some salience if the insured actually seeks specific performance of the insurer's duty to defend to obtain the benefits listed above.[54] In this context, the insured is claiming a specific performance (defense by the insurer) that would be negated if the insured was required to mitigate damages, such as by assuming the defense of the claim. That is a rare occurrence. Few insureds seek specific performance because it is unlikely a court would treat the injury alleged (failure of the insurer to provide a defense) as sufficiently unique and irreplaceable as to satisfy the irreparable injury requirement that is a precondition to equitable relief.[55]

A defense by counsel retained by the insurer is not likely to be meaningfully different from a defense by counsel retained by the insured. This is not to denigrate the experience and competence of retained defense

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[53] An anonymous reviewer suggested this perceptive argument while the *Connecticut Insurance Law Journal* was considering this article for publication.

[54] *See* XL Specialty Ins. Co. v. Level Global Investors, L.P., 874 F. Supp. 2d 263, 273-74 (S.D.N.Y. 2012) (holding that insurer's failure to pay defense costs under a professional liability policy at the time they were incurred constituted an immediate and direct injury sufficient to satisfy the irreparable harm requirement for preliminary injunction).

[55] *See* Dover Steel Co. v. Hartford Accident & Indem. Co., 806 F. Supp. 63, 66-67 (E.D. Pa. 1992) (holding that insured had an adequate remedy at law by way of damages for insurer's failure to pay defense costs; moreover, granting preliminary injunction would give the insured the very relief the insured was seeking in the litigation); *cf.* Weathersby v. Gore, 556 F.2d 1247, 1258-59 (5th Cir. 1977):

> Weathersby was adequately protected from any damages occasioned by Gore's breach of the contract, if any occurred. He could have acquired additional cotton on the open market when Gore informed him he would no longer perform under contract. He did not do so and thus, if entitled to damages at all, must settle for the difference between the contract and the market price at the time Gore cancelled.

counsel hired by insurers. It simply reflects the reality that an insured who can mitigate damages, i.e., has the resources to retain defense counsel, faces no significant impediment to securing competent legal assistance. Of course, if the insured lacks the financial resources to secure counsel, the mitigation issue is elided. The insured need not do what he is not reasonably able to do. If the insurer's refusal to defend is deemed wrongful, the insurer will ultimately reap the consequences of its shortsighted decision.

Even if retained defense counsel provided by the insurer were deemed qualitatively better than defense counsel that would be retained by the insured, it is questionable whether a court would specifically enforce the insurer's duty to defend. A court might have reservations about its ability to specify in sufficient detail the insurer's obligations if specific performance was ordered. What after all is the content of the duty to defend? An order that the insurer defend the insured, without further elaboration, would be vulnerable to the claim that the order was imprecise and uncertain.[56] Providing the required precision might involve the court in a degree of day-to-day supervision of the defense that courts would prefer to avoid.[57] Should the order to defend specify whether depositions should be taken and, if so, of whom? Should the order specify whether experts are to be retained and, if so, whom and how much should they be paid? Should the order specify whether the matter should be jury tried, whether summary judgment motions should be filed, etc. How would a court determine whether the order to defend was being observed by the insurer? Either the order would be massively detailed or the parties would be constantly before the court seeking clarification and instruction. Neither approach is likely to encounter judicial favor.

If the insured seeks damages, as is generally the case when the insured fails to defend, the insured has conceded that monetary compensation is an adequate remedy for the insurer's breach. When damages become the issue, the focus is now properly directed on the actual cause of the monetary losses. This brings into consideration the issue of mitigation, which asks no more than who (plaintiff or defendant) was the

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[56] *See* 1 DOBBS, *supra* note 36, §2.8(7), at 12 (noting that "as a matter of substantive and procedural justice" injunctions must be clear and understandable as to what the defendant must or must not do, otherwise the injunction is not valid); FISCHER, *supra* note 3, §34, at 1 ("An injunction must be 'specific and definite' if it is to be enforceable.").

[57] *See* 1 DOBBS, *supra* note 36, §2.5(4), at 12 (noting traditional judicial reluctance to issue orders in private disputes that require substantial judicial oversight); FISCHER, *supra* note 3, §24, at 1 (noting traditional judicial reluctance to issue orders in private disputes that require substantial judicial oversight).

actual cause of the monetary losses the plaintiff seeks to recover.[58] Whether the plaintiff (insured) acted reasonably in seeking to mitigate damages post-breach is not the issue here – although it clearly will play a significant role in actual cases. The issue here is whether there is a duty to mitigate at all, which is anterior to the question whether the plaintiff properly discharged that duty.

Insureds contract for specific types of performances by insurers. The failure on the insurer's part to provide that performance does not mean that the insured's claim for damages is analogous to a specific performance claim. Insurance contract exceptionalism, insofar as the duty to mitigate is concerned, must turn on public policy factors that are unique to insurance contracts. It is to that issue, this paper now turns.

5. Insurer Bad Faith Should Excuse the Duty to Mitigate

Should the duty to mitigate turn on whether the insurer acted in bad faith?[59] The mitigation obligation has not been deemed to turn on the defendant's state of mind or motivation for breaching its legal obligation. This follows from the causal underpinnings of the mitigation requirement,[60] which applies independently from the defendant's motivation and state of mind. There is some support for excusing the mitigation requirement when the defendant engages in intentional misconduct,[61] but this exception is buttressed on the thesis that the mitigation requirement should not require the plaintiff to surrender a right of substantial value, e.g., submit to extortionistic demands to mitigate damages.[62] As discussed previously, in the insurance context a mitigation requirement does not require the plaintiff insured to surrender a right of substantial value.[63]

Excusing the duty to defend when the insurer acted in bad faith would be difficult to implement as a practical matter. The line that separates simple breach from bad faith breach is difficult to define in practice. Disagreement whether insurer conduct evidenced bad faith or not

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[58] *See supra* note 7 and accompanying text; *see infra* notes 65-66 and accompanying text.

[59] The reviewer of this article perceptively raised this question.

[60] *See supra* note 7 and accompanying text.

[61] RESTATEMENT (SECOND) OF TORTS § 918(2) (1977).

[62] *Compare* Sinclair v. Fotomat Corp., 189 Cal. Rptr. 393 (Cal. Ct. App. 1983), ordered not published per Cal. R. Court 976(c) (requiring plaintiff to pay illegal charge of $1 to reacquire his property (film) in order to mitigate his damages), *with* O'Brien v. Isaacs, 116 N.W.2d 246 (Wis. 1962) (requiring plaintiff to pay $1 illegal charge to retrieve his property (car)).

[63] *See supra* notes 29-39 and accompanying text.

is endemic among lawyers and commentators.[64] And even if a bad faith exception were recognized, the determination whether the breach was in bad faith or not would occur long after the time mitigation would have practical value. An insured who by passed a reasonable opportunity to mitigate in effect assumes the risk that the court will ultimately conclude the insurer acted in bad faith. If the court finds that the insurer breached, but the breach did not amount to bad faith, the insured would be deemed to have failed to mitigate. One suspects that even if a bad faith exception to the duty to mitigate was recognized in theory, insureds who could mitigate would mitigate rather than assume the risk that they would be exposed to a *ex post* mitigation requirement.

D. SHOULD INSUREDS BE REQUIRED TO MITIGATE WHEN SEEKING DAMAGES CAUSED BY INSURER BREACH?

The duty to mitigate is modernly predicated on the belief that losses resulting from a legal wrong should be minimized and that regardless of the initial cause of the loss, when a party could, through reasonable care, ameliorate an existing loss, the law should incentivize that party to act.[65] The basic principle is one of legal responsibility for loss that reasonable conduct could have avoided.[66]

The idea that a plaintiff must always seek to reduce his losses through the exercise of reasonable diligence has not been enthusiastically embraced by all commentators. Professor Dobbs, for example, argued that mitigation is not required in two situations: (1) when a party bargains to avoid the requirement and (2) when enforcement of a mitigation

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[64] Bad faith is an imprecise label for what is essentially unreasonable insurer conduct. *See* Sharon Tennyson & William J. Warge, *The Law and Economics of FirstParty Insurance Bad Faith Liability*, 16 CONN. INS. L.J. 203, 208 (2009) (noting uncertainty over proper standard to determine whether an insurer has engaged in bad faith regarding a coverage decision and discussing various approaches used by courts to address the issue).

[65] RESTATEMENT (SECOND) OF CONTRACTS §350 cmt. a (1981) (stating that the policy behind the mitigation requirement is to encourage parties to avoid further loss); *cf.* RESTATEMENT (SECOND) OF TORTS §918 cmt. c (1977) (stating that mitigation principle is based on principle of causation; the party that fails to exercise reasonable care to prevent further loss should bear the loss that party has caused).

[66] *See* Douglas H. Cook, *Personal Responsibility and the Law of Torts*, 45 AM. U.L. REV. 1245, 1252 (1996) (noting that the mitigation is one of a number of common law doctrines that allocated to the plaintiff's responsibility for losses sustained through the actions of another).

requirement would encourage breach.[67] More directly, Dobbs suggested that these principles were particularly relevant to insurance contracts. First, insureds, as a group, bargain for a specific performance that a mitigation requirement would negate. Second, a mitigation requirement would subject insureds to opportunistic leverage by the insurer. Dobbs's first argument, exemplified by the duty to defend cases, that the insured has contracted for a specific performance – a defense, which a mitigation requirement would negate, has already been addressed in this paper. While insureds no doubt bargain for a specific performance, insureds are no different from all contracting parties who bargain for specific performances by their reciprocal contracting parties. Bargaining for a specific performance is, however, vastly different from the remedy of specific performance and Dobbs unfortunately confuses the two.

Dobbs's second argument is evidenced by the disability insurance cases. Here, the insured has contracted for benefits because he is unable to engage in certain types of gainful employment; yet, a mitigation requirement would require him to work and, at the same time, provide the insurer with some evidence that the insured is not disabled and not entitled to continuing benefits. Dobbs argues that a mitigation obligation would require the plaintiff to undermine his or her own claim and, thus, incentivize insurers to deny claims in the hope that the plaintiff's mitigation effort would demonstrate the correctness of the denial. In this sense Dobbs treats the mitigation requirement as opportunistic (my characterization not Dobbs) in that it allows the insurer to use the requirement to force the insured to undermine her own claim.

The "no mitigation" argument relieves the insured of any duty to exercise reasonable care to reduce his losses. The problem is carving out a "no mitigation" requirement exception for insurance contracts cannot be justified by treating insurance contracts as different from other contracts without identifying a reason for different treatment. The proponents of a "no mitigation" requirement have not done this.[68] Every claim that is subject to a mitigation requirement presents the potential that the plaintiff's efforts to mitigate will work against the overall success of the claim. The landlord who must relet to mitigate damages defeats, to some extent, the claim against the tenant who abandons the leasehold, as does the buyer who must cover to mitigate losses when the seller breaches and refuses to

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[67] 1 DOBBS, *supra* note 36, §3.9, at 385.

[68] This is not to say that insurance contracts are not different in some respects from ordinary contracts. I acknowledge that they are. *See supra* notes 29-39 and accompanying text. The issue is whether the differences warrant nonapplication of the general requirement that a plaintiff exercise a reasonable care to mitigate losses.

deliver contracted-for goods. The insured who must mitigate is in no different position. It is difficult to see how tenants or sellers are any more or less opportunistic than insurers when it comes to breach.

While a generalized, unproven concern regarding incentives to breach does not justify negating a mitigation requirement, there are situations when a mitigation requirement should not be recognized because it may confuse rather than enlighten. For example, in the disability cases there is usually a substantial overlap between the insurer's claim the insured is not disabled and the mitigation issue – are there reasonable steps the insured could take to ameliorate the disabling condition. In some cases, a duty to mitigate should not be recognized because the mitigation requirement is directly at odds with the contentions raised by the insurer as to its coverage obligations. Cases such as *Moots v. Bankers Life Company*[69] illustrate this point. When the insurer contends the insurer can work and, therefore, is not disabled, imposing a mitigation requirement on the insured that the insured find work can be reasonably understood as tending to encourage the breach. A mitigation requirement would give insurers unfair leverage in this situation.

Decisions like *Heller*[70] and *Miller*[71] are different, although the difference can be fine and nuanced. In these cases, there is some overlap between the insurer's no coverage position and the mitigation obligation. In *Heller* the issue is whether the insured should submit to surgery to ameliorate the disabling condition (Carpal Tunnel Syndrome). In *Miller* the issue is whether the insured should take insulin and watch his diet to control his disabling condition (diabetes). In these cases the insurer is not contending, as in *Moots,* that the insured is not disabled; rather, the insurer is conceding present disability if the condition is untreated, but arguing that the insured has the means to end the disabling condition. The position argued here is that in the latter situation the mitigation requirement is properly imposed. An insured should be required to expend reasonable efforts to reduce damages.

One can justify the "no mitigation" rule in true specific performance cases because specific performance is an equitable remedy that requires that the remedy at law be inadequate. In most cases, this requires that the subject matter for the contract be unique. A mitigation requirement may be truly inconsistent with the plaintiff's desired remedy because mitigation would deny the plaintiff the specific, unique thing that was contracted for initially and for which money is not an adequate substitute. Insurance contracts are, on the other hand, all about money.

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[69] *See supra* notes 43-44 and accompanying text.
[70] *Heller*, 833 F.2d 1253, *discussed supra* notes 15-17 and accompanying text.
[71] *Miller*, 289 N.W. 399, *discussed supra* note 35 and accompanying text.

There is nothing unique about the subject matter of the insurer's performance.[72] While an insurer's performance itself may not be substitutable because, in most cases, the insured cannot purchase a substitute insurance policy to cover a known, existent loss;[73] the fact remains that the insurer's performance is essentially an obligation to pay money, whether for a defense or for indemnity, and money is not unique.

Insurance contracts are different in some respects from other contracts and this has caused courts to treat them differently, particularly insofar as remedies for breach as concerned. I offered several doctrinal justifications for this approach in a prior paper.[74] Because of these differences, many courts permit tort-based[75] or extra-contractual remedies[76]

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[72] *See supra* notes 55-58 and accompanying text.

[73] ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW §5.3(a), at 475 (1988) (stating that it is a basic principle that insurance cover only the risk of fortuitous loss); 1A COUCH ON INSURANCE 3D §13:15 (2010) ("When the insured knows or has reason to know when it purchases a policy of insurance that there is a substantial probability that it will suffer or has already suffered a loss, the risk ceases to be contingent and becomes an uninsurable "known loss."); *see* Foley v. Interactive Data Corp., 765 P.2d 373, 39596 (Cal. 1988) (noting the special dilemma faced by an insured who cannot secure replacement insurance to cover the same loss).

[74] James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation: Text Versus Context*, 24 ARIZ. ST. L.J. 995 (1992) (noting, for example, the (1) quasipublic status of insurers, (2) informational asymmetry between insurer and insured, and (3) the desire to require insurers to internalize the costs of breach, among others).

[75] *See* DOUGLAS LAYCOCK, MODERN AMERICAN REMEDIES 6062 (4th ed. 2010) (stating that if the insurer refuses or delays payment in bad faith, the insured may recover consequential and punitive damages for nonpayment of a legitimate claim); Roger C. Henderson, *The Tort of Bad Faith in FirstParty Insurance Transactions: Refining the Standard of Culpability and Reformulating the Remedies by Statute*, 26 U. MICH. J.L. REFORM 1, 2226 (1992) (describing the creation of the tort of insurer bad faith); *see generally* A. S. Klein, Annotation, *Insurer's Liability for Consequential or Punitive Damages for Wrongful Delay or Refusal to Make Payments Due Under Contracts*, 47 A.L.R.3d 314 (1973).

[76] BiEconomy Market, Inc. v. Harleysville Ins. Co. of New York, 886 N.E.2d 127, 132 (N.Y. 2008) (holding that an insured may recover consequential damages flowing from an insurer's breach of an insurance contract); the traditional rule in the United States when a breaching party failed to pay a claim was to limit the nonbreaching party's recovery to the sum owed but not paid by the breaching party, plus delay damages in the form of prejudgment interest. *See, e.g.*, Loudon v. Taxing Dist., 104 U.S. 771, 774 (1881) (holding that an aggrieved party in a contract action is entitled only to the amount owed and any interest that has accrued during the delay period). *See generally* 11 SAMUEL WILLISTON, A TREATISE ON THE LAW OF CONTRACTS §1410, at 60406 (Walter H.E. Jaeger ed., 3d

to discourage opportunistic breaches by insurers. Would a mitigation requirement encourage insurers to breach? If so, this would support not imposing such a requirement on insureds.

There is no empirical evidence one way or the other as to whether a mitigation requirement has any impact on the insurer's decision to breach. It is reasonable to suppose that any rule that reduces the cost of breach produces some incentive, to a rational actor, to breach, all other things being equal. This supposition may not, however, reflect the actual world of insurer breaches. All other things are rarely equal and the incremental push toward breach that a mitigation requirement could provide in theory may be too small to measure in practice, much less attribute significance to in calculating legal responses. For example, the threat of consequential and punitive damages for breach may nullify any offsetting benefits a rational insurer could derive from breach. The assumption that the insurer acts rationally in deciding whether to breach may also be questioned. Insurers are large, diverse organizations and identifying how a decision is made, much less why it was made, may be challenging. Moreover, rationality may be compromised or preempted by cognitive biases that distort decision making and result in decisions inconsistent with the actual facts and not in the best interests of the insurer. Incentives don't work effectively unless the responding parties understand the signal the incentive is sending.

While one must be respectful of known unknowns, the lack of empirical evidence and the uncertainty of reasoned speculation cuts both ways; a mitigation requirement is neither supported nor derailed. Notwithstanding this uncertainty, the position taken here is that a mitigation requirement should be imposed on the insured for the following reasons.

First, mitigation does not impose a heavy burden on the insureds. An insured must act reasonably to mitigate breach related losses.[77] Moreover, what is reasonable is determined based on the facts realistically available to the insured when mitigation is required.[78] A party who makes, with the benefit of 20/20 hindsight, a bad choice does not fail to mitigate damages if the choice was reasonable under the circumstances as they existed at the time of the party acted.[79]

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ed. 1968) (citing several cases in which the only relief awarded in a suit for nonpayment of a debt was the debt itself plus interested from the time due); CHARLES T. MCCORMICK, HANDBOOK ON THE LAW OF DAMAGES §139, at 569 n.28 (1935) (citing cases in which recovery for "normal damage" resulting from breach of contract to lend money was limited to excess costs incurred in securing a loan elsewhere).

[77] FISCHER, *supra* note 3, at 134.

[78] *Id.*

[79] RESTATEMENT (SECOND) OF CONTRACTS § 350(2) cmt. b (1981).

Second, mitigation does not require a party to do what that party cannot do. It is a difficult proposition to sustain, as the "no mitigation" advocates must, that acting reasonably is undesirable. If the insurer refuses to defend the insured, the insured need not reduce himself to poverty to defend the claim.[80] Rather the insured may enter into a reasonable, non-collusive settlement of the dispute even if the insured has a good defense to the claim.[81] In disability insurance context, why should an insured be incentivized to reject reasonable efforts to reduce or cure the disabling condition? In *Miller v. Mutual Life Ins. Co. of New York* the court upheld the insured's decision to refrain from taking insulin or following a physician recommended diet to control his disabling condition (diabetes) on the rationale the insured owed no duty to mitigate damages.[82] What social policy is advanced here? Recognizing a duty to mitigate would at least permit a trier-of-fact to assess whether the insured's conduct was reasonable. If the insured has a reasonable basis for not taking insulin or watching his diet, the mitigation requirement is met. The "no mitigation" approach encourages unreasonable conduct. How is that beneficial or a goal to be advanced by insurance law?

Third, mitigation doctrine has always been respectful of the right of the plaintiff to maintain his bodily and personal integrity, which need not be compromised to reduce the defendant's damages exposure. The plaintiff need not expose himself to risk nor must the plaintiff accept a materially different outcome as a substitute for the defendant's promised performance.[83] The mitigation requirement has always been tempered with the realization that the plaintiff's mitigation obligation is not one that was voluntarily assumed, but is one that has been imposed by the defendant's commission of a legal wrong. In this regard, courts and juries tend to give plaintiffs substantial space by viewing the reasonableness requirement elastically and with a pro-plaintiff bias.[84] Concerns that a mitigation requirement will provide insurers with a cudgel they can use to attack their insureds are unrealistic.

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[80] *See* Damron v. Sledge, 460 P.2d 997, 999 (Ariz. 1969) (stating that when the insured is exposed by his insurer "to the sharp thrust of personal liability . . . [h]e need not indulge in financial masochism").

[81] *See* Arizona Prop. & Cas. Ins. Guar. Fund v. Helme, 735 P.2d 451, 460 (Ariz. 1987) (holding that insurer breach permits the insured to enter into a reasonable settlement, as long as the settlement is not fraudulent, collusive, or against public policy). 2 WINDT, *supra* note 14, §6.29, at 6236.

[82] *Miller*, 289 N.W. at 402.

[83] 1 DOBBS *supra* note 36, § 3.9, at 382 ("The plaintiff is not required to accept great risks, undertake heroic measures, or accept great personal sacrifice to minimize damages for the benefit of the defendant.").

[84] *See* FISCHER, *supra* note 3, at 135.

Fourth, it is difficult to avoid the force of the basic argument that the insured should act reasonably, when he can do so to mitigate damages. It may be argued that greater damages will result in a greater sanction and, thus, greater deterrence to insurer breach. There is, no doubt, some truth to the basic proposition, but the question courts must ask is how much sanction can one impose before the sanction loses its compensatory element and become punitive? And even if a punitive measure of damages is warranted, is encouraging the insured to act unreasonably a good method of punishing the insurer for its breach?

Fifth, courts have not extended the "no mitigation" rule to contractual expectancies that contain a durational element. By a durational element I mean a contract that envisions that a party's performance will extend over a period of time. A contract of sale is usually not a durational contract because it envisions a specific closing date when performance is due. Employment contracts are examples of contracts that are durational.[85] The bargained for earnings are a contract expectancy, yet since the 19th century courts have imposed a mitigation obligation on the non-breaching employee. The underlying reason here was moral concerns over encouraged idleness and abnegation of a social duty to be a productive member of society. Insurance contracts often possess this durational element. In the liability and disability insurance context where the mitigation argument has been most frequently claimed and challenged, the insurer's obligations are often continuing, for example, the providing of a defense to a claim against the insured or the providing of periodic payments to an insured. In this sense, insurance contracts possess an element that aligns them with employment contracts.

This common element supports assigning a mitigation requirement to insureds even though they are seeking nothing more than the performance that was promised them under the insurance contract. The durational element creates the opportunity post-breach for the insured to reduce the quantum of loss. Because the loss is ongoing, mitigation efforts parallel the onset of each loss producing event. And because the insurance contract is designed to indemnify against loss, rather than produce a windfall, mitigation efforts directly correlate with both the actual realization of loss and the quantification of that loss. The insured has meaningful control over the realization or size of the loss. This is a valid reason for requiring the insured to act reasonably to mitigate that loss.

A reviewer of this Article raised the provocative question whether instead of imposing a duty to mitigate on insureds a better approach would be to require insurers to timely commence declaratory relief actions when coverage disputes arise between the insurer and the insured. Quicker

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[85] *See Id.* at 136-39.

resolution of coverage disputes would address some of the concerns raised in this paper. Unfortunately, use of declaratory relief is unlikely to affect the mitigation issue unless the insurer is required to perform under the insurance contract (e.g., pay or defend) until the declaratory relief action is resolved. Insurers are unlikely to accept this as a fair resolution of the controversy. Absent the imposition of an ongoing duty to perform, institution of declaratory relief does not avoid the mitigation issue. Litigation tends to be a long, drawn out process, to which declaratory relief is no exception.[86] During that time period, the insured may be able to ameliorate his losses by exercising reasonable care. The position asserted in this Article is that when that situation presents, the insured should be required to exercise reasonable care to do so. If he does not, his recovery should be reduced *pro tanto*.

D. CONCLUSION

The duty to mitigate has been aptly described as "an application of common sense."[87] Rejecting a duty to mitigate adopts the views that damages post-injury should be augmented rather than lessened. Mitigation asks no more of the plaintiff than to act reasonably under the circumstances to ameliorate the plaintiff's own injuries. That is not an unreasonable expectation. If the plaintiff fails to act reasonably, that is ample justification to hold the plaintiff responsible for the resulting losses reasonable care would have avoided.

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[86] In some jurisdictions, courts defer resolving declaratory relief claims (e.g. no duty to defend) until the related litigation (claim against the insured for which the insured seeks a defense) is resolved. *See* Johansen v. California State Auto. Ass'n InterIns. Bureau, 538 P.2d 744, 752 (Cal. 1975) (holding that the insurer does not have right to delay trial of a personal injury action in which its insured is a defendant pending resolution of a declaratory relief action in which the issue of coverage is to be determined); *cf.* Zurich Ins. Co. v. Rombough, 180 N.W.2d 775, 778 (Mich. 1970) (holding that permitting insurer to pursue declaratory relief would impede resolution of the underlying lawsuit).

In these jurisdictions, resort to declaratory relief would not help resolve the mitigation issue. Other jurisdictions take the opposite approach, seeing declaratory relief as an expeditious means of reducing confusion and avoiding needless delay and expense. *See* Elliot v. Donahue, 485 N.W.2d 403, 406 (Wis. 1992) (requiring insurer to institute declaratory relief action to resolve coverage dispute with insured). *See generally* Davis J. Howard, *Declaratory Judgment Coverage Actions: A Multistate Survey and Analysis and State Versus Federal Law Comparison,* 21 OHIO N.U. L. REV. 13 (1994).

[87] 3 JACOB A. STEIN, PERSONAL INJURY DAMAGES TREATISE § 18:1 (3d ed. 2012).

PEICL – THE PROJECT OF A EUROPEAN INSURANCE CONTRACT LAW*

CHRISTIAN ARMBRUESTER**

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This article discusses the newly drafted "Principles of European Insurance Contract Law" (PEICL). The article explores the possibility of the PEICL becoming an optional legal instrument that parties to an insurance contract may use as an alternative to relaying on the laws of the various Member States in the European Union. The article includes an in-depth investigation of the PEICL and concludes that while the draft language could benefit from certain adjustments, it nonetheless offers a strong basis for discussion amongst policymakers in the European Union and the U.S.

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I. INTRODUCTION

From a U.S. perspective it used to be quite a difficult task to become acquainted with the main principles that govern insurance contract law within the European Union, as each of the twenty-seven Member States have their own law, and in addition the legal traditions that are reflected in these laws vary considerably. However a recent initiative for a European Insurance Contract Law has changed the situation. This set of rules has been elaborated on the basis of a thorough comparative analysis of the existing laws. The initiative, which has recently been expedited by the European Commission, has led to a draft statute that shall be discussed here, as it might offer some inspiration for future law reform in the U.S. and other countries.

The initiative mentioned above has to be seen in the context of a broader project of a common European contract law. This project has led to the publication of the so-called Draft Common Frame of Reference (DCFR).[1] While only few references to insurance contracts can be found in

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* Updated written version of a talk given at the University of Connecticut Insurance Law Center on January 30, 2013. See Studi in onore di Aldo Frignani, 2011, pp. 51-75 ss.

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[1] PRINCIPLES, DEFINITIONS AND MODELS OF EUROPEAN PRIVATE LAW: DRAFT COMMON FRAME OF REFERENCE (2008) [hereinafter 'DCFR']; *see generally Proposal for a Regulation of the European Parliament and of the Council on a*

the index of the DCFR, this does not mean that no detailed provisions regarding the common European insurance law could be found. On the contrary, a "Project Group on a Restatement of European Insurance Contract Law", founded by Fritz Reichert-Facilides and now led by Helmut Heiss, has drafted a comprehensive set of rules called the "Principles of European Insurance Contract Law" (PEICL).[2] The draft dated 1 August 2009 is accessible online under www.restatement.info.

The PEICL rules are strongly connected to a project that has been discussed for decades within the European Union: the development of a common European insurance contract law. As early as in 1979, the Commission published the first and quite ambitious draft of a Directive.3 This draft included rules on classical insurance contract law topics such as the reduction of risk and the payment of premiums. During the following decades, however, the Commission focused on the harmonization of the conflict of law rules for insurance contracts while the draft for a harmonization of material insurance contract law seemed to be almost forgotten.

Now with the PEICL – following the DCFR – a new attempt has been made to develop a consistent European insurance law. On January 17, 2013 the European Commission set up an Expert Group that is aimed at analysing the need for a common insurance contract law.4 The main task of this Expert Group will be to examine whether differences in contract law pose an obstacle to cross-border trade in insurance products, and to identify such products.

The PEICL are neither aiming at a European Directive, nor at a mere restatement of the law in force, but rather at an "optional instrument" which is at the disposition of the parties. Thus the PEICL shall apply when the parties have agreed that their contract shall be governed by them (Art. 1:102 PEICL).[5] The technique of an "optional instrument" is remarkable in

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Common European Sales Law, COM (2011) 635 final (Oct. 11. 2011), for the European Commission's 2011 proposal of a common European sales law.

[2] *See* Hulmut Heiss, *The Common Frame of Reference (CFR) of European Insurance Law*, *in* CFR AND EXISTING EC CONTRACT LAW, 229 (Reiner Shulze ed., Sellier 2008). For more information on the goals and intentions of this project; see also Christian Armbruester, *Das Versicherungsrecht im* CFR 775, (2008) for a comparison to the reformed German Insurance Contract Law offer by the author.

[3] See Commission Proposal for a Council Directive on the Coordination of Laws, Regulations and Administrative Provisions Relating to Insurance Contracts, O.J. C 190/2 (July 10, 1979).

[4] Commission Decision of 17 January 2013 on setting up the Commission Expert Group on a European Insurance Contract Law, 2013 O.J. C 16/6.

[5] Principles of European Insurance Contract Law art. 1:102 (2009) [hereinafter PEICL].

several respects. It gives parties a choice between the laws that govern the contract under Private International Law and an alternative set of rules. At the same time if the PEICL turn out to be considered an attractive alternative to domestic law by the parties of insurance contracts this may encourage Member states to change their domestic laws in order to make them more attractive for those parties. However until now the PEICL are just a proposal by a working group; they are not in any sense binding law. In order to provide such a choice for the parties, the European Union would have to formally admit such an "optional instrument". Today no one can predict the likelihood of such a step, by which Member states would put their national insurance contract laws at the disposal of the parties to the insurance contract. In any case the PEICL provide an important basis for the further discussion about a common European insurance contract law.[6]

A. DESCRIPTION AND ASSESSMENT OF THE ESSENTIAL PARTS OF THE PEICL

The draft of PEICL dated August 1, 2009 consists of four parts. Part One contains common provisions, Part Two comprises provisions common to indemnity insurance, Part Three focuses on provisions common to the insurance of fixed sums, and the final Part Four is dedicated to special provisions. While Parts One and Two already contain a considerable number of provisions, there are no special provisions yet, and in Part Three, for the time being, only an enumeration of different insurances (Art. 14:101 PEICL) can be found. In the following analysis the provisions shall be both explained and critically assessed.

II. COMMON PROVISIONS (PART ONE)

A. INTRODUCTORY PROVISIONS (CHAPTER ONE)

1. Application of the PEICL (Art. 1:101 – Art. 1:105 PEICL)

Art. 1:101 PEICL clarifies that the PEICL shall apply to private insurance in general, including mutual insurance. Their application to the highly professionalized area of reinsurance is excluded, as legal provisions of contract insurance law which are mandatory or half-mandatory (i.e., mandatory insofar as they offer an advantage for the insured) are, in general,

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[6] *See* Daniela Weber-Rey, *Harmonisation of European Insurance Contract Law, in* THE HARMONISATION OF EUROPEAN CONTRACT LAW: IMPLICATIONS FOR EUROPEAN PRIVATE LAWS, BUSINESS AND LEGAL PRACTICE 207 (Stefan Vogenauer & Stephen Weatherill eds., Hart Publishing 2006).

meant to protect the insured, whereas professional market participants such as insurers and reinsurers do not need such protection. Therefore, professional participants do not need the type of general framework that PEICL provides because they have the sophistication and bargaining power to protect themselves when negotiating individual agreements.

A very important rule concerning PEICL's optional use – especially in context with the private international law – is contained in Art. 1:102 sentence 1 PEICL. According to this provision the PEICL rules apply whenever the parties have agreed that their contract shall be governed by them (notwithstanding any limitations of choice of law under private international law). This is necessary in case that – according to private international law – the contract is governed by the law of a state that is not a Member of the European Union and that state's law does not allow parties to choose the PEICL.

However it is not entirely clear whether any restrictions concerning the choice of law – in case the law of a Member state of the European Union governs the contract – also affect the PEICL. As the PEICL are an "optional instrument" that is destined to become part of European law[7] (e.g., by regulation), any restrictions on the choice of law in the law of the Member states as shaped by the Rome I Regulation or the Directives concerning international insurance contract law cannot apply.[8] Art. 1:102 sentence 1 PEICL needs to confirm that outcome by more clearly stating that PEICL only refers to restrictions of the choice of law in non-EU states but not in Member states.

According to Art. 1:102 sentence 1 PEICL, the possibility of agreeing on the application of the PEICL is independent from the connection of the contract to one or more Member states. The PEICL are therefore applicable as well if the contract has no connection to more than just one Member state,[9] notwithstanding the fact that the PEICL are aimed at harmonizing the different national insurance contract laws and thus at helping to realise the single European Market in the insurance sector. Art. 1:102 sentence 1 PEICL offers parties – even if they are doing business exclusively in their common domestic market – a second set of rules beside the domestic insurance contract law. This may indeed help to simplify the insurer's actuarial calculations, especially with regard to risk pooling.[10] At

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[7] *See* Heiss, *supra* note 2, at 242 (explaining what an "optional instrument" is); *see also* Jurgen Basedow, *Der Gemeinsame Referenzrahmen und das Versicherungsvertragsrecht*, *in* ZEITSCHRIFT FÜR EUROPÄISCHES PRIVATRECHT 280, 285 (2007).

[8] Heiss, *supra* note 2, at 240.

[9] Heiss, *supra* note 2, at 229, 240, 250.

[10] Heiss, *supra* note 2, at 229, 246.

the same time the PEICL compete with the national insurance law systems. If the PEICL are seen as a first step on the way towards a common European insurance law this might be considered to be an advantage, as the national legislators could be forced to adjust their national provisions at least in a few significant points. However, it is uncertain whether Member states are willing to accept this type of pressure with respect to a sector that is only partly covered by the law-making competence of the European Union.[11] Furthermore, it remains unclear if the parties to a contract that is related only to one single state will be ready to agree on the application of the PEICL, especially if national provisions are imperative.[12]

It is very reasonable that the parties cannot agree just partly on the application of the PEICL, but that if they want them they have to agree on them as a whole.[13] This rule prevents abuse[14] and helps to keep contracts understandable and clear. Furthermore fewer doublings or gaps are to be expected if there is only one law that governs the contract and if interpretation rules are the same for the whole contract.[15]

It is a different question whether the PEICL are binding or whether they may be modified by agreement of the parties. According to Art. 1:103 (1) PEICL, some provisions which are not yet finally enumerated shall be mandatory. As Art. 1:103 (2) PEICL shows, the basic rule, however, is that the contract may derogate from all other provisions of the PEICL as long as such derogation is not to the detriment of the policyholder, the insured, or the beneficiary. Exceptions are made, generally speaking, for major risks as defined in European Directives[16] as well.

The rule of Art. 1:104 sentence 1 PEICL on interpretation of PEICL provisions states what may be considered as *opinio comunis* (common opinion) in European law. Thus, interpretation is based on the wording, context, and purpose of the respective PEICL rule. Besides, the

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[11] The Treaty on the Functioning of the European Union (TFEU) does not grant the EU comprehensive law-making competence in the field of contract law but only with regard to specific issues such as consumer protection. Von Christian Armbrüster, Ein *Schuldvertragsrecht für Europa? Bemerkungen zur Privatrechtsangleichung in der Europäischen Union nach "Maastricht" und "Keck" in* RABELS ZEITSCHRIFT 72 (1996).

[12] Heiss, *supra* note 2, at 241.

[13] PEICL, *supra* note 5, at art. 1:102 sentence 2.

[14] Heiss, *supra* note 2, at 229, 248; Petr Dobiáš, *Insurance Soft Law?, in* PRINCIPLES OF EUROPEAN INSURANCE CONTRACT LAW 287, 289-95 (Jürgen Basedow et al., 2009).

[15] Dobiáš, *supra* note 14, at 289, 295.

[16] Council Directive 73/239, art. 35, 1973-2013 O.J. (L 228) 3-19 (EC); Directive 2001/83, of the European Parliament and of the Council as of 5 November 2002 concerning life insurance, 2002 O.J. (L 345) 1.

comparative background of the PEICL shall be taken into account. This is essential as the PEICL are modelled on national provisions and have been developed on the basis of a comparative analysis of European principles of insurance law. However, taking into account the comparative background may lead to some difficulties, especially as European law and the PEICL are to be interpreted autonomously, *i.e.*, independently from national perceptions. Interpretation is made much easier by the comprehensive comparative remarks regarding the single rules that have been published along with the PEICL, including hints concerning possible alternatives that are discussed.[17]

According to Art. 1:104 sentence 2 PEICL, good faith and fair dealing in the insurance sector is a key canon of interpretation, in addition to the principles of certainty in contractual relationships, uniformity of application,[18] and the adequate protection of policyholders. Some of these canons have also been laid down in I.-I:102 DCFR, while some others are not expressly mentioned in the PEICL, e.g. the fundamental freedoms granted by the EU.[19] In this respect, harmonization seems necessary, especially with regard to the principle of protection of policyholders. The latter is an indispensible element of the purpose of the provision, at least as mandatory provisions are concerned. If a provision, on the other hand, is not meant to protect the policyholder, this criterion cannot be taken into account for the interpretation.

As parties cannot agree on a partial application of the PEICL, no recourse to national law, whether to restrict or to supplement the PEICL, shall be permitted.[20] An exception is made in Art. 1:105 (1) sentence 2 PEICL for national laws specifically enacted for insurance branches which are not covered by special rules contained in the PEICL. Any questions arising from the insurance contract which are not expressly addressed in the PEICL are to be settled in conformity with the Principles of European Contract Law (PECL), and in the absence of relevant rules within that instrument, they shall be in accordance with the general principles common to the laws of the Member states. Obviously, the PEICL are not considered to be part of the PECL (now the DCFR).

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[17] PEICL, *supra* note 5; *see also* Jürgen Basedow & Till Fock, Europäisches Versicherungsvertragsrecht (Mohr Siebeck 2002).

[18] PEICL, *supra* note 5, at art. 7.

[19] The four basic freedoms guaranteed by the EU to each citizen are the freedom of movement of goods, the freedom of movement of persons, the right of establishment and the freedom to provide services, Treaty on the Functioning of the European Union art. 34, 45, 49, 57, Mar. 25, 1957 O.J. (C. 83) [hereinafter TFEU].

[20] PEICL, *supra* note 5, at art. 1:105 (1).

2. General rules (Art. 1:201 – 1:207 PEICL)

Art. 1:201 PEICL and 1:202 PEICL contain some definitions of essential terms. A number of important terms, however, are missing, e.g., "insurance money"[21] or "insurance benefits"[22], which are probably meant to be synonymous.

Art. 1:203 (1) PEICL is modelled on the provisions on transparency contained in the Directive on unfair terms in consumer contracts.[23] There are, however, no sanctions mentioned in case the insurer does not comply with these transparency requirements. Art. 1:203 (2) PEICL, modelled on Art. 5 (2) of the Directive,[24] stating that any doubt in interpretation must be resolved in favour of the policyholder, cannot be seen as a sanction. This is because there is a significant difference between transparency rules and interpretation rules. An application of II.-9:402 (2) DCFR is possible but is not satisfactory, as the PEICL are meant to be an independent set of rules.

Art. 1:203 (1) PEICL contains an important liberalization concerning the language of the contract. Until now, European rules in the insurance sector have hardly dealt with the question of the language in which the documents provided by the insurer are to be offered. It was considered a basic rule that the language of the Member state of the commitment [25] governed the whole contract. Usually, the contract is provided in the language of the Member state of the residence of the policyholder. According to Art. 1:203 (1) PEICL, all documents provided by the insurer shall be plain and intelligible and in the language in which the contract is negotiated. With regard to language, this rule offers an advantage for the insurer, which is not forced to translate documents in all languages spoken in the place of residence of any future clients. There is no express sanction for a breach of this rule, which is fine as it is to be expected that insurers will comply with the rule anyway. As to the transparency requirement, this is governed by a separate rule, which provides sanctions for opaque wordings.[26]

The burden of proving that the policyholder has received any documents to be provided by the insurer shall lie with the insurer.[27] This

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[21] PEICL, *supra* note 5, at art. 2:102(5).

[22] PEICL, *supra* note 5, at art. 7:102.

[23] Council Directive 93/13, of the European Parliament and of the Council of 5 April 1993 on unfair terms in consumer contracts, 1993 O.J. (L 95) 29.

[24] *Id.*; *see also* Dobias, *supra* note 14, at 289-95.

[25] Directive 2001/83, of the European Parliament and of the Council as of 5 November 2002 concerning life insurance, 2002 O.J. (L 345) 1.

[26] PEICL, *supra* note 5, at art. 2:304.

[27] PEICL, *supra* note 5, at art. 1:204.

provision might be misused by some policyholders, especially in cases when the beginning or expiration of a time limit depends on the receipt of the documents. Nevertheless, this rule on the burden of proof does not appear to be inappropriate. It is possible for the insurer to ensure the policyholder has received the documents, e.g. by using special methods of delivery or by asking the insured to confirm the receipt of documents. However, this can be costly, and in any case some risk of abuse remains. Therefore, Art. 1:204 PEICL should be modified and the proof relaxed, e.g., in case a policyholder repeatedly denies the reception of documents.

The "imputed knowledge" Art. 1:206 PEICL deals with is of particular practical impact. According to this provision, any knowledge persons entrusted by the policyholder have or ought to have is considered to be the knowledge of the policyholder. This rule does not just aim at proxies of the policyholder, but includes any person somehow entrusted by him.

Like the DCFR (II.-2:101 ff.), and unlike the PECL, the PEICL also include provisions concerning anti-discrimination. They are modelled on the Gender[28] and Anti-racism[29] Directives. Contrary to the Gender Directive, the PEICL does not prohibit all forms of gender-related distinctions. Based on Art. 5 (2) of the Gender Directive, Art. 1:207 (1) PEICL admits distinctions to be made if "the insurer shows that proportionate differences in individuals' premiums and benefits are based upon relevant and accurate actuarial and statistical data" (except for differences resulting from pregnancy and maternity). However, Art. 1:207 (1) PEICL does not have exactly the same wording as the Gender Directive, as the latter expressly states that it is legally sufficient if gender-related differences are a determining factor. Notwithstanding that difference, it is only necessary that the gender is one factor among others. This is due to the actuarial reality[30] and to multi-factorial calculation.[31] However, as the ECJ held on December 21, 2012, Art. 5 (2) of the Gender Directive is incompatible with EU anti-discrimination law as laid down in Art. 5 (1) of the Gender Directive, as well as in Art. 21,

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[28] Directive 2004/113, of the European Parliament and Council of 13 December 2004 implementing the principle of equal treatment between men and women in the access to and supply of goods and services, 2004 O.J. (L 373) 37.

[29] Directive 2000/43, of the European Parliament and of the Council of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin, 2000 O.J. (L 180) 22.

[30] *See* M. Wandt, Geschlechtsabhängige Tarifierung in der privaten Krankenversicherung 1341 (Marlene Danzl, 2009).

[31] *See* Christian Armbrüster, Bedeutung des Allgemeinen Gleichbehandlungsgesetzes für private Versicherungsverträge [Importance of the General Equal Treatment Act for Private Insurance Contract], VERSICHERUNGSRECHT (VERSR) 1297, 1300 (2006) (Ger.).

23 EU Charter, so that no gender-based distinctions are admissible,[32] Art. 1:207 (1) PEICL needs to be changed.

Nationality, "racial" or ethnic origin may – the latter in accordance with the Anti-Racism Directive – never justify differences in individuals' premiums and benefits.[33] Any contract terms in breach of Art. 1:207 (2) PEICL, including those concerning the premium, are not binding on the policyholder or the insured.[34] In such a case the contract continues to bind the parties on the basis of non-discriminatory terms.[35] These two provisions leave it open whether the insurer shall be bound to the discriminatory terms or not.[36] This point needs to be clarified. As a further sanction the policyholder shall be entitled to terminate the contract.[37] This seems to be inconsistent: if the discriminatory terms are eliminated,[38] there is no need for a termination of the contract. The entitlement to terminate the contract could even lead to misuse: the policyholder gets the possibility to terminate, by referring to discrimination, a contract which he or she does not want to continue for quite different reasons. It is true that the Directives demand sanctions that have to be "effective, proportional and dissuasive,"[39] the latter meaning that the sanctions need to have a deterring effect on the purveyors of services. This, however, refers much more to indemnification than to a right of termination, as the discriminatory terms contain some kind of "attack" on personal dignity, which is based on factors like gender or ethnic origin. An indemnification of that "attack" would be much more effective than the right to terminate the contract, and it would allow for a reaction that is proportionate to the intensity of the discrimination.

Furthermore there are a certain number of other questions for which Art. 1:207 PEICL does not offer an answer. This is partially due to the fact that the PEICL are only applicable if the parties agree on them. If the conclusion of the contract is declined to an interested party in a discriminatory way, the PEICL are not applicable, and therefore no

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[32] *See* Case C-236/09, Association belge des Consommateurs Test-Achats ASBL v. Conseil des Ministres, 2011 E.C.R. I-00773. In this case a Belgian consumer protection association as well as two male citizens challenged a Belgian law that, in accordance with Art. 5 (2) of the Gender Directive, allowed differences in premiums and conditions of insurance contracts based on gender.

[33] PEICL, *supra* note 5, at art. 1:207(2).

[34] PEICL, *supra* note 5, at art. 1:207(3).

[35] PEICL, *supra* note 5, at art. 1:207(3).

[36] PEICL, *supra* note 5, at art. 1:207(3) (compare sentence one with sentence two).

[37] PEICL, *supra* note 5, at art. 1:207(4).

[38] PEICL, *supra* note 5, at art. 1:207(3).

[39] Council Directive 2000/43, art. 15 sentence 2, 2000 O.J. (L180) (EC); Council Directive 2004/113, art. 8 sec. 2, 2004/113 (L373) (EC).

provisions concerning an obligation to contract or a "culpa in contrahendo" are necessary. However some answers should be given, e.g. whether a positive (or reversed) discrimination may be justified.

It is wise that the PEICL limits the rules on discrimination to the criteria of nationality, ethnic or "racial" origin and gender. This means that different treatments with regard to other criteria – especially of those included in the employment Directives – do not have to be individually justified, which is reasonable as insurance premiums are risk-based and therefore any insurance contract implies a need for differentiation. Nevertheless, it is to be expected that European anti-discriminatory legislation will be extended to different treatment based on age, disability, sexual identity and religion/belief as well.[40] Any such future legislation concerning insurance contracts will have to be implemented in the PEICL.

3. Enforcement (Art. 1:301 – 1:302 PEICL)

The final provisions of Chapter One deal with injunctions seeking an order to prohibit infringements of the PEICL. The provisions refer to the Directive on injunctions for the protection of consumers' interests.[41] However it has to be taken into consideration that this Directive's scope of application is limited to consumer protection. The entities mentioned in the Commission's list of entitled entities usually serve the purpose of consumer protection, while the application of the PEICL may be agreed on by commercial parties as well. Of course this does not mean that there might be a lack of legal protection, as in the commercial sector there is no need for any such specific protection.

Art. 1:302 PEICL clarifies that the application of the PEICL does not preclude access to other out-of-court complaint and redress mechanisms otherwise available to the policyholder. This is important especially with regard to the Ombudsman systems which have been established in many Member states. As to the recourse to State courts or to arbitration, the PEICL offer no specific rule.[42]

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[40] See Resolution on the Proposal for a Council Directive on Implementing the Principle of Equal Treatment between Persons Irrespective of Religion or belief, Disability, Age, or Sexual Orientation, COM (2008) 0426, EUR. PARL. DOC. P6_TA (2009) 0211.

[41] Directive 98/27/EC of the European Parliament and of the Council of 19 May 1998 on injunctions for the protection of consumers' interests 1998 O.J. (L 166).

[42] *See* Heiss, *supra* note 2, at 239 sec. (f).

A. INITIAL STAGE AND DURATION OF THE INSURANCE CONTRACT (CHAPTER TWO)

1. Applicant's Pre-contractual Information Duty (Art. 2:101 – 2:105 PEICL)

For the decision whether and with which contents to conclude a contract the insurer obviously needs some risk-related information from the applicant. Art. 2:101 PEICL deals with the applicant's duty of disclosure. The applicant has to inform the insurer about the circumstances of which he is, or ought to be, aware, including such circumstances of which the person to be insured was or should have been aware. Art. 2:101 PEICL limits the duty to those circumstances which have been subject to clear and precise questions that have been put forward to the applicant by the insurer. Nevertheless, in case of any inaccurate additional information given to the insurer, there are the same sanctions that apply to information given in fulfilment of the duty of disclosure.[43]

In the case of fraudulent breach of the duty of disclosure, the insurer is entitled to terminate the contract and to retain the right to any premium due.[44] In any other case, the insurer is entitled to propose a "reasonable" variation of the contract.[45] In that case the contract will be continued on the basis of the variation proposed for the future, unless the policyholder rejects the proposal within one month.[46] Termination of the contract by the insurer is only possible if the policyholder is not in innocent breach of his duty of disclosure or if the insurer proves that the contract would not have been concluded had he known of the information concerned. Whether the information was "material" in the decision to conclude the contract has to be determined, according to Art. 2:103 (b) PEICL. The question is whether a "reasonable insurer" would have considered the circumstances to be essential for the decision to enter into the contract.

These provisions should be reconsidered. It is hard to understand why an insurer should only be entitled to terminate the contract in case of fraudulent breach of the duty of disclosure, and why there should be no

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[43] PEICL, *supra* note 5, at art. 2:105.

[44] PEICL, *supra* note 5, at art. 2:102.

[45] Concerning the insurer's duty to provide information, the wording of PEICL art. 2:102(1)-(2) refers on the one hand to the *intention* of the insurer and on the other hand to the *decision*; but in fact, the meaning here is the same as both times the PEICL refer to the chosen legal consequence.

[46] PEICL, *supra* note 5, at art. 2:102 (2) (referring to the *agreement* of the parties, but obviously means that the policyholder does not reject according to Art. 2:102 (2)).

right of rescission.[47] However, at least the insurer shall be entitled to avoid the contract according to Art. 2:104 PEICL.

Even more important is a second point which concerns the criterion of the "reasonable insurer". This new creature seems questionable. First of all there is no need for it. In addition it appears to be highly problematic to introduce objective criteria – such as the "reasonable insurer" – while trying to establish the (hypothetic) intention of the individual insurer concerned. A policyholder who breaches his duty of disclosure may, if the criterion of the "reasonable insurer" is applied, obtain an undeserved advantage compared to an honest policyholder. The latter probably has to pay higher premiums than the former, accept surcharges or even risk that the insurer might refuse to conclude the contract. It is absolutely sufficient to limit private autonomy by applying the general contract law principles (anti-discrimination rules, semi-mandatory provisions, etc.), and not by asking what a "reasonable insurer" might consider to be appropriate. The objective approach of the PEICL would lead to a general control of the contract terms in case of breach of the duty of disclosure, while in the case that the duty is fulfilled according to the PEICL, no such control takes place. This would lead to unequal treatment, and any such control regarding the adequacy of the terms would be incoherent with the principle of private autonomy.

Some exceptions to the duty of disclosure are made in Art. 2:103 PEICL. According to lit. d of this provision, the sanctions shall not apply in respect to information which the insurer was or should have been aware. In this matter it can be difficult to draw the lines, e.g. if a policyholder features various risks that are covered by the same insurer. The PEICL offer no further details, so that this will be a task of the courts.

2. Insurer's Pre-contractual Duties (Art. 2:201 – 2:203 PEICL)

There exist a wide range of pre-contractual duties of the insurer, especially the duty to provide information before the applicant has decided on the contract. Art. 2:201 PEICL is modelled on several European Directives. This rule says that the insurer has to provide the applicant with a copy of the proposed contract terms, as well as with a document that includes further information about a number of circumstances if relevant. According to paragraph 2, the information shall be provided – "if possible" – in sufficient time to enable the applicant to consider whether or not to conclude the contract. Although this is not expressly stated in the text, the purpose of the provision is to enable the applicant to decide on the basis of the information rendered by the insurer. This is in accordance with the

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[47] Especially as, according to PEICL, *supra* note 5, at art. 2:102 (5), the insurer is released from the obligation to perform only in case of negligence.

European Directives, which are based on the concept of a well-informed, reasonable consumer.[48] Apart from that, it is only the title of Art. 2:201 PEICL that clarifies that the duties mentioned have to be fulfilled prior to the conclusion of the contract.

The scope of application of this provision, as well as the question of how a breach of duty is sanctioned, remains unclear. As to the scope of application, Art. 2:402 PEICL states that Art. 2:201-203 PEICL do not apply to preliminary insurance contracts. However it is an open question as to how distance selling contracts are to be treated. Taking into account that "if possible" the information shall be provided "in sufficient time" to enable the applicant to consider whether or not to conclude the contract, it is likely that there will have to be a control regarding the circumstances of every single contract. In this context a certain standardisation is desirable. As far as the sanctions are concerned, the time limit for the avoidance of the contract according to Art. 2:303 (1) PEICL starts with the receipt of the insurer's acceptance or delivery of the documents enumerated in Art. 2:501 PEICL.49

The insurer has to warn the applicant of any inconsistencies between the coverage offered and the applicant's requirements.[50] Upon closer inspection of Art. 2:202 PEICL, it becomes obvious that this provision establishes a comprehensive duty of the insurer to advise the applicant, including an initial identification of his needs and wishes with regard to the risk coverage, and to give a recommendation. It is remarkable that the insurer has to take into consideration the circumstances and mode of contracting and, in particular, the fact whether the applicant has been assisted by an independent intermediary. However, it is hardly understandable why there should be a duty to advise the applicant, even if he has been assisted by an independent intermediary. This is especially true given that the intermediary is himself liable according to the European Directive on insurance mediation.[51]

Finally, the insurer immediately has to warn the applicant that the coverage does not commence until the contract is concluded and, if applicable, the first premium is paid,[52] if the applicant mistakenly believes that the coverage begins earlier. This article does not just represent a special case of the duty to give advice, as the insurer's duty depends on the error of the applicant.

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[48] *See also* DCFR, *supra* note 1, at sec. II-3:102 (1).

[49] PEICL, *supra* note 5, at art. 2:303(3)

[50] PEICL, *supra* note 5, at art. 2:202 (1).

[51] *See* Directive 2002/92/EC of the European Parliament and of the Council of 9 December 2002 on insurance mediation, 2002 O.J. (L 9).

[52] PEICL, *supra* note 5, at art. 2:202(1).

3. Conclusion of the Contract (Art. 2:301 – 2:304 PEICL)

According to Art. 2:301 PEICL, the insurance contract need not be concluded or evidenced in writing. This provision was modelled on the basic rule in II.-I:107 (1) DCFR.[53] It is, however, of no practical importance as insurance contracts are usually concluded in writing.

Much more important is the right to revoke a contract. While according to Art. II.-402 DCFR revocation is possible until the insurer has declared acceptance of the applicant's offer,[54] according to Art. 2:302 PEICL, the applicant may revoke the contract if the revocation reaches the insurer before the applicant has received an acceptance from the insurer. In addition, Art. 2:303 PEICL grants the applicant a right to revoke the contract within two weeks after receipt of acceptance or delivery of the documents referred to in Art. 2:501 PEICL. There are no further requirements for this right to revoke, and only a few exceptions. Both provisions offer the applicant the possibility to withdraw from the contract for any reason or motive, even after the insurer has received the applicant's offer.

It is arguable why an offer that has been consciously and validly declared shall remain close to non-committal. This seems extraordinary, especially if one keeps in mind the wide range of duties that the insurer already has to fulfil before the contract is concluded. This comprehensive right to revoke the contract appears questionable if the applicant, *e.g.*, as an entrepreneur, doesn't need any protection. Even major risks are not excluded from the right of revocation.

Art. 2:304 PEICL is modelled on the European Directive on unfair terms in consumer contracts.[55] Therefore, the provisions regarding a significant imbalance of rights and obligations, as well as the exceptions concerning the premium and the essential description of the covered risk and terms individually agreed on, can be considered as European standard. However, according to Art. 2:304 paragraph 3 lit. b PEICL, the principle that the terms have to be in plain and intelligible language is only applicable on terms stating the essential description of the coverage granted. This allows the conclusion that any other term that is not in plain and intelligible language might cause a significant imbalance in rights and obligations pursuant to Art. 2:304 (1) PEICL as well. However, in order to meet the requirements of the Directive, a clearer wording appears to be necessary. It is, above all, not possible to apply exclusively Art. 1:203 (1) PEICL, as this provision contains no sanction.[56] Besides, many other

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[53] PEICL, *supra* note 5, at art. 2:101(2).
[54] PEICL, *supra* note 5, at art. 2:202(2).
[55] PEICL, *supra* note 5, at art.1:102(2).
[56] PEICL, *supra* note 5, at art. 2:203(1).

requirements of the Directive are not met, *e.g.* with regard to the interpretation of ambiguities. However, the reference to the PECL/DCFR made in Art. 1:105 (2) PEICL should lead to satisfying results. This article provides that any questions arising from the insurance contract, which are not expressly settled in the PEICL, are to be settled in conformity with the PECL and, where those do not contain any rules as well, in accordance with the general principles common to the laws of the Member States.

As to the sanctions in case of a significant imbalance, Art. 2:304 PEICL states that the term concerned is not binding for the policyholder (or the insured or the beneficiary). In contrast, the insurer cannot claim that the term is not binding; thus he will not benefit from the breach of law which he is responsible for.[57] The unfair term shall be substituted by a term which reasonable parties would have agreed upon had they been aware of the unfairness of the term.[58] The idea of substituting the real parties with an abstract category like "reasonable" parties seems questionable but not as problematic as in the context of the duties of disclosure (see above a).

4. Retroactive and Preliminary Coverage (Art. 2:401 – 2:403 PEICL)

The provisions concerning retroactive insurance rule that if, at the time of the conclusion of the contract, the insurer knows that no insured risk has occurred, then the policyholder owes premiums only for the period after the time of conclusion.[59] Inversely, if the policyholder knows at the time of the conclusion of the contract that the insured event has occurred, the insurer shall provide coverage only for the period after the time of the conclusion of the contract. The reason for this provision that does not declare the contract void is that retroactive coverage is possible yet quite unusual. The provisions deserve approval. However, there is a problem if the retroactive coverage is aimed at covering the risk between application and conclusion of the contract. According to Art. 2:401 (2) PEICL, this may not be achieved as the insurer does not need to provide coverage for this period if at the relevant time of the conclusion of the contract the policyholder already knows that the insured risk has occurred.

Only few provisions of the PEICL deal with preliminary coverage, which is an independent contract with no or only a limited risk assessment. According to Art. 2:402 PEICL, only very little information has to be given, and no contract terms have to be provided. Therefore, it is necessary to

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[57] *See* Ch. Armbrüster, 'Das Transparenzgebot für Allgemeine Geschäftsbedingungen' [2004] DNotZ 437, 439.

[58] PEICL, *supra* note 5, at art. 2:304(2).

[59] PEICL, *supra* note 5, at art. 2:401.

determine which contract terms shall be applicable to the preliminary coverage contract. Neither is there a legal provision concerning the payment of premiums. Furthermore, the important question of the duration and ending of the preliminary coverage remains unaddressed. Art. 2:403 (1) PEICL does not state whether the conclusion of another preliminary coverage contract, or the beginning of a coverage provided by another insurer, will lead to the termination of the contract. It should also be clarified that a revocation of the application according to Art. 2:302 PEICL terminates the preliminary coverage. Finally, it would make sense to give the policyholder a right to terminate the agreement in case preliminary coverage was agreed on without a time limit. Without such a possibility, the policyholder would find it difficult to secure coverage by another insurer, e.g. if the insurer does not react to the application for the main contract in reasonable time.

It does not seem necessary to expressly entitle the insurer to terminate the preliminary coverage contract as according to Art. 2:403 (1) PEICL he is able to do so by declining the conclusion of the main contract. Art. 2:403 (2) PEICL contains a special provision in case preliminary coverage is granted to a person who does not simultaneously apply for a main contract with the same insurer. Such coverage may be cancelled by either party giving two weeks' notice, which is a reasonable rule.

5. Insurance Policy (Art. 2:501 – 2:502 PEICL)

According to Art. 2:502 PEICL, under certain conditions the contents of the insurance policy may determine the contents of the contract. If the terms of the insurance policy differ from those in the policyholder's application or any prior agreement between the parties and these differences are highlighted in the policy, they are deemed to have been accepted to by the policyholder unless he objects within one month of receipt of the policy. The insurer has to inform the policyholder about the right to object to the differences. However, it remains unclear how the "prior agreements" are related to the application. According to the wording "*any* prior agreement", even prior independent contracts are included. It seems questionable why such agreements should have to be considered although they are not part of the application.

6. Duration of the Insurance Contract (Art. 2:601 – 2:604 PEICL)

The provisions regarding the duration of the insurance contract are very strict. According to Art. 2:601 PEICL, the duration of the insurance contract is one year. Exceptions are only possible in case this is indicated by the nature of the risk and in the area of personal insurance.

There are many possibilities for a maximum duration, varying from one year in French law, three years proposed in the 1979 draft for a Directive already mentioned,[60] to ten years in Spanish law. The policyholder will frequently be interested in binding himself only for a short period in order to remain flexible: he may wish to adjust the contract to changed circumstances or even opt for another insurer. A short period is also advantageous for new market participants within the insurance industry, as this facilitates their access to customers. However, the advantages of a longer insurance period are considerable. First of all, continuity leads to an improvement of the basis for actuarial calculations. Furthermore, a longer period allows the insurer to save administrative costs, which implies an advantage for policyholders as well, as premiums may be lower. The possible need for an adjustment of the contract terms may be met by inserting adjustment clauses. And last but not least, establishing a maximum period for insurance contracts constitutes an interference with private autonomy. Therefore, the proposed maximum period of one year appears to be very short, unnecessarily preventing the parties from opting for the advantages of a longer period. In addition, the exceptions admitted by Art. 2:601 (1) PEICL need to be clarified.

Another severe interference with private autonomy is that the maximum period of one year at the same time constitutes the minimum period. The exceptions provided in sentence two are identical with those for longer periods than one year. They are necessary as otherwise, a travel insurance policy, for example, would have to run for a whole year. It is difficult to see the reason why the maximum as well as the minimum duration should not, within a maximum limit of three years, for example, be left to the agreement of the parties. There is no need for a legally determined insurance period, and Art. 2:601 PECL therefore appears to be over-regulating the topic. This strict rule makes the PEICL, in this respect, a less attractive alternative to the national insurance laws, especially for commercial policyholders.

Art. 2:602 PEICL states asymmetric time limits for the termination of the contract. The insurer has to give notice that he does not want the contract to be prolonged at least one month before the expiration date. The policyholder has to give notice at the latest by the day the contract period expires or within one month after having received the insurer's premium invoice. The latter provision leads to insecurity: until the very end of the contract he has to prove the receipt of the premium invoice, even after the end of the contract the insurer will not know for sure whether the contract has expired or not. At the same time, there is no need to protect the policyholder, as he usually knows that he should not wait with the

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[60] *See* Council Directive, art. 3-4, 1979 O.J. (C 190) at 3-4.

declaration of termination until the expiration date of a contract that will otherwise be automatically prolonged. Therefore, a rule that contains symmetric time limits is clearly preferable.

Any adjustment of premiums and terms of contract has to meet very strict requirements,[61] notwithstanding further requirements (e.g. the rules on abusive clauses laid down in Art. 2:304 PEICL).[62] For instance, any alteration shall not take effect before the next prolongation. In addition, the insurer has to send a notice of alteration no later than one month before the expiration of the current contract period. Both these rules, taken together, may lead to a delay of more than one year. Thus, a quick reaction in case of changed circumstances becomes impossible. This seems too strict, especially as adjustment clauses are anyway controlled separately under the fair contract term rules.

The provision in Art. 2:604 PEICL on termination after an insured event has occurred is convincing, especially with regard to private autonomy. The rule only contains requirements for clauses dealing with the termination without giving a right to terminate. In any such clause, the right to terminate has to be granted to both parties, which seems reasonable. However, it is systematically unsatisfactory that both the provision on termination and the exercise of the right to terminate have to be "reasonable."[63] Here, the question arises as to where exactly the difference of this provision to the rules on abusive clauses[64] is to be found. In addition, as far as the exercise of the right to terminate is concerned, the fact that this must be "reasonable" should be part of the general rules as it constitutes a general principle of law.

7. Post-contractual Information Duties of the Insurer

In the section "Post-Contractual Information Duties of the Insurer" (what would be more accurate is to say "Information Duties After Conclusion of Contract"), the PEICL deal with duties of the insurer in the period between conclusion and termination. Among other duties, there is a duty of the insurer to provide the policyholder with information in writing on any change concerning his name and address and other related information, such as a change of his legal form, etc., without undue delay.[65] However, there is neither a sanction in case of lack of compliance nor a corresponding

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[61] PEICL, *supra* note 5, at art. 2:401.

[62] Those rules are modeled on Council Directive 93/13 on unfair terms in consumer contracts. 1993 O.J. (L 095) 0029 (EEC).

[63] PEICL, *supra* note 5, at art. 2:604(2).

[64] PEICL, *supra* note 5, at art. 2:304.

[65] PEICL, *supra* note 5, at art. 2:701.

duty of the policyholder. On request of the policyholder, the insurer has to provide him with information about all matters relevant to the performance of the contract, as well as about new standard terms offered by the insurer for insurance contracts of the same type as the one concluded with the policyholder. [66] Unfortunately, the PEICL do not state whether the policyholder can claim incorporation of the new standard terms in the contract or whether the incorporation is only possible after termination of the contract by concluding a new one. If the insurer was forced to incorporate new terms – even terms developed for the acquisition of new clients – in every existing contract, this might discourage it from developing new terms.

There is no duty to give advice comparable to Art. 2:202 PEICL for the time after the conclusion of the contract. This is advantageous for the insurer as the fulfilment of such duties can be cost-intensive. For the policyholder, however, the limited duty of information is of questionable use. He has to be provided with information about relevant matters, but that will often not suffice as a basis for the decision whether a change is advantageous for him or not. This is especially true as the duty according to Art. 2:702 (1)(b) PEICL is not limited to changes that are wholly or at least partly advantageous for the policyholder. With regard to the interest of the policyholder to be provided with information on the one hand, and the high costs and constraining effect for innovation on the other, it seems preferable to not only develop a duty to provide information, but to also give advice. However, this should be limited to the case that the innovation provides a reasonable benefit to the policyholder or the insured.

B. INSURANCE INTERMEDIARIES (CHAPTER THREE)

The Chapter about insurance intermediaries only deals with two questions about the powers of insurance agents and the liability of agents purporting to be independent. The insurance agent shall be authorized to perform all acts on behalf of the insurer are within the scope of his employment according to current insurance industry practice. Restrictions are only possible if disclosed to the policyholder in a separate document. But, even then, the authority has to cover at least the actual scope of his employment.[67] This rule is aimed at the case where the insurance agent performs more acts than he is allowed to by the insurer, be it because his authority has been restricted by notice or by the scope of his employment. In this context, the usual activity of the agent, and not his behavior in the particular case, should be considered relevant. However, this conclusion

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[66] PEICL, *supra* note 5, at art. 2:702.
[67] PEICL, *supra* note 5, at art. 3:301.

cannot be clearly drawn from the wording of PEICL. The fact that the restriction of the authority may only be achieved by written notice – without it being necessary that the policyholder knows or ought to know of the restriction – results from the legal powers given to the insurance agent, and it secures legal certainty.

Besides this, it is worth mentioning that the agent has the power to receive notices from the policyholder,[68] and that relevant knowledge which the insurance agent has, or ought to have, shall be deemed to be the knowledge of the insurer.[69]

A special provision concerning agents only purporting to be independent intermediaries can be found in Art. 3:102 PEICL. If such an agent acts in breach of duties imposed on him by law, it is not only he but also the insurer who is liable for such breach. The fact that the insurer is liable for the actions of the agent deserves approval, as in practice damages often cannot be obtained by the policyholder due to the absence of a liability insurance of the agent.

Despite the headline of Chapter Three, the requirements of the Directive concerning insurance brokering[70]have not yet been incorporated in the PEICL.[71]

C. THE RISK INSURED

1. Precautionary Measures

After a breach of an obligation, the insurer is only entitled to terminate the contract if the policyholder (or the insured) breached his obligation with the intent to cause the loss or if he acted recklessly and with the knowledge that the loss would probably result.[72] "Recklessness" has to be interpreted as being more than just grossly negligent; it is close to *dolus eventualis* (awareness of an action's possible outcome which the policyholder is willing to accept, rather than abstain, from the perilous action). The burden of proof lies with the insurer, who in practice will

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[68] PEICL, *supra* note 5, at art. 3:101(2).

[69] PEICL, *supra* note 5, at art. 3:101(3).

[70] *See* Directive 2002/92/EC of the European Parliament and of the Council of 9 December 2002 on insurance mediation, 2002 O.J. (L 9).

[71] Heiss, *supra* note 2, at 229, 238 (objecting to incorporation).

[72] PEICL, *supra* note 5, at art. 4:102(1). Looking at the wording, it is not clear whether the intent of causing a loss is sufficient or whether an additional element, like the knowledge that the act will cause a damage, is required. It is more likely that this latter requirement only applies to the case of "recklessness." This is also evidenced by the clarifying comma in the parallel clause in art. 9:101.

often find it difficult to prove that the policyholder acted with the knowledge that the loss would probably result. As a policyholder who does not think about the losses caused by his behaviour is not in need of protection, it should be sufficient that the policyholder ought to know that he could probably cause losses.

Of great importance is the question under which circumstances the insurer is exempted from liability. According to Art. 4:103 (1) PEICL, this is only the case if the loss was caused by the non-compliance of the policyholder (or the insured). This deserves approval. However, the fact that the exemption depends on the knowledge of the policyholder that the loss would probably result should be criticised (see above).

In the case that the loss was caused by negligent non-compliance it is possible to reduce the insurance money according to the degree of fault by a "clear clause".[73] This rule is remarkable. The exemption depends on the degree of fault, proportionality, and a clause that has to meet (as the mention of "clearness"[74] superfluously suggests) special requirements. Yet, there are certain disadvantages of such a clause that cannot be denied. Firstly, there is no need for any reduction of the insurance money according to the degree of fault in case of simple negligence. Secondly, it will often be difficult to establish what grade of reduction should correspond to which kind of negligence. Thirdly, if the policyholder acts recklessly, but without knowing the loss that can result, Art. 4:103 (2) PEICL is, according to the wording, not applicable, although systematically this rule should apply. In addition, there seem to be only few situations in which the insurer is totally exempted from liability as the subjective elements refer to the loss and not to the breach of obligation.

Considering everything, the rule in Art. 4:103 (2) PEICL needs to be modified. Most importantly, in case of simple negligence, the breach of an obligation that aims at avoiding the occurrence of the insured event should not even partially lead to an exemption from liability.

1. Aggravation of Risk (Art. 4:201 – 4:203 PEICL)

Usually, insurance contracts contain a clause about the consequences of an aggravation of risk. Such rules may provide for the insurer not to be held liable if the insured event occurs as the result of an aggravation of a risk that has intentionally been caused by the policyholder or the insured, but there may be provisions on legal consequences in less obvious cases as well.

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[73] PEICL, *supra* note 5, at art. 4:103(2).
[74] PEICL, *supra* note 5, at art. 1:203.

At the beginning of the section of PEICL which deals with the aggravation of risk, there is a provision that limits the impact of clauses concerning the aggravation of risk. Those clauses shall have no effect unless the aggravation of risk in question is material and of a kind which is specified in the insurance contract.[75] This provision offers some kind of definition. It clarifies that immaterial aggravations of risk have no consequences for the insurance contract. In addition, it states that the clause only has effects if the aggravation of risk is of a kind specified in the contract. This seems problematic as the insurer is forced to foresee every kind of aggravation of risk that might occur in the future and describe it precisely in the insurance contract. This is hardly possible. Furthermore, the contract terms become lengthier, and thus, the policyholder risks excessive burden. There is no predominant interest of the policyholder to be protected from a termination of the insurance contract or an exemption of liability by an exhaustive enumeration of possible aggravations of the insured risk, especially as only material aggravations are concerned.

The further provisions concerning the aggravation of risk seem suitable. There is a duty to give notice of an aggravation of risk.[76] In the event of breach of the duty of notification, the insurer is not entitled to refuse to pay any subsequent loss resulting from an event within the scope of the coverage unless the loss was caused by the aggravation of risk. Furthermore, it is necessary that the policyholder is, or ought to be, aware of the aggravation and that the insurer would not have insured the aggravated risk at all. If, however, the insurer would have been prepared to insure the aggravated risk at a higher premium or on different terms, the insurance money is payable proportionately or in accordance with such terms.[77]

If the contract provides that in the event of an aggravation of the risk insured, the insurer is entitled to terminate the contract, further requirements have to be met.[78] However, it seems too strict that there is no possibility at all to continue the contract with adjusted conditions (e.g., higher premium, exclusion of risks). In fact, the PEICL forces the insurer, even if he is prepared to continue the contract, to terminate it as long as he is not willing to stick to the original terms. This is unsatisfactory for the policyholder as well as he is obliged to react in case of an "adjusting"

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[75] PEICL, *supra* note 5, at art. 4:201.

[76] PEICL, *supra* note 5, at art. 4:202.

[77] *See* PEICL, *supra* note 5, at art. 4:202(3); 4:203(3). The rule in art. 4:203(3) does not match with the headline of this article, particularly as it should not only apply to the termination of contracts; from a systematic perspective, it would be preferable to combine this provision with art. 4:202(3) and create a separate article with the headline "release from obligation to perform in the event of aggravated risk."

[78] PEICL, *supra* note 5, at art. 4:203(1), (2).

termination (termination combined with an offer to conclude a new contract adjusted to the new risks). If he does not react in due time, he will lose protection and will have to face all the risks of a new conclusion of contract (e.g., a new risk assessment and the consequences of a delayed payment of the first premium).[79]

2. Reduction of Risk (Art. 4:301 PEICL)

In the case of a material reduction of risk, the policyholder is entitled to request a proportionate reduction of the premium for the remaining contract period.[80] As the wording is not very precise, this rule implies a risk of uncertainty. It seems that the authors of the PEICL were well aware of this risk as paragraph two provides a right of the policyholder to terminate the contract in case the parties do not agree on a proportionate reduction of the premium within one month of the request.

The difficulties start with the need for a "material" reduction of risk. Contrary to the provisions concerning the aggravation of risk,[81] the hypothetic reaction of the insurer is of no importance in this context. Further uncertainty is caused by the term of "proportionate" reduction. This makes a quantification of the reduction of risk necessary, even if the tariff structure contains no such quantification. The provision therefore contradicts the insurer's principles of calculation. This may result in higher costs for calculation and administration, especially since according to the PEICL, the contract period may not exceed one year anyway. It would clearly be preferable to insert a provision which is modelled on the structure of the tariffs of the particular insurer with differentiations based on certain circumstances.

D. INSURANCE PREMIUMS

The chapter on insurance premiums contains no provision which deals with modalities such as the date on which when the premium payment is due. Obviously, the more general provisions of the PECL/DCFR shall be applicable. This should cause no problems, even though those provisions are not specially designed for insurance contracts.

As to the consequences of non-payment of the premiums, the PEICL distinguish between non-payment of the first (or single) premium and subsequent premiums. In the case of non-payment of the first premium, stricter rules are justified than in the case of the non-payment of subsequent

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[79] *See* PEICL, *supra* note 5, at art. 5:101.
[80] PEICL, *supra* note 5, at art. 4:301(1).
[81] PEICL, *supra* note 5, at art. 4:202(3); 4:203(3).

premiums, as in the latter case the policyholder fulfilled his contractual duty to participate in financing the risk pool at least once. According to Art. 5:101 PEICL, it is possible for the insurer to make the payment of the first premium a condition of the formation of the contract or the beginning of the coverage. However, this requires that the condition be communicated to the applicant in writing and that a period of two weeks has expired after receipt of an invoice. The notice has to be in clear language. It remains an open question whether this means the same as the "plain and intelligible" language mentioned in Art. 1:203 PEICL. However, it seems more important whether the condition has to be accentuated (e.g., communicated by extra notice). The PEICL should clarify this issue. The warning that the applicant lacks coverage until the premium is paid has to be given.[82]

In accordance with the consideration made above, in case of non-payment of a subsequent premium, it is more difficult for the insurer to be relieved of his obligation to cover the risk. According to Art. 5:102 PEICL the insurer has to state the precise amount of premium due as well as the date of the payment and has to grant an additional period of payment of at least two weeks while he still has to cover the risks comprehensively.

According to Art. 5:103 PEICL, the insurer is entitled to terminate the contract by written notice, provided that the invoice or the reminder states his right to terminate the contract, no matter what kind of premium has not been paid. The contract is deemed to be terminated if the insurer does not bring an action for payment of the first premium within two months after expiration of the period mentioned in Art. 5:101 or Art. 5:102 PEICL respectively. This is meant to avoid requiring the policyholder to pay the premiums while he is no longer entitled to payment of the insurance money. The solution found in the PEICL seems easy to handle. Nevertheless, it is preferable to grant a right of rescission if the first premium is not paid because in this case the contract has never been fully executed. Furthermore, it is necessary to grant the right to terminate the contract only if the non-payment is due at least to negligence of the policyholder. Otherwise, the provision would be too strict.

According to Art. 5:104 PEICL, the premium is divisible. This is appropriate as Art. 5:104 PEICL has to be seen in the context of Art. 2:104 PEICL. That rule contains an exception to the principle of divisibility of the premium in the case that the policyholder is in fraudulent breach of a duty of disclosure. Here, there is an important pre-emptive effect if a policyholder has to pay the entire premium even though he is not being protected in case of the occurrence of the insured event.

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[82] PEICL, *supra* note 5, at art. 2:203 (without expressly referencing to the details of art. 5:101(a)-(b)).

At the end of the chapter on premium, Art. 5:105 PEICL states under which circumstances third parties are entitled to pay the premium. This is important because in case of non-payment of the premium, the insurer may be relieved from his obligation to cover the risk, and he may be entitled to terminate the contract. A third party is entitled to pay the premium if this party acts with the assent of the policyholder, or it has a legitimate interest in maintaining the coverage, and the policyholder has failed to pay or it is clear that the policyholder will not pay at the time the payment is due. The latter case should be laid down more clearly. Beneficiaries and insured persons usually have a "legitimate interest," as well as lien creditors. It is worth discussing if in addition, tenants and other only obligatorily entitled persons, as well as friends and relatives of the policyholders, have a "legitimate interest" in the payment. Furthermore, it is difficult to assess in which case it is "clear" that the policyholder will not pay at the time the payment is due. This leads to the question why it shall be necessary that the policyholder has failed to pay or will not pay the premium. In the relevant cases, there is no specific need to protect the policyholder. If he is not interested in having the premiums paid by a third party, this will be taken into account if the third party asserts its claims against the policyholder.

F. INSURED EVENT (CHAPTER SIX)

The occurrence of an insured event has to be disclosed to the insurer without undue delay.[83] If the contract requires notice to be given within a stated period of time, such time shall be reasonable and no shorter than five days. The insurance money payable shall be reduced to the extent that the insurer proves that he has been prejudiced by undue delay,[84] no matter whether the policyholder has acted negligently or not. A comparable provision is contained in Art. 6:102 (2) PEICL, which concerns a breach of the duty to cooperate with the insurer in the investigation of the insured event. Both provisions appear to be too strict, especially as in other sections of the PEICL proportional reductions of the insurance money according to the degree of fault are common.[85]

Art. 6:103 (2) PEICL contains a fiction which is of considerable importance: any claim shall be deemed to have been "accepted" unless the insurer rejects the claim or defers acceptance by written notice giving reasons for his decision within one month after receipt of the relevant documents and other information. This provision is obviously meant to

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[83] PEICL, *supra* note 5, at art. 6:101(1)-(2).
[84] PEICL, *supra* note 5, at art. 6:101(3).
[85] *E.g.,* PEICL, *supra* note 5, at art. 2:102(3), (5); 4:102(1); 4:203(2)-(3).

speed up the insurer's decision about the claim. However, it seems questionable whether a period of one month is too short, especially as the beginning of the period depends on the receipt of the relevant documents and other information. The insurer will often need to be able to investigate the event carefully (e.g., by contacting authorized experts). In these cases, Art. 6:104 PEICL forces the insurer to give a notice (and, if necessary, prove its receipt by the policyholder) in order to avoid the fiction.

Furthermore, it is questionable that the beginning of the period depends on the receipt of the documents and information. If one keeps in mind the purpose of the provision, which is to give an incentive to the insurer to decide speedily, this can only mean the receipt of *all* relevant documents and information. In practice, however, the information given to the insurer by the policyholder often leads to further investigations and requests (which must be responded to).[86] This may lead to uncertainties about the beginning of the period.

Art. 6:103 (2) PEICL does not state expressly who shall be the addressee of the notice. While duties to give notice and to cooperate may bind the insurer, the policyholder or the beneficiary, the addressee of the notice should solely be the claimant. However, this is not completely self-evident, as the policyholder is party to the insurance contract. It seems necessary to clarify this point.

When a claim has been accepted, the insurer shall pay or provide the services promised without undue delay, meaning that the payment of insurance money has to be made no later than one week after the acceptance and quantification of the claim.[87] If the insurance money is not paid on time, the claimant is entitled to interest on that sum from the time when payment was due at a rate applied by the European Central Bank. Furthermore, he may recover damages for any additional loss caused by late payment. While a short period of only one week is appropriate according to the PEICL, the Directive on motor vehicle liability insurance[88] concedes a period of three months. Art. 6:104 PEICL therefore seems too strict, especially as the sanctions do not depend at least on negligence of the insurer. As far as the interest is concerned, PEICL are modelled on III.-3:708 DCFR (Art. 9:508 PECL), while according to those rules damages are only paid if the insurer acted at least negligently.[89]

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[86] PEICL, *supra* note 5, at art. 6:101(2).

[87] PEICL, *supra* note 5, at art. 6:104(1), (3).

[88] Directive 2000/26, art. 4, 2000 O.J. (L 181) 65, 70 (EEC).

[89] DCFR, *supra* note 1, at art. III-3:701 (stating creditor is entitled to damages for loss caused by debtor's non-performance of an obligation); PEICL, *supra* note 5, at art. 9:501.

D. PRESCRIPTION (CHAPTER SEVEN)

As to the limitations period or prescription, the PEICL distinguish between actions for payment of premiums (period of one year)[90] and actions for payment of insurance benefits (in general, a period of three years).[91] Art. 7:102 PEICL is modelled on the basic rule III.-7:201 DCFR.[92] One of the few passages in the PEICL that expressly refer to the PECL is Art. 7:103 PEICL. In this respect, further harmonization is necessary, as Art. 1:105 (2) PEICL states that any questions arising from the insurance contract which are not expressly addressed by the PEICL are to be settled in conformity with the PECL. The fact that there is no corresponding provision in other sections leads to the question of whether the provisions of the PEICL are meant to be exhaustive. If the PEICL will be integrated into the DCFR, Art. 1:105 (2) PECL will become obsolete.

III. PROVISIONS COMMON TO INDEMNITY INSURANCE (PART II)

A. SUM INSURED AND INSURED VALUE (CHAPTER EIGHT)

Art. 8:101 PEICL contains the basic principle for the obligation of the insurer to make payments. According to this provision, the obligation is limited to the amount necessary to indemnify losses actually suffered by the insured. However, this provision is not mandatory.[93] Therefore, according to Art. 1:103 (2) sentence 1 PEICL, the contract may diverge from Art. 8:101 PEICL, as long as the derogation is not to the detriment of the policyholder.

As far as agreements about the subject-matter are concerned, Art. 8:101 (2) PEICL offers the parties quite a wide scope of choice. Even if the value agreed upon exceeds the actual value of the subject-matter, it is considered valid except for the case when there is operative fraud or misrepresentation on the part of the policyholder or insured. However, it has to be taken into consideration that the PEICL distinguish between indemnity insurance and insurance of fixed sums. Typically, an indemnity insurance is meant to provide compensation for a loss actually suffered (e.g., the destruction of a home caused by a fire where the insurance money enables the owner to rebuild the home or to buy another one) contrary to

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[90] PEICL, *supra* note 5, at art. 7:101.
[91] PEICL, *supra* note 5, at art. 7:102.
[92] PEICL, *supra* note 5, at art. 14:201.
[93] *See* PEICL, *supra* note 5, at art. 9:501. The PEICL in this version does not include any mandatory regulations.

the insurance of fixed sums (e.g., life assurance where the death of a person, as the insured event, does not cause the specific monetary loss which the insurance contract shall cover, so that no relation between an actual loss and the payment of the sum agreed by the insurer needs to be established). The higher the sum, the more the policyholder might find himself tempted to bring about the insured event. Keeping this in mind, it would be appropriate to implement a proportional reduction of the sum agreed upon in case it is much higher than the actual value.

Another provision that deserves special attention is contained in Art. 8:102 PEICL. According to this provision, the insurer is liable for any insured loss up to the sum insured even if the sum insured is less than the value of the property insured at the time when the insured event occurs. This is astonishing as it obviously results in an unequal treatment of different policyholders. A policyholder who correctly assumes that in most cases only a partial loss will occur and who therefore opts for a smaller sum is treated more favourably than a policyholder who opts for a sum corresponding to the value of the insured property and who consequently has to pay higher premiums. Art. 8:102 PEICL cannot be explained by stating that measures taken to increase the value of the insured property or inflation would make an adjustment necessary in due course. The first of these points cannot be generally assumed as value increasing measures result from individual decisions of the policyholder, while the latter (the effects of inflation) may be avoided by implementing a contract clause which contains an increase of the premiums in relation to inflation. Furthermore, the parties have the possibility to avoid the situation of underinsurance.

Obviously, the authors of the PEICL themselves have some doubts concerning Art. 8:102 PEICL as they entitle the insurer to offer insurance on the basis that the indemnity to be paid may be limited to the proportion that the sum insured bears to the actual value of the property at the time of the loss.[94] This kind of technique is unusual for the PEICL, while the provision itself is very reasonable. It should not only apply when agreed on and thus would correspond with the rule on over-insurance.[95] However, the right of termination granted in paragraph two in the case that no agreement can be reached is as questionable as in the case of aggravation of risk. Unfortunately, contrary to other provisions such as Art. 2:104 PEICL, there is also no special provision in case of fraudulent over-insurance.

Art. 8:104 (1) PEICL dealing with multiple insurance appears to be acceptable. However, a provision about the elimination of the multiple insurance should be added as well as a special provision dealing with fraudulent acts of the policyholder.

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[94] PEICL, *supra* note 5, at art. 8:102.
[95] PEICL, *supra* note 5, at art. 8:103(1).

B. ENTITLEMENT TO INDEMNITY (CHAPTER TWO)

According to Art. 9:101 (1) PEICL – under the somewhat vague title of "entitlement to indemnity" – neither the policyholder nor the insured is entitled to indemnity to the extent that the loss was caused by an act or omission on his part with intent to cause the loss or recklessly and with knowledge that the loss would probably result. The causation of loss includes failure to avert or to mitigate loss. This means that the policyholder has the duty to actively prevent the occurrence of an insured event even if the future losses have not at all been caused by him. This may lead to gaps in cases of negligence.[96]

Art. 9:102 PEICL that deals with the costs of mitigation, appears to be basically suitable. Those costs have to be reimbursed by the insurer to the extent the policyholder was justified in regarding the measures as reasonable under the circumstances even if they were unsuccessful in mitigating the loss. However, it is not easy to see why this rule shall not apply on costs meant to avoid the loss. At first sight, it seems possible to interpret "to mitigate insured loss" as including the case of avoidance of loss. However, Art. 9:101 (3) PEICL makes an express distinction between "mitigating" and "avoiding" the loss.

C. RIGHTS OF SUBROGATION (CHAPTER TEN)

According to Art. 10:101 (1) PEICL, the insurer is entitled to exercise rights of subrogation against a third party liable for loss to the extent that he has indemnified the insured. These "rights of subrogation" are structured differently; there is normal subrogation as well as the possibility for the insurer to claim in the name of the policyholder. The purpose of subrogation is to avoid unjust enrichment of the policyholder through two indemnifications for one and the same case of loss. Furthermore, the insurer has an interest in getting the revenues resulting from the insured event for the benefit of the collective of policyholders. Therefore, the insured is not allowed to waive his rights against third parties,[97] while the insurer must not exercise his rights of subrogation to the detriment of the insured.[98] In order to pursue his rights effectively, the insurer will often have to rely on the insured. Therefore a duty to cooperate – modelled on Art. 6:102 PEICL – should be added.

Quite a range of persons who may be liable for the damage are protected against subrogation by Art. 10:101 (3) PEICL. This rule not only

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[96] *See* PEICL, *supra* note 5, at art. 9:101(2).
[97] PEICL, *supra* note 5, at art. 10:102(2).
[98] PEICL, *supra* note 5, at art. 10:101(4).

concerns members of the household of the policyholder or the insured but also persons in an "equivalent social relationship" with the policyholder or insured, as well as employees. Especially the protection of persons in "equivalent social relationships" could lead to some problems as there is no definition of such a relationship and it seems hard to specify the persons protected. The provision offers an incentive for misuse as well. If there is any doubt, a court will have to disturb the privacy of the involved persons in order to assess whether a relationship is already "equivalent" to that of a household member. In contrast, the criterion of a member of the household is a clear and specified one, and it appears to be preferable that the protection should be limited to these persons.

D. INSURED PERSONS OTHER THAN THE POLICYHOLDER (CHAPTER ELEVEN)

The possibility to entitle a third party to request performance of a contractual obligation is dealt with in the DCFR.[99] Nevertheless, Chapter Eleven of the PEICL contains some special provisions (which are amended by several provisions in other Chapters such as Art. 5:105 PEICL).[100] In order to complete the provisions in accordance with Art. 1:105 (2) PEICL, the PECL as well as the DCFR must be applicable, including, e.g., the right to reject the right under the contract.[101]

According to Art. 11:101 (1) PEICL, the person for which the insurance has been taken is entitled to the insurance money. The provision does not use the words "insured" or "beneficiary" as defined in Art. 1:202 (1, 2) PEICL. Located in Part II of the PEICL, the provision is applicable exclusively to indemnity insurances and not to the insurance of fixed sums. This might cause some problems concerning the right of revocation: the policyholder is entitled to revoke the coverage unless the insured event has occurred.[102] On first glance, this seems to be necessary as in this case, the insured person is already entitled to the insurance money. The question, however, remains under which conditions does the policyholder have a right of revocation. The PEICL do not grant such a right nor do they mention what consequences the revocation might have. If in an insurance of fixed sums the policyholder only revokes without naming another third person, it is likely that the policyholder himself becomes the beneficiary, and Art. 11:101 PEICL would be not applicable then. However, this is completely different in the case of indemnity insurance. In that case, only a

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[99] DCFR, *supra* note 1, at art. II-9:301; PEICL, *supra* note 5, at art. 6:110.
[100] Weber-Rey, *supra* note 6, at 207.
[101] DCFR, *supra* note 1, at art. II-9:303; PEICL, *supra* note 5, at art. 6:110(2).
[102] PEICL, *supra* note 5, at art.11:101(2)(b).

person who has suffered a loss because of the occurrence of the insured event can be entitled to the insurance money. Therefore, a revocation of the coverage (not of the contract as a whole) granted by Art. 11:101 (2) PEICL only makes sense if the risk of damage has shifted to another person.

There is no provision dealing with the question how a person entitled to the insurance money may prove his position to the insurer. Furthermore, the relationship between this person and the policyholder is not addressed.

A rule of considerable significance is Art. 11:102 PEICL. According to this provision, the knowledge of the person insured is not attributed to the policyholder (unless that person is aware of his status as insured) when the policyholder is obliged to provide relevant information to the insurer. A clarification is necessary concerning the question whether the person has to be positively aware of his status as insured. It seems appropriate to extend the rule to the case in which the person ought to be aware of his status but negligently fails to be. Otherwise, it could be difficult for the insurer to prove that the conditions of Art. 11:102 PEICL are met. If this extension is added, it seems acceptable that in any other case the knowledge of the person insured is not attributed to the policyholder.

Art. 11:103 PEICL contains the principle that the breach of duty by one insured cannot adversely affect the rights of other persons insured under the same insurance contract unless the risk is jointly insured.

E. INSURED RISK (CHAPTER TWELVE)

If at the time of conclusion of the contract the insured risk does not exist, no premium will be due.[103] Nevertheless, the insurer is entitled to a "reasonable" sum for expenses incurred. According to paragraph two, the contract is terminated by law if the insured risk ceases to exist during the insurance period at the time that the insurer is notified thereof. In this case, the insurer is entitled to the premium in respect to the period prior to termination. This is principally acceptable. However, the provision should include an exception for fraudulent acts of the policyholder. In this case, it would be highly inadequate to release the policyholder from his duty to pay the premiums. At least for the period of time until the insurer realizes that the risk has ceased to exist, the premiums should have to be paid.

The transfer of property as a special case of the risk ceasing to exist is dealt with in Art. 12:102 PEICL. According to this provision, the insurance contract is terminated by law one month after the time of the transfer if the title to insured property is transferred, unless the policyholder and transferee may agree on termination at an earlier time. Nevertheless, it

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[103] PEICL, *supra* note 5, at art. 12:101(1).

is possible that the insurer, policyholder and transferee agree otherwise.[104] In the absence of an agreement, the contract will be terminated. This rule makes the insurance more flexible. It takes into account that neither the insurer nor the transferee had the occasion to choose their potential contractual partner. Therefore, it appears justified to terminate the contract after an orientation period. However, it seems more suitable to grant the insurer and the transferee a right to terminate the contract instead. Thus, it can be assured that the risks are still covered which helps to protect the transferee. Especially as far as immovable property is concerned, this protection may be quite essential. At the same time, the flexibility of the parties is ensured by granting them a right of termination.

F. GROUP INSURANCE (CHAPTER THIRTEEN)

There are, as of yet, no provisions in the PEICL dealing with group insurance.

III. PROVISIONS COMMON TO INSURANCE OF FIXED SUMS (PART THREE)

As to the insurance of fixed sums, the PEICL only contains a description of the scope of application for the time being. According to Art. 14:101 PEICL, the insurance of the person (examples given include accident, health, life, marriage and birth) may be taken out as an insurance of fixed sums. This means that the parties alternatively may agree on an indemnity insurance. It becomes clear, vice versa, that the insurance of fixed sums is possible only as insurance of the person following the traditional perception. The reason is that the specific interest in an insurance of the person often can hardly be exactly determined as a sum of money especially as it depends on various individual factors and circumstances. In contrast, in indemnity insurance, due to the indemnity principle laid down in Art. 8:101 (1) PEICL, it is essential to fix the interest, even if the rule on the maximum sum payable is somewhat flexible.[105] Art. 14:101 PEICL therefore is appropriate.

A. SUMMARY

Considering everything, it can be stated that the PEICL in their current version contain a wide range of basic principles which are the fruits of a careful analysis of the different insurance contract laws in Europe.

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[104] PEICL, *supra* note 5, at art. 12:102(3)(a).
[105] *See* PEICL, *supra* note 5, at art. 8:101(2).

Many rules have to be assessed as being so essential for the functioning of the insurance contract that their necessity is beyond doubt. This is especially true for the pre-contractual duty of disclosure (Art. 2:101 PEICL) and to the consequences of the aggravation of risk (Art. 4:201 ff. PEICL).[106]

However, a number of issues should be subject to further discussion. This concerns especially those provisions that are not part of the basic principles of insurance contract law. As pointed out above, the provisions dealing with the duration of the insurance contract,[107] for example, and prescription[108] deserve further attention.

The basic concept of the PEICL, which consists in just drawing the limits of private autonomy without trying to impose a certain content of the contract on the parties, seems to be very appropriate. In certain matters, however, this idea is not consistently pursued (e.g., when it comes to the binding duration of the insurance contract, allowing different periods only if indicated by the nature of the risk).109 If the PEICL are supposed to be perceived by both parties as an attractive alternative to the application of national insurance laws, such strict provisions should be eliminated. Furthermore, the attractiveness of the PEICL could certainly be increased if the "reasonable insurer" were replaced by the particular insurer involved. Furthermore, it seems questionable that in some cases the contract is terminated if the parties do not reach an agreement about certain issues.110 This legal technique sounds better than how it works in practice. It will certainly be time-consuming and therefore result in high additional costs; thus, it does not appear suitable for the mass business of (non-industrial) insurance.

Another point is that it seems important to harmonize PEICL with DCFR, in which essential parts of the PECL have been included. The references to the PECL should be revised, as mentioned above, in order to avoid uncertainties resulting from the general reference in Art. 1:105 (2) PEICL and some special references in other Chapters. Should the PEICL be integrated into the DCFR, Art. 1:105 (2) PEICL will become superfluous while some special references will still be necessary.

Furthermore, it is of great importance to increase the amount of the provisions and to make them more detailed. As the PEICL are meant to offer parties an attractive alternative to national insurance laws and are supposed

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[106] *See also* Commission Proposal for a Council Directive on the Coordination of Laws, Regulations and Administrative Provisions Relating to Insurance Contracts, art. 2-4, 1979 O.J. (C 190) 2, 3-4 [hereinafter Proposed Council Directive].

[107] PEICL, *supra* note 5, at art. 2:601.

[108] PEICL, *supra* note 5, at art. 7:101.

[109] PEICL, *supra* note 5, at art. 2:601.

[110] This kind of regulation can already be found in proposed Council Directive, *supra* note 106, at art. 3-4.

to be applicable all over Europe, it is obvious that certainty and feasibility are indispensable. There are many questions still awaiting answers. For instance, it should be laid down if there is a general duty of the insurer to give advice. Art. 2:202 and 2:203 PEICL only contain a number of special rules concerning this matter. They leave open if there is a duty to give advice after the contract is concluded. Just to name a few further questions that need to be tackled: Who has to bear the cost of investigations after the occurrence of the insured event? Who will be entitled to possession of the policy in case of insurance for the account of a third party? Which rules govern an open policy (i.e., coverage where the goods that are insured against loss or damage are not individually defined in the contract but where any kind of goods that fall under a general definition) (e.g., all goods transported by a specific carrier during a stated period) are covered? In addition, there are a number of problems that have been left to be solved by the courts in the Member states but which should, if possible, be addressed by the PEICL, such as the responsibility of the policyholder for the behaviour of other persons or the rules for interpreting insurance contract clauses.

Of course, the PEICL are only meant to be "principles." Provisions that are too comprehensive and detailed could limit private autonomy in an unacceptable manner. Yet, legal certainty and the possibility of specific, clear answers to questions of law are merits that must not be underestimated. In addition, the PEICL are meant to be an optional instrument for the parties much more than just a "restatement" (although the group of authors of the PEICL has been modestly named "Project Group Restatement of European Insurance Contract Law"). Therefore, it will be necessary to transpose all European Directives, including those dealing with specific insurance branches.

As law suits arising from the application of the PEICL will be decided by the regular courts in the Member states, a unitary mode of their interpretation[111] is essential as well as detailed provisions dealing with the most important problems. It should be kept in mind that the national insurance contract laws have the advantage that the courts already have had and used the opportunity to apply and interpret them, which leads to a comparatively high level of legal certainty. In any case, the PEICL, even as a draft that still needs completion, offers a very solid basis for further discussion in the European Union as well as in other countries such as the United States.

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[111] Heiss, *supra* note 2, at 229, 239.

AN INTRODUCTION TO CLIMATE CHANGE LIABILITY LITIGATION AND A VIEW TO THE FUTURE

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JOSEPH A. MACDOUGALD**

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This article discusses the advancement of climate change litigation. It explores two approaches to climate change litigation; the first is to use the federal regulatory apparatus and the second is to use the tort system. The article explores key questions in climate change litigation such as, who is responsible for deciding the appropriate level of harmful emissions? How should courts handle the long tail effects of climate change? What are the proper forums to litigate in? And, what is the role of the federal government in climate change litigation?

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Climate change liability litigation is a United States phenomenon. Though climate related litigation exists in other countries,[1] more climate change cases have been brought in the United States than in the rest of the world combined, and the United States stands alone in seeing significant litigation that seeks to hold greenhouse gas (GHG) emitters liable for the harms caused by climate change.

The first wave of climate liability litigation began in the mid-2000's during President George W. Bush's administration. Frustrated by the absence of a national climate change regulatory scheme in the United States, climate liability litigation began as environmental groups sought to compel policy development through two litigation avenues. One approach was to use the existing United States legal and regulatory apparatus to

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[1] A collection of non-U.S. climate litigation can be found at http://web.law.columbia.edu/climate-change/resources/non-us-climate-change-litigation-chart (last visited Aug. 24, 2013). *See also* CLIMATE CHANGE LIABILITY: TRANSNATIONAL LAW AND PRACTICE (Richard Lord et al., eds., 2012).

address rising GHG emissions. The second approach was to use the tort system to seek monetary or injunctive relief from the largest emitters of GHGs, such as coal fired power plant operators, and the manufacturers of emitting equipment, such as automobile companies.

This article introduces both approaches through their leading cases. It also serves as an introduction to a volume arising from an October 2012 conference at the University of Connecticut School of Law, *Climate Change Risks & Liability - The Future of Insurance & Litigation*. It is adapted in part from Michael Gerrard's morning keynote address to that conference.

Now is a remarkable time in the nearly decade long history of this topic. As of the writing of this article, the United States Environmental Protection Agency (EPA) has proposed its first regulatory framework for GHGs from coal fired power plants as anticipated by the Supreme Court's rulings in this area. Many of the liability cases discussed at the October 2012 conference came to their procedural end only by June 2013. However, this subsequent litigation history only serves to reinforce the view of the future and questions presented at the end of the conference and recounted here.

A. MASSACHUSETTS V. EPA – ENGAGING THE EPA

One avenue of climate litigation is to invoke the existing environmental laws to address climate change. Following this plan of attack, a collection of states, municipalities, non-profits, and land trusts filed a set of rulemaking petitions with EPA. These petitions sought to establish GHGs as air pollutants under the Clean Air Act (CAA).[2] The administrative and court cases around this strategy culminated in 2007 in the landmark decision from the United State Supreme Court of *Massachusetts v. Environmental Protection Agency* (hereinafter *Mass v. EPA*).[3]

The CAA requires the EPA Administrator to set emissions standards for any air pollutant from stationary or mobile sources that contributes to air pollution that "may reasonably be anticipated to endanger the public health or welfare."[4] While the case presented to the Court sprang from the part of the CAA that addressed mobile sources of pollution, Respondents made clear at oral argument that a ruling in their favor would establish CO_2 as a pollutant under the CAA for the purpose of regulating not only motor vehicles, but also stationary sources (of which the largest category is coal fired power plants).

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[2] 42 U.S.C. §§ 7401 – 7671 (2006).
[3] Massachusetts v. EPA, 549 U.S. 497 (2007).
[4] 42 U.S.C. § 7521(a)(1) (2006).

In initially responding to the rulemaking requests, EPA adopted the position that it should not regulate GHGs as air pollutants as a result of various policy considerations.

The Agency's rationale was based on several considerations[5] including, among others, the assertion that since GHG emissions were the subject of international negotiations by the Executive Branch, regulatory development by the EPA would disrupt these delicate, international proceedings. In disagreement, twelve States, several United States cities, and land trusts[6] brought suit. In March of 2007, the Supreme Court, by a vote of 5 to 4, held that carbon dioxide and other GHGs are within the definition of air pollutant under the Clean Air Act and that EPA does indeed have the authority to regulate them.[7] Subsequent to the decision, the EPA under the Obama administration did indeed issue a two-part endangerment finding, concluding that rising GHG levels endanger public health, safety, and welfare.[8] Thereafter, the EPA began issuing substantive regulations to restrict GHG emissions.

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[5] At oral argument, Justice Breyer made much of EPA's considerations (plural). As the agency attempted to argue that there were legitimate grounds throughout their responses that would be consistent with administrative deference provided by Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837 (1984), Justice Breyer noted that their responses consistently integrated all *considerations* including a separation of powers argument involving international negotiations. For those interested in such matters, the oral argument, easily found on websites such as oyez.org, represents high theater for listeners. "JUSTICE BREYER: If they write that all of these considerations justify our result, again, one of them by themselves, it sounds, they think would not have been sufficient." *Massachusetts v. Environmental Protection Agency*, THE OYEZ PROJECT AT IIT CHICAGO KENT COLLEGE OF LAW (Nov. 10, 2013), http://www.oyez.org /cases/2000-2009/2006/2006_05_1120/.

[6] The inclusion of land trusts in the litigation was strategic and presented itself in the briefing and oral arguments for the case. Land trusts hold an unusual position as large landowners who have a declared public purpose for stewardship of the land.

[7] Massachusetts v. EPA, 549 U.S. 497, 500 (2007).

[8] Little happened for the balance of the Bush Presidency except that EPA issued an Advanced Notice of Proposed Rulemaking. When President Obama took office, however, the agency began acting very quickly, promulgating the Endangerment Finding required under the Clean Air Act and triggering EPA's authority to regulate GHGs as pollutants that endanger the public as defined by the CAA, and served as the formal finding that greenhouse gases do indeed cause a danger to public health and welfare. *See* Endangerment and Cause or Contribute Findings for Greenhouse Gases Under Section 202(a) of the Clean Air Act, 74 Fed. Reg. 66,495 (Dec. 15, 2009) (codified at 40 C.F.R. pts. 9, 81, 63). That finding is the basis for all further GHG regulations under the CAA. Next, the Obama administration introduced a period of active climate regulation in the United States,

B. NUISANCE LAW AND TORT LITIGATION – TYING EMITTERS TO CLIMATE CHANGE'S CONSEQUENCES

In parallel to *Mass v. EPA*, four lawsuits sought redress from large scale GHG emitters under various nuisance law theories.[9] These cases were *Connecticut v. American Electric Power*,[10] *California v. General Motors Corporation*,[11] *Comer v. Murphy Oil USA*,[12] and *Native Village of Kivalina v. ExxonMobil Corporation*.[13]

Connecticut v. American Electric Power (hereinafter *Connecticut*) was filed in 2004 by eight states, New York City, and three land trusts, against five major electric utilities that cumulatively burned a substantial amount of coal and released a significant amount of GHG emissions.[14] This lawsuit sought injunctive relief from the Southern District of New York. It asked the district judge to issue an abatement order mandating that these companies' power plants reduce their GHG emissions by specific amounts each year.[15] In addition to being the first lawsuit of its kind, *Connecticut* stands out for being the only such case that sought injunctive relief instead of money damages.[16]

In *California v. General Motors Corporation*, California sued several of the major automakers over the GHG emissions produced by vehicles they manufactured.[17] California alleged that these pollutants were causing injury to the State, its coastline and other harms. The case sought monetary relief. [18]

Comer v. Murphy Oil (hereinafter *Comer*) was filed in Mississippi on behalf of many property owners against thirty or so chemical companies,

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which invited counter-response litigating from industries and states alleging overregulation by the EPA.

[9] Maxine Burkett, *Legal Rights and Remedies*, *in* THE LAW OF ADAPTATION TO CLIMATE CHANGE 815, 824-25 (Michael B. Gerrard & Katrina Fischer Kuh eds., 2012).

[10] Connecticut v. Am. Elec. Power Co., Inc., 582 F.3d 309 (2d Cir. 2009), *rev'd*, 131 S. Ct. 2527 (2011) [hereinafter *Connecticut*].

[11] California v. Gen. Motors Corp., No. C06-05755 MJJ, 2007 U.S. Dist. WL 2726871 (N.D. Cal. Sept. 17, 2007).

[12] Comer v. Murphy Oil USA, No. 1:05-CV436-LG-RHW, 2007 WL 6942285 (S.D. Miss. Aug. 30, 2007), *rev'd*, 585 F.3d 855 (5th Cir. 2009); Comer v. Murphy Oil USA, 839 F.Supp.2d 849 (2012), *aff'd,* 718 F.3d. 460 (2013).

[13] Native Vill. of Kivalina v. ExxonMobil Corp., 663 F. Supp. 2d 863 (N.D. Cal. 2009), *aff'd*, 696 F.3d 849 (9th Cir. 2012).

[14] *Connecticut*, 582 F.3d at 309; Burkett, *supra* note 9, at 825.

[15] *Connecticut*, 582 F.3d at 309; Burkett, *supra* note 9, at 826.

[16] *See* Burkett, *supra* note 9, at 827.

[17] *California*, 2007 WL 2726871 at *1.

[18] *Id.*

oil companies, and others.[19] The plaintiffs alleged that the property damage caused by Hurricane Katrina had been exacerbated, and the Hurricane's power enhanced, by climate change. The plaintiffs further alleged that the defendants' emissions had substantially worsened that change. The case sought money damages in the amount of the additional property damage that they had suffered as a result.[20]

Finally, *Kivalina v. ExxonMobil Corporation* (hereinafter *Kivalina*), which serves as the keystone case for this journal issue, was filed on behalf of the remote Alaskan Village of Kivalina that, according to their complaint, had been severely damaged by the effects of global climate change. The village, located on a narrow isthmus, was once protected from violent spring and fall storms by a natural sea ice barrier. As the climate has warmed, wave action and loss of ice eroded this safeguard. Rising temperatures meant that the natural ice barriers formed later and later in the season, leaving the village exposed to the harsh fall storms and currents. This exposure created even further erosion, destroying the subaquatic protective sand bars and barriers. Alleging that a large number of fossil fuel companies, chemical companies and others exacerbated the climate change that will ultimately force the Kivalina villagers to relocate, the Village sued these companies for several hundred million dollars in money damages to cover the associated costs.[21]

Each of these four original lawsuits was dismissed at the district court level on grounds that it raised a non-justiciable political question and each was appealed.[22] These district courts all held that issues of global warming policy were not suitable for adjudication by the courts, but rather more appropriately decided by the Congress and by the Executive Branch.[23] Some courts found other preclusive basis for dismissal, such as that the plaintiffs lacked standing to assert their claim.[24]

The notice of appeal for *California v. General Motors Corporation* was filed in the Ninth Circuit at the same time the automobile industry found itself deeply embedded in financial trouble. The highly publicized government bailout of the automobile industry brought an end to this case

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[19] *Comer*, 2007 WL 6942285 at *1.

[20] *Id*.

[21] Native Vill. of Kivalina v. ExxonMobil Corp., 663 F. Supp. 2d 863 (N.D. Cal. 2009) *aff'd*, 696 F.3d 849 (9th Cir. 2012). Michael Gerrard was formerly a partner, and is currently Senior Counsel, in the law firm of Arnold & Porter LLP, which represented a defendant in *Comer* and a defendant in *Kivalina*. He has written this article purely in his academic capacity.

[22] Burkett, *supra* note 9, at 824 n.110. For background on the political question doctrine, *see* United States v. Nixon, 418 U.S. 683 (1974).

[23] Burkett, *supra* note 9, at 824 n. 110.

[24] *Id.* at 824.

by including, as a term of the settlement among the Obama Administration, the automobile industry and the State of California, that the lawsuit be dropped.[25]

The *Comer* case enjoyed a more colorful and much less common procedural history. On appeal to the Fifth Circuit, a three-judge panel reversed the decision upon finding that the case was not, in fact, barred by the political question doctrine, and reinstated the case to the district court for further proceedings.[26] The defendants moved for an en banc hearing, to which the full court issued a decision granting that right and vacating the decision below.[27] The very day that briefs were due to the en banc court, though, it announced that it had lost a quorum.[28] Presumably due to the great number of defendants and the judges' ownership of stocks of some of them, enough judges had recused themselves that the case could no longer be heard en banc. There was, however, a quorum at the time that the panel decision was vacated. Thus the case was remanded to the district court, but since it had previously been dismissed at that level, the case was over.[29] The court did provide plaintiffs with the right to apply for certiorari to the Supreme Court, but instead they applied for a writ of mandamus, requesting that the Fifth Circuit be ordered to decide the case. The Supreme Court declined the plaintiffs' request and effectively ended that version of the case.[30] The *Comer* case was subsequently re-filed[31] and dismissed by the District Court on many grounds including res judicata. In May 2013, the Fifth Circuit confirmed that this refiling was barred by res judicata.[32] The time for plaintiffs to petition the Supreme Court for certiorari has now expired, so the *Comer* litigation appears to have ended.

The *Connecticut* case was argued in the Second Circuit in July 2005. It sat year after year without resolution.[33] The absence of this

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[25] For a discussion of the overall settlement, see Jody Freeman, *The Obama Administration's National Auto Policy: Lessons from the "Car Deal,"* 35 HARV. ENVTL. L. REV. 343 (2011).

[26] Burkett, *supra* note 9, at 827.

[27] Comer v. Murphy Oil USA, 598 F.3d 208, 210 (5th Cir. 2010), *reh'g granted en banc*, 607 F.3d 1049 (5th Cir. 2010).

[28] *See Comer*, 607 F.3d at 1055.

[29] *Id.*

[30] Comer *v.* Murphy Oil *USA,* 585 F.3d 855 (5th Cir. 2009), *opinion vacated pending reh'g en banc,* 598 F.3d 208 (5th Cir. 2010), *appeal dismissed,* 607 F.3d 1049, 1055 (5th Cir. 2010) (en banc), *mandamus denied,* No. 10-294 (Jan. 10, 2011); *In re Comer*, 131 S. Ct. 902 (2011); Burkett, *supra* note 9, at 827.

[31] Comer v. Murphy Oil USA, Inc., 839 F. Supp. 2d 849 (S.D. Miss. 2012), *aff'd*, 718 F.3d 460 (5th Cir. 2013).

[32] *Id.*

[33] Am. Elec. Power Co. v. Connecticut, 582 F.3d 309, 385 (2d Cir. 2009), *rev'd,* 131 S. Ct. 2527 (2011).

decision had begun to emerge as one of the great mysteries in climate change litigation. Finally in 2009, three and half years after the argument was heard, the Second Circuit issued a decision and reversed, holding that the case did not implicate the political question doctrine.[34] (One of the members of the Second Circuit panel that had heard argument, Sonia Sotomayor, had been elevated to the Supreme Court and did not participate in the Second Circuit decision.)

Upon the dispositions of *Comer* and *Connecticut*, where two circuits held that the issue of liability for global climate change could properly be considered by the courts, the defendants in *Conn. v. AEP* applied for, and were granted, certiorari in December of 2010.[35] In a unanimous eight justice decision, with Justice Sotomayor recusing herself, the Supreme Court reversed the appellate panel.[36] The decision was written by Justice Ginsberg and turned on *Massachusetts v. EPA's* holding that established the EPA's authority to regulate GHGs.[37] Congress had decided that it was the job of EPA, and therefore not the courts, to regulate GHG emissions. The federal common law of nuisance for GHG emissions had ultimately been displaced by the Clean Air Act, and these cases should have been dismissed after all.[38]

Kivalina was the last of these cases to be decided. As *Connecticut* had been the only GHG nuisance law case to be decided by the Supreme Court,[39] and in that case plaintiffs sought only injunctive relief, the *Kivalina* plaintiffs hoped their case was distinguishable since it claimed money damages instead. In 2012, however, the Ninth Circuit dismissed the *Kivalina* case, holding that the same rationale of displacement in the *Connecticut* case applies to money damages as well.[40] Finally, in the very end of the 2012-2103 term, the Supreme Court denial of the Village of Kivalina's petition for certiorari effectively ended the case's storied history.[41]

Although federal common law for greenhouse gas nuisance claims has been displaced by federal regulation, there continues to be the

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[34] *Id.*

[35] Am. Elec. Power Co. v. Connecticut, 582 F.3d 309 (2d Cir. 2009), *cert. granted*, 131 S. Ct. 813 (Dec. 6, 2010) (No. 10-174).

[36] Am. Elec. Power Co. v. Connecticut, 131 S. Ct. 2527, 2531 (2011).

[37] *See id.* at 2537.

[38] Burkett, *supra* note 9, at 825.

[39] By contrast, *Massachusetts v. E.P.A.*, 549 U.S. 497 (2007), was an administrative law case regarding statutory construction and agency obligations.

[40] Native Vill. of Kivalina v. ExxonMobil Corp., 696 F.3d 849, 858 (9th Cir. 2012).

[41] Native Vill. of Kivalina v. ExxonMobil Corp., 696 F.3d 849 (9th Cir. 2012), *cert. denied*, 133 S. Ct. 2390 (May 20, 2013) (No. 12-1072).

possibility of a state common law cause of action.[42] Such a claim was appended to the *Connecticut* case, but the Supreme Court explicitly declined the opportunity to address whether it could survive. The Connecticut plaintiffs chose not to pursue this claim. Other plaintiffs may press such a claim, but these or any similar claims face many significant hurdles.

C. LESSONS FROM THE NUISANCE LAWSUITS

Collectively, the four cases discussed above all foundered on a threshold barrier: separation of powers. Each of the cases has turned on some variation of this constitutional issue. Whether sounding in political question or displacement, the issue remains: whose job is it to decide how much GHG emissions are too much? These cases found that the Congress gave that job to EPA and that the courts therefore are without this power.

None of these cases progressed beyond that foundational point. There was never any discovery or judicial fact-finding in any of these cases. Presuming further advancement is even possible, it will likely be met with an onslaught of additional obstacles. There would be a question of whether the particular injury suffered is really attributable to climate change, a very difficult and technical issue.[43] In the case of *Kivalina*, this connection was easier to argue. An Army Corps of Engineers analysis concluded that the melting ice was directly related to a changing climate.[44] Contrast this with *Comer*, where the plaintiffs would have had the difficult task of proving that Hurricane Katrina struck with a force augmented by global warming.

There is also the issue of how the law and courts should account for the long time scales of climate change. GHGs may reside in the atmosphere for a century or longer and, by their nature, spread rapidly and evenly across the globe. The gasses residing in our atmosphere today are the culmination of more than a century's worldwide pollution from many countries. Unclear authority, common harm, long time spans separating the injuries from the emission, and multiple emitters of varying sizes all coalesce to show the difficulty the law has in attaching any single liability to one particular defendant. As in *Kivalina*, additional defendants would almost certainly be continuously joined in the litigation, resulting in a potentially unlimited number of parties.

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[42] *See* Burkett, *supra* note 9, at 842 n.143.

[43] *See* Burkett, *supra* note 9, at 828-29. *See generally* Michael B. Gerrard, *What Litigation of a Climate Nuisance Suit Might Look Like*, 121 YALE L.J. ONLINE 135 (2011).

[44] ALASKA DIST., U.S. ARMY CORPS OF ENG'RS, ALASKA VILLAGE EROSION TECHNICAL ASSISTANCE PROGRAM 4-5, 23 (2006), *available at* housemajority.org/coms/cli/AVETA_Report.pdf.

Additional hard questions arise from jurisdictional issues. How does a U.S. court get personal jurisdiction over all emitting parties, many of which are outside the United States? What about a state court? What is the capacity for a state court in Mississippi to bring in the Chinese electric power companies emitting CO_2? If admitted, what are the mechanisms for enforcing the judgment? What set of laws apply? Would the laws of the jurisdiction where the injury occurred prevail? Or rather the law where the offending power plant is located? If the parent company owns plants in several states, is it the law of each state that applies?

And finally, what is the federal government's role in such litigation? The construction and use of coal-fired power plants, the use of motor vehicles, and other practices that would emit greenhouse gasses have all been a matter of United States government policy for decades. The government subsidizes these activities, issues permits, builds interstate highway systems, and leases federal lands for coal mining and oil drilling. These greenhouse gas emitters are a central part of the economy, and certainly the historical emissions were all blessed by the government at some point, as evinced by the issued permits.

There is also a conceptual problem with liability concerning the supply chain. The use of electricity generated from coal requires one party to mine coal, one to transport it, another to burn it for electricity, a utility to deliver that power, and finally a consumer to use the electricity. Where along that supply chain does liability attach? The same issue arises with car emissions. Somebody drills the oil, somebody else refines it and another, or perhaps the same company, transports it to gas stations, where people individually put it in their cars. In addition to this supply chain, cars are also made by various manufacturers, and still additional people drive them. Every one of these activities is lawful, and many government policies and expenditures encourage them. Finally, is every injured community going to bring its own lawsuit for individual adjudication of these issues? All of these obstacles and more will need to be considered if any of these cases are to proceed.

A separate line of cases was launched in 2011 by a non-profit group called Our Children's Trust. These cases were all founded on the common law doctrine of the public trust, in which certain features of the natural world are held by the government in a public trust, and the government is obligated to protect them, at least unless the relevant legislature takes a different view. This doctrine had long been applied to certain coastal waters, and in some jurisdictions to parkland. The 2011 cases sought to extend it to the atmosphere. The lawsuits were brought against state and federal governments, and sought court orders that these governments adopt and enforce plans to reduce GHG emissions so that the atmosphere is preserved.

None of these cases has succeeded. The one that got furthest was in Texas, where a judge found in July 2012 that a provision of the Texas

constitution did include the atmosphere in the public trust; but less than a month later the judge said that it was not the court's role to intrude on the legislature's decisions as to environmental policy.[45] The other cases were dismissed on the grounds that the public trust doctrine does not extend to the atmosphere, or that the doctrine of separation of powers does not allow the courts to make policy decisions of the sort requested.[46]

D. THE FUTURE OF CLIMATE LITIGATION

So what is the future of climate litigation? Despite the failure of common law tort and public trust litigation against GHG emitters, from an alternate perspective one can argue that climate litigation has been extremely effective. Lawyers are struggling to find appropriate roles for the courts in this difficult debate, where the legal apparatus was not even previously engaged. While the claims attaching direct liability have recently subsided, the legitimacy of climate change as a legal and regulatory concern has been strengthened. In reviewing EPA actions regulating GHGs under the Clean Air Act, the courts have strongly reaffirmed the legitimacy of EPA's role in the face of strong challenges from industry and from states that oppose climate regulation.[47] Further EPA and state regulatory actions will surely be challenged in court by the same forces, but the battles will concern administrative procedures and statutory minutiae and not the underlying rationale behind protecting the climate.

It is likely that we will soon see a new phase litigation over climate change liability -- responsibility for adaptation to the effects of climate change, such as sea level rise. This kind of litigation has a much greater potential for success than common law litigation against GHG emitters, and will involve a much different set of defendants.

Perhaps the story of the Mississippi River Gulf Outlet, or MRGO, points the way to climate litigation's next phase. At issue in the case is a channel that was constructed by the Army Corps of Engineers to facilitate maritime travel to the Port of New Orleans, enabling passage so that ships

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[45] Bonser-Lain v. Tex. Comm'n on Envtl. Quality, No. D-1-GN-11-002194, 2012 WL 2946041, at *1 (D. Tex. July 9, 2012); Bonser-Lain v. Tex. Comm'n on Envtl. Quality, No. D-1-GN-11-002194, 2012 WL 3164561, at *1 (D. Tex. Aug. 2, 2012).

[46] *See, e.g.,* Alec L. v. Jackson, 863 F. Supp. 2d 11, 17 (D.D.C. 2012); Barhaugh v. State, 264 P.3d 518 (Mont. 2011).

[47] *E.g.*, Coalition for Responsible Regulation v. EPA, 684 F.3d 102 (D.C. Cir.), *reh'g denied*, 2012 WL 6621785, and *reh'g en banc denied,* 2012 WL 6681996 (D.C. Cir. 2012), *cert. granted sub nom,* Utility Air Regulatory Group v. EPA, 134 S.Ct. 418 (2013).

could enter from the Gulf of Mexico without having to navigate through the circuitous Mississippi River. When Hurricane Katrina came ashore, however, the impact revealed that the Army Corps of Engineers had done a very poor job of maintaining MRGO. Consequently, the channel had become much larger. This widened channel facilitated the rapid delivery of massive quantities of water, which overwhelmed dikes and levees in New Orleans, and augmented the damage caused during the hurricane.

In Re: Katrina Canal Breaches Litigation[48] constituted the numerous resulting lawsuits brought by homeowners and other parties whose property had been damaged by the breaches of those levees.[49] According to a federal statute, flooding related to flood control projects cannot be the basis of liability, but liability may attach to other projects, including navigation projects. Thus, when trial was held in the District Court of New Orleans on behalf of bellwether plaintiffs, the first question asked was whether MRGO was a flood control project, or a navigation project. The Court made a preliminary finding that MRGO was a navigation project, and not a flood control project. The next question at issue was whether this suit fell under the discretionary function exemption in Federal Tort Claims Act, which provided immunity from liability. The Court again found in favor of the plaintiffs, holding that this was not a discretionary function case; the Army Corps of Engineers did not make a policy choice not to maintain the canal adequately, but rather did so out of negligence.

The National Environmental Policy Act had obligated the Army Corps of Engineers to update the environmental impact statement for MRGO to reflect significant new conditions, and their failure to do so constituted a breach of duty. The District Court awarded $750,000 in damages to the five bellwether plaintiffs. With thousands or tens of thousands of similarly situated plaintiffs, this could easily amount to billions of dollars, and the Army Corps of Engineers appealed. The Fifth Circuit affirmed, allowing the lawsuit to proceed.

This decision opened up a completely new avenue of liability litigation against the providers of infrastructure, as well as the designers and builders of structures that do not withstand foreseeable events. When the Army Corps of Engineers moved for an en banc hearing, though, the Fifth Circuit reversed itself, treating the motion as a rehearing and unanimously changing the disposition. With barely an acknowledgement or explanation, the three members of the original panel issued a decision

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[48] 696 F.3d 436 (5th Cir. 2012), *cert. denied sub nom.* Latimore v. United States, 133 S. Ct. 2855 (2013) (mem.).

[49] Robert R.M. Verchick & Joel D. Scheraga, *Protecting the Coast*, *in* THE LAW OF ADAPTATION TO CLIMATE CHANGE 235, 247 (Michael B. Gerrard & Katrina Fischer Kuh eds., 2012).

holding the exact opposite of their previous decision on the issue of sovereign immunity. Following the *Comer* case, this next internal reversal of the Fifth Circuit only generated more curiosity. The Supreme Court denied the writ of certiorari challenging the Fifth Circuit's decision on June 24, 2013.[50]

Although this case has presently exited the legal stage, it has successfully created an air of credibility concerning the liability for infrastructure providers and building designers. In contrast to the long list of difficulties and obstacles that pertain to the common law nuisance cases, there is a much shorter list for this type of liability litigation. These cases are not against greenhouse gas emitters, and thus do not depend on a showing that any particular event was caused by greenhouse gas emissions or by any party in particular. Here, the burden of proof pertains merely to whether this kind of weather event was foreseeable to the builders or designers of infrastructure, and whether they had a duty to take precautions.

For governmental defendants, there will still be a sovereign immunity issue. Every state has its own tort claims act and every state has its own way of interpreting the discretionary function exemption. Therefore, much to the disappointment of private architects, engineers, builders and so forth, it remains to be seen on an individual basis how each state will resolve the issue. There also remains the question of who has the ability to sue, that is to say, who owes a duty to whom. But despite these issues, this remains an area ripe to become a major and growing subject of litigation, and where there is litigation, there are, of course, claims for insurance coverage.

In closing, climate change will remain a motivation for litigation in our court system. Through *Mass. v. EPA* and many state and municipal actions, climate change has gained legitimacy as a source of harm and a cause of action. In this next phase of our evolving, societal reckoning with our changing world, litigation will surely focus on the responsibility of public and private parties to adapt to our new normal, the realities of a climate changing world.

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[50] *In re* Katrina Canal Breaches Litig., 696 F.3d 436 (5th Cir. 2012), *cert. denied sub nom.* Latimore v. United States, 133 S. Ct. 2855 (2013) (mem.). *See also* Willis Hon, Field Report, *5th Circuit Reverses Itself on Hurricane Katrina Liability Lawsuit*, COLUM. J. ENVTL. L., (2013).

KEYNOTE ADDRESS, CLIMATE RELATED EXTREME EVENTS, LIABILITY REGIMES & THE ROLE OF THE GLOBAL INSURANCE INDUSTRY

JOHN H. FITZPATRICK*

Climate change is a topic of great and increasing significance. The inherent risk it presents to people all over our planet will require the best and the brightest to address many different aspects of the problem, and many perspectives from the world of insurance, and its management of extreme risks, so that societies can, and will, utilize them to address some of the issues presented by climate change.

The unique characteristics of risk management, and of the insurance industry itself, create an integral and dynamic role for insurance as a tool to mitigate several aspects of climate change. Today, the messages of greatest importance revolve around the recognition and examination of what the insurance industry can achieve in the face of climate change risk, and also what it cannot.

For centuries insurance has ameliorated the damage of extreme weather events, and in the last two centuries, has protected many cities around the globe against the risks of extreme weather. The unique capacity of the world's insurance industry to protect society from the damage that can come from extreme weather events is based on a deep knowledge of risk engineering that can be employed to foster sound land use planning, more secure construction techniques and widespread adoption of protective building codes. Insurers can, and do, develop new products that foster better loss prevention while utilizing the best of global operating methods to bring initial and essential relief to the victims of climate related damage. Regrettably, however, these industry resources are all too often ignored by policymakers who favor a narrow, short term, and sometimes politically motivated, role for the insurance industry to minimize loss from extreme events for their constituencies.

Property insurance, which is free to be sold in conditions and at prices that fairly reflect the risks of the location and facilities seeking coverage, is distinctively competent in providing first party compensation for climate related losses. In this regard, insurance, by the pooling of large numbers of risks, reduces the individual's risk of loss and therefore the expense of loss. These competencies should be deployed in tandem with community, state, and national resilience movements. Regarding climate risks, this requires the terms and prices to grow with the frequency and

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severity of anticipated losses. Allowing these risk management tools to be freely applied will cause commercial and personal property owners to reconsider where they wish to locate and how they should operate. But all too often, laws and regulations limit or prohibit such tools from being utilized, depriving many property owners of any insurance coverage and further burdening taxpayers and other insureds, impairing climate change sustainability rather than fostering it.

The industry can fill this role of facilitating resiliency more effectively than it does today, but it has been inhibited by public policies that view many functions, such as the setting of building codes, land use patterns, and others, as exclusively government functions. As a result, there has been little opportunity for the "market" to inform the debate on such topics. As an exclusively governmental function, it is inevitable that the decisions regarding such important long-term subjects are informed by politics, rather than by a proper risk management or reflection of risk pricing. In this area, it is the insurers and stakeholders that are able to achieve more than is currently being done through effective public-private sector collaborations.

But insurance, as it stands today, remains limited in its capacity to improve the risks and minimize the effects of climate change. For instance, the frictional cost of compensating loss through liability litigation at 40-50% of the throughput of funds seems like an unsound and expensive social policy that would threaten the sustainability of insurance as a resource for sustainable development. Still more evidence of these shortcomings emerge through a reflection on the developments of the past twenty years, and two seminal events that galvanized the U.S. public attention to the confluence of climate change and the law.

The first event was Earth Summit, held in June, 1992, in Rio de Janiero. It was a global call to arms, warning that the acceleration of global warming constituted a meaningful threat to the sustainability of the comforts of life in developed countries and the opportunities for those comforts in the not yet developed parts of the world. The nations and institutions gathered in Rio committed to change behaviors through both governmental and private actions, with ambitious goals for reducing carbon emissions contributing to global warming. The Rio commitments have not been implemented as their authors hoped, but the message of urgency that Rio launched remains with us today.

The second event came just three months later in September 1992. Hurricane Andrew attacked Florida with a vengeance: a Category 5 hurricane with wind gusts up to 206 mph. The storm's toll included 126 lives lost, 126,000 homes destroyed and over $18 billion (in 1992 dollars) in property damage. As significant as those storm totals were, it was fortunate that the storm was just a glancing blow south of Miami. Yet it still created devastation, lowering property values and alerting many in America to the potential for loss of life and property if a Category 5

hurricane struck Miami directly, or any major U.S. costal city in the changing storm tracks of the future.

The events of 1992 changed the direction of the world, but not enough. Individual regard for the environment has improved, and organizations have mobilized various forms of remedy, but geo-politics has not made climate change a priority. There are however, two consequences of note.

First, the insurance industry "got it." It saw the need for better protection of its shareholders assets, and understood the need for commitment to the requirements of climate related sustainability. By the mid-1990's most of the world's leading insurers had adopted sustainability programs that influenced discretionary investments, captured the collective energies of employees and elevated sustainability consciousness among shareholders and business partners. Individually the industry leaders began producing annual sustainability reports as complements to annual shareholder financial reports. More important, those early movers invested in the action programs described in the reports. The insurance industry became the first industry to truly embrace sustainability.

The insurers embrace of the implications of climate change was rational as self-interest became clearer. While no single storm can be attributed to climate change, a defining moment of US weather related extreme events occurred thirteen years later in 2005 when four Category 5 hurricanes struck the U.S. and Mexico. Hurricanes Katrina, Rita and Wilma, demonstrated the enormous energy and destructive potential of windstorms as never before. The combined death toll exceeded 2,000, and the property damage topped $125 billion. Katrina alone cost $81 billion, triple that of Andrew. The costs of a changing climate pattern affecting frequency and severity, clearly exceeded the loss models on which property insurance had been priced.

The initial reaction from the public sector was slow and woefully insufficient. Insurers went about their responsibilities as fast as the public sector could allow, and sometimes even faster than the public sector was able to allow access. Adjusters were on site as the flooding subsided; processing claims rapidly to assist homeowners and businesses in restoring life amidst the ruins. When the final loss data was compiled, it showed that reinsurers from all parts of the world had paid 61% of the damage. Combined with the losses paid by direct insurers, the insurance industry paid approximately 75% of the property losses.

For The Geneva Association, Katrina, Rita and Wilma were the signals that the world needed to pay much more attention to the risks of climate change. The "Climate Risk and Insurance" program, a special initiative of the Association, works with the United Nations and other organizations to assure that the knowledge and special competencies of the insurance industry contributes to the understanding and modeling of

climate events and the measurement and quantification of those risks. The Climate Risk and Insurance Working Group also assisted in the development of a statement by CEO members declaring the responsibilities of the industry in coping with the challenges of climate risks. Titled "The Kyoto Statement of the Geneva Association" (for its adoption in Kyoto on May 29, 2009), the Statement reads as follows:[1]

> The latest climate science strongly indicates that climate change is happening, Mankind's influence is very material and the changes are occurring faster than earlier projected. The prospect of extreme climate change and its potentially devastating economic and social consequences are of great concern to the insurance industry. Against this backdrop, we, the leaders of the world's largest insurance and reinsurance companies, as assembled in The Geneva Association wants to make known our view through the following key messages.

Those key messages involve commitments to customers, policymakers and the industry on a global basis. It is in this regard that the second consequence to emerge from the events of 1992 bears significance. Not only did the insurance industry "get it", but others interested in compensating victims of climate related catastrophes, and their attorneys, got their own message: with vast needs for compensation, and no humanitarian solution in sight as a result of governments that could not or would not pick up the tab, invoking the liability regimes of the world, or creating new ones to justify the transfer of assets from the pools where they could be found to where relief was needed, was the solution.

The humanitarian appeal of changing a tort liability system to a compensation system is undeniable. However, one can question the utility of transforming a system founded on principles of fault to one founded on principles of need without first creating a sustainable model of linkage between economic reality and responsible behaviors. One need not be a legal scholar to recognize the clumsy process of attempting to squeeze a square peg into a round hole. Nor does it take an expert on constitutional law to recognize efforts to convert the U.S. civil justice system into a system to socialize losses from massive weather related events. One can question the motives, but more importantly, one can question the method

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[1] The Kyoto Statement of the Geneva Association, The Geneva Association, May 29, 2009 *available at* https://www.genevaassociation.org/media/206439/GA2009-Kyoto_Statement.pdf.

with concern that the short-term objectives will undermine long-term sustainability.

Beginning with consideration of economic scale, there is no doubt that the defendants in the *Kivalina* case,[2] and their insurers, would be able to bear the costs of relocating that unfortunate community. The costs will be *de minimis* compared to what the U.S. Army Corps of Engineers spent enabling large sections of New Orleans to rebuild below sea level after it drowned in Katrina. But was that public cost a wise use of national resources? There was little, if any debate about that decision and certainly almost no economic analysis.[3] Nor was there much concern that the new levees were rebuilt to withstand only a once-in-100-year weather event, when there have been several such events in the U.S. in just these past twenty years. If the public sector is the place to fund the rebuilding of New Orleans below sea level, perhaps it is the proper source of funds to relocate the Inuits to safe ground.

These, however, are all affordable issues, but the potential costs of climate related extreme events may not be. A study conducted by Trucost consultants for the financial institution branch of the UN Environmental Protection Agency recently produced some striking numbers that UNEP FI has endorsed. Trucost has determined that the annual global cost of climate related extreme events attributable to greenhouse gas emissions is $6.6 trillion, annually.[4] Further calculations lead Trucost and UNEP FI to attribute $2.15 trillion of this annual amount to the GHG emissions of our global industrialization—the "anthropogenic" component.[5]

UNEP FI helpfully notes that the $2.15 trillion could be compensated out of the operating revenues of the 3,000 largest public companies in the world, and presumably their insurers.[6] What is the connection that links the universe of business and the community of need? That has not been explained, but the implication drawn by these policymakers seems clear: large businesses are likely large emitters of greenhouse gasses and should be held responsible for the consequences.

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[2] Native Vill. of Kivalina v. ExxonMobil Corp., 663 F. Supp. 2d 863 (N.D. Cal. 2009), *aff'd*, 696 F.3d 849 (9th Cir. 2012).

[3] It has to be said that politicians get the microphone first after an event, and it is as predictable as the sun rising after a dark night that they immediately vow to "Rebuild their City", New Orleans in 2005, the vast neighborhoods south of Miami in 1992, and if one is a student of insurance you can find the same said about San Francisco in 1906.

[4] Trucost, report, Universal Ownership: Why Environmental Externalities Matter to Institutional Investors, April 6, 2011.

[5] *Id*. at 25.

[6] *Id.*

There seems a similarity of approach between the Inuits and the global victims; the similarity being the lowering of tort and mass claim liability standards to a point that they do not impede the flow of funds from owner to a new beneficiary.

The scale and precision of the numbers may be difficult to accept, but there lies no reason to question the good faith belief behind that effort. If costs of that magnitude were to be incurred, the theories of socializing those costs through a liability system would not be a sustainable commercial or governmental model for any country in the world.

Good things have emerged from the climatological and political events triggered by Rio 1992 and the new era of catastrophic hurricanes that began with Andrew. The humanitarian movement understands that insurance assets are a resource to be utilized, and the insurance industry understands that climate change and its consequences are of great concern for which it must play a leading role in finding solutions.

These insights clearly need to be conjoined in a constructive way, but perhaps draining the river of business and insurance assets as fast as climate related extreme events requires is not such a constructive way, as the river is not fed by a bottomless well of resource.

As for the financial resources available, it is important to note that the coffers of the insurance industry were depleted not just by extreme insurance events of recent years, but also by the financial crash of 2008. Much more damaging to these coffers, however, is the daily erosion that comes to the insurance industry from the cures implemented to fix our ailing western and eastern economies. The collective action of the world's central banks to repress interest rates over several years is more than hurting the margins of the insurance industry, it is reducing the industry's ability to resiliently deal with future climate events. This financial repression caused the entire industry's equity to be valued by investors below book value, a condition which, if it continued, would severely limit the likelihood and amount of post-event financing that could ever be supplied by investors.[7] So, as long as the sustainability challenge operates within a clearly financially limited insurance industry there will have to be a better way.

The search for a better way requires clarity about the problem. The expectation that climate risks will rise in frequency and severity is not the problem. The problem lies in the approach to mitigate the effects of climate change and how to most efficiently deal with the impending losses

[7] After September 11, 2001, an extreme event that no insurer was ever paid for, 6 billion Swiss francs of capital was raised to replenish Swiss Re's balance sheet post event. This tool of post-event financing is severely limited in today's world given these, arguably rational, valuations.

and hardships. The use of liability mechanisms or artificial surrogates operating under the procedures of liability litigation, with frictional costs of 40-50% for payers and beneficiaries, is the least efficient option. It is worth noting that the frictional costs of workers compensation systems in the U.S. are at 3%, so at the very least it can be said that choosing the liability route to compensation is not in the interests of either the providers or victims.

The components of the problem are numerous and often debated: flawed land use planning, weak and poorly enforced building codes, absence of resilience planning from the community level on up, and the absence of post-event recovery planning, especially for events that spread over the borders of many sovereign jurisdictions. The commitment adopted in the Geneva Association's Kyoto Statement provides directional guidance about dealing with these problems:

> In dealing with our customers insurers:
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> - …[A]re committed to enhancing our research capabilities in order to provide a better evaluation and management of climate risks.
> - …[P]romote mitigation efforts by developing products which incentivize offsetting
> or reducing greenhouse gas emission levels.
> - …[D]esign insurance products to support low carbon energy development projects
> and to help attract investments to such projects.
> - As major institutional investors, the insurance industry (will) encourage mitigation and adaptation efforts such as investing in low carbon energy projects.
>
> In dealing with those who make or influence public policy insurers:
>
> - …([W]ill) help counter climate risk through active cooperation in implementing building codes or similar means which encourage the use of sustainable practices.
> - …[W]ork closely with policymakers on communicating to our customers their climate risk levels, possible strategies of mitigation and adaptation, and in quantifying the financial benefits of those strategies.
> - …([P]rovide) innovative solutions for climate risk issues. These include funding relevant research and providing tools to its customers to assess and counter climate risks.

- …[R]ecognize the significant benefits of pooling climate risks. We urge policy-makers to collect robust data and make it freely available to allow risk assessment and to facilitate efficient solutions where premiums are risk based.[8]

These may sound like institutionalized, high sounding phrases without meaningful content, but they are not. There is no better place to begin addressing the real issues of climate change. Each of those simple statements has a depth of thought and substance embedded in it to determine what is optimally possible and about how to construct sustainable solutions to the climate change challenge.

But if that is correct, why has there been only a modest, and generally unrecognized, progress in the three years proceeding the issuance of that Statement? Has the insurance industry failed to deliver on its commitments? No, but the progress and effort behind it have not been as robust as it should and can be. The causes for the snail's pace of progress are complex and intertwined. However, one factor stands out as the primary obstacle: the absence of needed cooperation from public sector policymakers, and regrettable public sector obstacles to the implementation of sound initiatives. Private sector actors, all acting in their acknowledged self-interests, have also contributed to the absence of take up of these and other like minded proposals.

Behind the insurance industry's pledges lie vast and unique competencies, data resources and analytics, risk management expertise, and the disciplinary tools of product terms and pricing to help policymakers, and the insured, take serious and immediate actions to mitigate risks to life and property. But there is little that can be done with these tools unless there are actors willing to incorporate them in response to the real climate change problem. Further, there will be few such actors if those who set public policy, law, and regulation interfere with market dynamics.

Responses to Hurricane Andrew illustrate the public sector's interference with the potential for effective private-public collaboration at a time it could be most valuable. The endless stretches of devastated housing flattened by Andrew were dramatic proof that the applicable building codes fostering those housing developments were not sound. One might have expected two things to have happened, not just in South Florida, but in many parts of the U.S., in the wake of Andrew's destruction: 1) major reformation of building codes, incorporating the data and expertise of the insurance industry, and 2) the escalation of property insurance premiums using insurance pricing tools to assure those who chose to settle in areas

[8] Kyoto Statement at 1.

vulnerable to hurricanes would pay according to their choice to live in harm's way.

But the State of Florida had other ideas. First, it prevented insurers from charging actuarially sound prices for the risk. As a result, insurers announced they would withdraw from the state. To combat the effects, Florida passed a law preventing any insurer from withdrawing more than 5% of its business in a single year. Insurers appealed this decision and spent the next year figuring out which 5% of their business would not be renewed. The most wind-exposed policies found their way into the Joint Underwriting Association ("JUA"), a state owned and operated insurer of last resort that provided insurance coverage at prices far below actuarially sound prices. These events reduced the pressure for a true rectification of building codes, land use restrictions, and movement of facilities off of heavily exposed coasts.

Four years into this march of folly, a consultant to the State of Florida submitted a study on the risk the JUA faced now that it was the third largest homeowners insurer in the state with more than a million policies on its books. The study pointed out that if the wind blew, not only would the JUA be bankrupt, it could also impede the State of Florida, which would be required to finance the claims of the JUA in such a large event.

The second act of the State was to pass legislation to entice new entrant insurers to take policies out of JUA at a high cost to JUA, a folly not required if the State would have allowed the actuarially proper price to be allocated. To this day, the Florida insurance market continues to be in an unsustainable position, given the frequency and severity of hurricane activity likely to occur, the limits placed on market-based catastrophe models and direct limits on pricing.

It does not require much thought to recognize the consequences of such a series of efforts to control the price of insurance. Poor land use planning continued into a statewide boom, slowed only temporarily by the financial crisis fifteen years later. Building codes were not rigorously corrected - another area where the expertise of insurers went largely unused - and the amount of commercial and residential property in coastal Florida has increased to this day. Subsequent storms much less fierce than Andrew will prove the risk that the state insurance fund face; the risk it would need to be bailed out at taxpayer expense when an extreme event occurs. In essence, it can be said that the relatively affluent developed the state and its coastal areas to a point where they will be the victims, predictably, of extreme windstorm losses. It can be argued that this affluent group is using the powers of the state to be bailed out in the future by the relatively less affluent not on the coast in their heavily exposed houses and other facilities.

The Florida experience has been replicated throughout the U.S. in a variety of ways, although there have been some examples of courageous public sector use of wiser principles and of the power of insurance industry advice and products that were properly designed and priced. But sadly, those wise courses chosen are not in the majority. Is it not fair to suggest that rebuilding large sections of New Orleans below sea level, at a hurricane prone location, was a massive misallocation of resources that benefitted the few with political influence at the expense of taxpayers nationwide?

These issues continue to unfold around the globe, and implementing the solutions embedded in the Kyoto Statement is considerably more difficult when dealing with multiple sovereign countries than here in the U.S. where public policy responsibilities operate in a largely federal context. However, the challenges of mitigation, adaptation, remediation, and resilience to climate change are not substantially different, and the impediments to sound public-private sector collaboration in the use of insurance expertise and tools, is as strong today as ever.

Beyond the politically motivated, there are other public sector obstacles facing the insurance industry in seeking to implement the goals of the Kyoto Statement. First, the public-private collaborations that are essential to meaningful solutions must begin with close cooperation among the leading insurers and reinsurers. That cooperation will be most useful if these groups can work with one another to design products and services for public authorities and private clients. But there are competition law constraints in all developed economies, and competition enforcement authorities in many, that create a serious risk if such cooperation were to be meaningfully pursued absent some accommodation in law.

That is not to suggest that the traditional role of competition authorities should be abandoned for insurers. In developed lines of business they are as warranted for insurance as for other industries. But where insurers are attempting to contribute their vital skills to solving crises as large as climate change, changes to laws should be implemented for the greater good of financial stability and social sustainability. Regrettably, to date there has been no sign of policymaker support for this accommodation.

Second, the insurance industry is undergoing massive regulatory and solvency revisions, arising out of the financial crisis. Politicians and regulators tend to view the insurance industry as an industry with a similar business model to that of investment banks, retail banks and other deposit taking institutions. Consequently, they worry about runs on insurance assets as systemic risk and look at our solvency needs as though our liabilities are as volatile and as easily callable as bank deposits.

In fact, there are structural and business model differences that make insurance a natural stabilizer for domestic and global economies. “Deposits” are premiums, for which the corollary obligation to pay is

contingent and largely outside the timing control of the insured. With the power of history as a guide, the severity and frequency of most claims exposures are quite predictable, especially over multiple years. The insurance position in the U.S., and elsewhere, is further secured by the claims reserve requirements of existing insurance regulation. For all its adverse publicity, AIG's regulated insurance subsidiaries were able to pay all legitimate claims when due and its holding company pay back the American taxpayers all loans, plus a $15 billion profit with another $8 billion of profit to be realized by future sales of stock by the U.S. Treasury. It is clear, however, that the industry faces uncertain outcomes regarding solvency standards and regulatory constraints that run directly counter to the flexibility required to innovate and respond to climate related risks.

Finally, politicians and regulators misperceive the purpose and role of insurance in the free market economy. Even those who realize the industry's financial resources do not magically descend to earth from another planet hold a similar assumption that whenever an insurer incurs losses beyond their expectation—a not uncommon experience in the property sector with the advent of climate change or in the liability sector with innovative efforts to lower the bar of recovery with retrospective effect that is unknowable at the time of underwriting— the industry has an endlessly elastic capacity to increase premiums in all classes of business to pay such losses and that investors have an unending appetite for insurance stocks such that capital can be replenished in this manner. If only that were so.

Commercial insurers cannot transfer the costs of Katrina to auto and homeowner customers in, Minnesota, or even to auto manufacturers and the energy sector. There is no legal or economic basis for doing so, and a healthy free market environment in which new capital can arise as competition at any time prevents such loss shifting —as it should. Insurance serves society and the economy by distributing losses on an equitable basis among the universe of insureds facing similar risks. In that process, the insurer often absorbs loss in greater or lesser amounts than anticipated. But the industry cannot consistently bear aggregate losses that are not recoverable over time, for our investor capital will quickly move to other industries with better and more reliable returns.

Those policymakers and humanitarian organizations who expect insurance to operate as a public resource, able to tax customers for whatever is necessary to meet evolving theories of climate related liability may harvest a few eggs in the short term, but will kill all the geese before the long term arrives.

In the greater context of climate risk liability, and at some risk of informality, a well-worn aphorism comes to mind: When one is up to your axx in alligators, it is difficult to remember that we are here to drain the swamp. Referring, of course, to draining the swamp as the counterpart to

finding the path toward a sustainable future, which adapts to climate change, the reference to alligators is not intended to be a metaphor for anyone, particularly some of our legal brethren in the audience today. Indeed it can be a term of respect for those with a different view of how to drain the swamp.

The work of the Geneva Association's liability regimes program has described and analyzed the trends of the past sixty years for innovations in liability law and practice to be used as a medium of social change and a form of regulation in the private sector. The asbestos and tobacco industries will testify to that, as will many consumers who give thanks to the model (or myth) of Erin Brockovich. But the forecasted effects of climate change envision property losses and human suffering far beyond the scale of all the world's swamps, and the players in the climate change drama need to find common ground and collaborative innovations if the dry land of sustainable development is to be secured from a vulnerable swamp.

Climate change and its manifestations in extreme weather events cannot be terminated by fiat, but the manifestations might be minimized by collective global wisdom. Reasonable doubt exists about the early prospects of accomplishing this until the goals and undertakings of close to 200 some sovereign states can be aligned. With so little progress toward that alignment since 1992, the duty now is to minimize the adverse consequences of climate change, using complementary skills and aligned interests of those like thinking parties in the private sector, combined with pursuit of collaboration with public sector bodies willing to participate.

Thus, the optimum foreseeable goals should be:

- Universal appreciation of the challenges.
- The transformation of political will from short term opportunism that creates moral hazard to the hard decisions of responsible planning.
- The removal of government owned insurers from distorting the policy terms and price signals that the insurance market can provide.
- Public sector regulation of land use, structural design and population center developments that give due consideration to the mitigation of losses, using insurance data and expertise and all other useful inputs.

- Appropriate accommodations from competition authorities and insurance regulators to allow full use of the industry's assets and competencies to address this issue.

- Maximum innovation of new products by insurers to foster better preparedness and to limit the need to depend on high carbon industrial processes.

- Public-private collaborations on readiness plans for post event recovery, utilizing the insurance industry's capacity to provide suitable market priced policies, to respond quickly with large numbers of trained personnel, and to be better able than most to deliver integrated attention across national borders where the climate event spans regions.

Bringing together all these several themes regarding the insurance industry, climate change, and the interplay between them, several conclusions emerge. First, climate change mitigation—the reduction of CO2 gas emissions—is a government responsibility and can be achieved by changes in technology such as: shifting from coal to low carbon shale gas or near zero carbon (hydro, geothermal, wind and solar). Second, adapting to extreme weather events is most efficiently done through the cooperation of governments, the insurance industry and the potential victims. Three, insurance is based on risk assessments, risk pricing and risk transfer and will thus promote cleaner technologies with lower risk potential by offering lower premiums for them. Finally, the inability of governments to mitigate climate change will lead to a shift of liability to the private sector. Similar to asbestos and tobacco, the insurance industry will be faced with the possibility of having to pick up this bill and here it has no realistic capacity to do so.

The insurance industry has a sound and sincere understanding of the challenges embedded in climate related extreme events, and is well suited as a contributor to drain the swamp. Implementation, however, holds a pace that is less promising, and cannot be accomplished without collaboration in conjunction with legal and regulatory cooperation. It is imperative, however, that the insurance industry continue to strive for further progress on all fronts with a required sense of urgency.

Finally, reliance on unadapted liability law and practice remains an unsuitable method to drain the swamp, insofar as using liability claims is a means of socializing the unavoidable hardships. The socialization of losses is likely to be a goal most thinking, feeling people would choose. But it is a goal that must begin with multi-governmental agreements that create an efficient and equitable basis of asset transfers. Such agreements are also necessary to enable insurers and other contributors to act in

compliance with domestic laws and regulations. Socialization of climate losses through the reshaping of liability law and practice is intrinsically inefficient, consistently confrontational where cooperation is required, and has the risk of preventing sustainable development.

Finally, reliance on modifying liability law and practice remains an unsuitable method to drain the swamp, insofar as using liability claims is a means of socializing the unavoidable hardships. The socialization of losses is likely to be a goal most thinking, feeling people would choose. But it is a goal that must begin with multi-governmental agreements that create an efficient and equitable basis of asset transfers. Such agreements are also necessary to enable insurers and other contributors to act in compliance with domestic laws and regulations. Socialization of climate losses through the reshaping of liability law and practice is intrinsically inefficient, consistently confrontational where cooperation is required, and has the risk of preventing sustainable development.

IS GLOBAL WARMING A COVERED "ACCIDENT"? AN ANALYSIS OF *AES Corp. v. Steadfast Insurance Co.*

REX HEINKE*
WARREN J. BIRO**

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This article discusses whether or not commercial liability insurers have a duty to provide coverage to policyholders who are sued because their activity contributes to global warming. The article focuses on a decision by the Virginia Supreme Court in AES Corp. v. Steadfast Insurance Co. in which the plaintiff insurance company sued its policyholder claiming that the act of emitting carbon dioxide into the atmosphere was not an "occurrence" as defined in the insurance policy and therefore no coverage was required. The Virginia Supreme Court agreed, ruling that coverage by the insurer was not necessary for any period in which the policyholder knew, or should have known, that the emission of carbon dioxide had a substantial probability of causing harm.

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I. INTRODUCTION

In *AES Corp. v. Steadfast Insurance Co.*,[1] the Virginia Supreme Court held that claimed injury due to a power company's alleged contribution to global warming was not an "accident."[2] Therefore, although the insurance company had issued the power company several commercial general liability ("CGL") insurance policies that provided coverage for an "occurrence," the insurance company did not have a duty to provide coverage for the insured's cost of defense because those policies defined "occurrence" as an "accident."[3] This Article contends the Virginia Supreme Court's decision in *AES* was wrong, and the insurance company should have been required to provide the insured with a defense.[4]

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[1] AES Corp. v. Steadfast Ins. Co., 725 S.E.2d 532 (Va. 2012).

[2] *Id.* at 537.

[3] *Id.* at 538.

[4] The views expressed in this Article are those of the authors. They do not necessarily reflect the views of the AES Corporation or Akin Gump Strauss Hauer & Feld LLP.

II. BASIC FACTS

The plaintiff in *AES* was Steadfast Insurance Company, a global insurance provider. From 1996 to 2000 and 2003 to 2008, Steadfast issued a series of CGL policies to the defendant, AES Corporation, a Virginia-based energy company that produces electrical power around the world.[5]

In the underlying litigation that gave rise to the issues in *AES*, the Native Village and City of Kivalina ("Kivalina"), a native community in Alaska, brought suit against AES and numerous other energy companies in 2008 in the Northern District of California. Kivalina alleged it was harmed as a result of global warming to which defendants contributed through the emission of greenhouse gases.[6]

Specifically, Kivalina contended: (1) defendants' fossil-fuel-fired electrical generating plants emit large quantities of carbon dioxide as a waste by-product of combustion,[7] (2) defendants fail to reduce these emissions by not using "alternatives to fossil fuel combustion,"[8] (3) these emissions "mix in the atmosphere"[9] and "merge[] with the accumulation of emissions in California and in the world,"[10] (4) the emissions further accumulate in the upper atmosphere and trap heat, along with carbon dioxide emitted many years ago by other sources,[11] (5) over a period of time the trapped heat raises the temperature of the atmosphere,[12] (6) the increased temperature raises ocean temperatures, which melts Arctic glaciers and ice caps, including Arctic sea ice in the upper northwest corner of Alaska that ordinarily builds up in front of Kivalina during the winter,[13] (7) this leads to sea ice forming later or melting earlier than usual in front of Kivalina, with the ice not being as substantial,[14] (8) this results in Kivalina, located on an Alaskan coastal barrier island, being more vulnerable to waves and storm surges that cause erosion and flooding, which render the island uninhabitable.[15]

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[5] *AES Corp.*, 725 S.E.2d. at 533.

[6] *Id*.

[7] Complaint for Damages; Demand for Jury Trial at 2, 4, 7, Native Village of Kivalina v. ExxonMobil Corp., 663 F. Supp. 2d 863 (N. D. Cal. 2008), *aff'd*, 696 F.3d 849 (9th Cir. 2012) (No. 08-01138) [hereinafter *Kivalina* Complaint]; *AES Corp.*, 725 S.E.2d. at 534.

[8] *Kivalina* Complaint*, supra* note 7, at 23–24.

[9] *Id*. at 34.

[10] *Id.* at 3.

[11] *See id.* at 31.

[12] *Id.* at 31; *see also id.* at 32 (alleging that the fourteen warmest years on record have all occurred since 1990).

[13] *Id.* at 33, 45.

[14] *Id.* at 45.

[15] *Id.*; AES Corp. v. Steadfast Ins. Co., 725 S.E.2d 532, 534 (Va. 2012).

Kivalina further asserted that there is "a clear scientific consensus that global warming is caused by emissions of greenhouse gases, primarily carbon dioxide from fossil fuel combustion and methane releases from fossil fuel harvesting."[16] Thus, Kivalina alleged that AES and the other defendants "*intentionally* emit[] millions of tons of carbon dioxide and other greenhouse gases into the atmosphere annually" and "*knew or should have known*" of the "impacts of [their] emissions on global warming."[17] Kivalina contended that "[d]espite this knowledge," AES continued to emit greenhouse gases as part of its daily business operations.[18] Kivalina concluded that AES "[i]ntentionally or negligently," has "created, contributed to, and/or maintained" global warming causing Kivalina's alleged injuries, and that AES and the other defendants intentionally and negligently violated federal and state nuisance law.[19]

AES requested that Steadfast provide it with a defense pursuant to the terms of its CGL policies. Steadfast provided a defense, but under a reservation of rights, and filed a declaratory judgment action in Virginia to determine whether Steadfast had a duty to defend AES.[20]

The Virginia trial court held that "Steadfast has no duty to defend AES in connection with the underlying *Kivalina* litigation because no 'occurrence' as defined in the policies has been alleged in the underlying Complaint."[21] AES appealed to the Virginia Supreme Court, which granted discretionary review.[22]

III. STEADFAST'S ARGUMENT

In making its argument that it had no duty to defend AES in the underlying Kivalina litigation, Steadfast pointed out that the CGL policies only applied to complaints alleging an "occurrence," which is defined in the CGL policies as an "accident."[23] Steadfast contended that Kivalina's complaint did not allege damages caused by an accident, but rather by

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[16] *AES Corp.*, 725 S.E.2d. at 534.

[17] *Id.*

[18] *Id.*

[19] *Id.* at 534–35. The Ninth Circuit rejected Kivalina's federal claims on the grounds that the federal Clean Air Act displaced any federal common law nuisance claim. Native Vill. of Kivalina v. ExxonMobil Corp., 696 F.3d 849, 853 (9th Cir. 2012). The federal court then declined to hear the state claims. *Id*. at 858.

[20] *AES Corp.*, 725 S.E.2d. at 533.

[21] Steadfast Ins. Co. v. AES Corp., No. 2008-858, 2010 WL 1484811 (Va. Cir. Ct. 2010).

[22] *AES Corp.*, 725 S.E.2d. at 535.

[23] Brief of Appellee, AES Corp. v. Steadfast Insurance Co., 715 S.E.2d 28 (Va. 2011) (No. 100764) 2010 WL 6893536, at *11, *18.

intentional conduct with known consequences. That is, Steadfast alleged that AES "knew or should have known" its actions would result in global warming and Kivalina's alleged injuries.[24]

Steadfast further contended that Kivalina alleged there was a clear scientific consensus that global warming is caused by the release of the type of greenhouse gases that AES regularly emitted every day.[25] Accordingly, Steadfast asserted it did not owe AES a defense because allegations of intentional conduct with known consequences are not allegations of an accident. Thus, it argued, Kivalina's allegations were outside the scope of the CGL policies that Steadfast issued to AES.[26]

IV. AES'S ARGUMENT

AES contended that well-established law distinguishes between an insured's acts and the consequences of its acts.[27] While AES acknowledged that intentional conduct that has direct and certain consequences is not an accident, it asserted that Kivalina's alternative allegation that AES acted intentionally in emitting greenhouse gases, but only "knew or should have known" the consequences of its action described an accident.[28]

More specifically, AES contended that Kivalina alleged that AES engaged in intentional conduct that, through a highly attenuated causal chain, led to global warming and damage to Kivalina.[29] AES contended that because Kivalina did not allege the harm was solely a direct and certain consequence of its acts, it was also an accident, so there was coverage.[30]

V. FIRST DECISION

The Virginia Supreme Court issued two decisions.[31] In its first decision, the Court held, consistent with standard insurance law, that to

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[24] *Id.* at *12–13, *26–27.

[25] *Id.* at *19–20.

[26] *Id.* at *20.

[27] Brief of Appellant, AES Corp. v. Steadfast Ins. Co., 715 S.E.2d 28 (Va. 2011) (No. 100764), 2010 WL 6893538, at *14–15.

[28] *Id*.

[29] *Id* at *14. The District Court in the underlying case held that causation was so attenuated that Kivalina had not even successfully pled causation under Article III of the federal constitution. Native Vill. of Kivalina v. ExxonMobil Corp., 663 F. Supp. 2d 863, 880–82 (N.D. Cal. 2009), *aff'd on other grounds*, 696 F.3d 849 (9th Cir. 2012).

[30] Brief of Appellant, *supra* note 27, at *14–16.

[31] AES Corp. v. Steadfast Ins. Co., 715 S.E.2d 28 (Va. 2011), *reh'g granted, opinion set aside*, 725 S.E.2d 532 (Va. 2012), *and superseded*, 725 S.E.2d 532 (Va.

determine if Kivalina's allegations come within the coverage provided by Steadfast's CGL policies, the "four corners" of the complaint must be compared with the "four corners" of the policy.[32] This is the *eight corners rule* (sometimes referred to as the *four corners rule*) that a duty to defend is determined by the underlying complaint's allegations and the terms of the policy.[33]

The Virginia Supreme Court also recognized, again consistent with standard insurance law, that Steadfast's duty to defend is broader than its obligation to pay a judgment, and arises whenever the complaint alleges any facts and circumstances, even in the alternative, that fall within the risks covered by the policy.[34]

Referencing authorities like *City of Carter Lake v. Aetna Cas. & Sur. Co*,[35] and Barry R. Ostrager and Thomas R. Newman's *Handbook on Insurance Coverage Disputes*,[36] the Virginia Supreme Court concluded that Steadfast did not have a duty to defend because "[w]hen the insured knows or should have known of the consequences of his actions, there is no occurrence and therefore no coverage."[37] The Court went on to hold that "[i]f an insured knew or should have known that certain results would follow from his acts or omissions, there is no 'occurrence' within the meaning of a comprehensive general liability policy."[38]

VI. REHEARING

AES petitioned for rehearing, arguing that the duty to defend is excused only when the complaint alleges that a defendant knew or should have known to a *substantial probability* that its conduct would cause the alleged harm, not merely when a defendant "should have known."[39]

2012) [hereinafter AES I]; AES Corp. v. Steadfast Ins. Co., 725 S.E.2d 532 (Va. 2012) [hereinafter AES II].

[32] AES I, *supra* note 31, at 31–32.

[33] *Id.*

[34] *Id.* at 32 (quoting Virginia Elec. & Power Co. v. Northbrook Prop. & Cas. Ins. Co., 475 S.E.2d 264, 265–66 (Va. 1996)).

[35] 604 F.2d 1052 (8th Cir. 1979).

[36] 1 BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES § 8.03[c] (15th ed. 1990).

[37] AES I, *supra* note 31, at 33–34 (citing OSTRAGER & NEWMAN, *supra* note 36).

[38] *Id*. at 34 (citing OSTRAGER & NEWMAN, *supra* note 36 (citing City of Carter Lake v. Aetna Cas. & Sur. Co., 604 F.2d 1052, 1058–59 (8th Cir. 1979)).

[39] Petition for Rehearing at 4–6, AES Corp. v. Steadfast Ins. Co.,725 S.E.2d 532 (Va. 2012) (No. 100764).

In making its argument, AES cited the very authorities relied on by the Court. AES pointed out that *City of Carter Lake* and Ostrager & Newman stand for the proposition that there is no "occurrence" within the meaning of a CGL policy if an insured knows or should have known there was a *substantial probability* that certain results would follow from the insured's acts.[40] However, if the insured only "should have known" of the consequences of his actions, then there is an "occurrence."[41] Thus, AES asserted that because Kivalina did not allege that AES "should have known to a *substantial probability*" that its actions would harm the village (Kivalina merely alleged that AES *should have known* this), there was an occurrence, and thus Steadfast owes AES coverage.[42]

AES also argued that by omitting the "to a substantial probability" element, the Court had redefined "accident" to exclude coverage in virtually all negligence cases because "should have known" is a foreseeability standard (that is, a mere negligence standard), and that to have a claim for negligence, a plaintiff must at least allege that a defendant "should have known" the consequences of its actions.[43]

AES further argued that if "should have known" allegations would defeat coverage, then there would almost never be coverage for an accident, because any plaintiff alleging negligence will allege that the defendant "should have known" of the consequences of its acts.[44] AES quoted *City of Carter Lake*, an authority the Virginia Supreme Court had relied on, rejecting the very argument the Virginia Supreme Court adopted: "Under [this] construction of the policy language if the damage was foreseeable then the insured is liable, but there is no coverage, and if the damage is not foreseeable, there is coverage, but the insured is not liable. This is not the law."[45]

The Virginia Supreme Court granted rehearing.[46]

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[40] *Id.* at 4–5 (citing OSTRAGER & NEWMAN, *supra* note 36, at 658–59 ("if an insured knew or should have known there was a 'substantial probability' that certain results would follow from his acts or omissions, there is no 'occurrence' within the meaning of a CGL policy.")).

[41] *Id.* at 5 (citing City of Carter Lake, 604 F.2d at 1059 ("if the insured knew or should have known that there was a substantial probability that certain results would follow his acts or omissions then there has not been an occurrence or accident.")).

[42] *Id.* at 1.

[43] *See id.* at 9–10.

[44] *See id.* at 10.

[45] *Id.* (citing City of Carter Lake v. Aetna Cas. & Sur. Co., 604 F.2d 1052, 1058 (8th Cir. 1979)).

[46] AES II, *supra* note 31, at 532 n.1.

VII. SECOND DECISION

In its second and final decision, the Virginia Supreme Court held that Kivalina alleged that the result of AES's intentional acts was not merely foreseeable, but a "natural or probable consequence" of those acts, and thus the resulting alleged injury was not an accident.[47] This holding is surprising because Kivalina, in its underlying complaint, did *not* assert that the harm it allegedly suffered was the "natural and probable consequence" of AES's intentional acts - it merely alleged that AES "knew or should have known" that would be the consequence.[48] Thus, Kivalina did not allege that AES knew to a substantial probability that harm would result. The Court did not discuss the substantial probability issue.

The Court further held that a natural or probable consequence of AES's intentional emissions of carbon dioxide was global warming because Kivalina alleged there is a scientific consensus that such emissions cause global warming.[49] However, as actually alleged by Kivalina, the consensus was equivocal, albeit it was alleged to have become more certain over time.[50]

Moreover, Steadfast began issuing CGL policies to AES in 1996.[51] Because Kivalina alleged the consensus became less equivocal over time,

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[47] *Id.* at 537–38.

[48] *Id.* at 534.

[49] *Id.* at 537.

[50] Kivalina cited in its complaint twenty-seven examples from 1896 to 2007 to support the allegation that there is a "clear scientific consensus that global warming is caused by emissions of greenhouse gases." Kivalina Complaint, *supra* note 7, at 33–39. But the majority of these examples use subjective language that merely suggests carbon dioxide emissions "could," "may," or "should" result in global warming. *See, e.g., id.* at 33 ("In 1956 scientist Gilbert Plass published a paper in American Scientist stating that global warming *could be* a 'serious problem to future generations.'" (emphasis added)); *id.* at 34 ("The First Annual Report of the U.S. Council on Environmental Quality in 1970 contained a Chapter entitled 'Man's Inadvertent Modification of Weather and Climate,' which stated that 'air pollution alters climate and *may* produce global changes in temperature . . . .'" (emphasis added)); *id.* at 35 ("[I]n 1988, NASA scientist James E. Hansen published results showing that 'global greenhouse warming *should rise* above the level of natural climate variability within the next several years, and by the 1990s there *should be* a noticeable increase in the local frequency of warm events . . . .'" (emphasis added)); *id.* at 37 ("In 1995 the [Intergovernmental Panel on Climate Change (IPCC)] published its Second Assessment Report in which it stated that 'the *balance of evidence suggests* a discernible human influence on global climate . . . .'" (emphasis added)); *id.* ("In 2001 the IPCC . . . stated that 'most of the observed warming over the last 50 years *is likely* to have been due to the increase in greenhouse gas concentrations . . . .'" (emphasis added)).

[51] AES II, *supra* note 31, at 533.

but did not allege when the consensus became certain, AES - at the very least - was entitled to coverage under some of the policies when the alleged consensus was still equivocal. The Court did not discuss this issue, either.

VIII. PROPER RULE

The proper rule, as reflected in *City of Carter Lake* and Ostrager and Newman, is that there is no coverage for an "accident" if either: (1) the insured's acts were intentional and it knew what the consequences of those acts would be; or (2) it "acted intentionally and should have known to a substantial probability" what the consequences of its acts would be.[52]

This rule ensures that only true accidents are covered, and that mere negligence allegations where a defendant should have known about the consequences of its acts will not defeat coverage. The Virginia Supreme Court's holding will, as *City of Carter Lake* and the two concurrences to the Virginia Supreme Court's two decisions recognized,[53] eliminate insurance coverage in all negligence cases if it is followed in other cases.

IX. HYPOTHETICAL

A hypothetical illustrates the issue presented and its proper resolution. Suppose there are two lanes of automobile traffic going in opposite directions east and west. Suppose further that the insured driver is

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[52] *See* OSTRAGER & NEWMAN, *supra* note 36, at 658 ("If an insured knew or should have known there was a 'substantial probability' that certain results would follow from his acts or omissions, there is no 'occurrence' within the meaning of a CGL policy."); City of Carter Lake v. Aetna Cas. & Sur. Co., 604 F.2d 1052, 1059 (8th Cir. 1979) ("If the insured knew or should have known that there was a substantial probability that certain results would follow his acts or omissions then there has not been an occurrence or accident . . . .").

[53] *See* City of Carter Lake, 604 F.2d at 1058 ("To adopt [the] interpretation that an injury is not caused by accident because the injury is reasonably foreseeable would mean that only in a rare instance would [a CGL] policy be of any benefit to [the insured] . . . ."); AES I, *supra* note 31, at 34 (Koontz, J., concurring) ("In my opinion, the majority does not adequately explain that the argument which Steadfast makes here would not be applicable to the vast majority of cases where a policyholder seeks to have his insurance company provide him with a defense for an accidental tortious injury."); AES II, *supra* note 31, at 538–39 (Mims, J., concurring) (asserting the majority's holding suggests "accidents" as defined by CGL policies do not include acts of negligence, and thus "[o]ur jurisprudence . . . is leading inexorably to a day of reckoning that may surprise many policy holders").

in the south lane of the two lanes headed west and decides to change to the north lane. That act is indisputably intentional.

The question is: What did the driver know about the consequences of his intentional act of changing lanes? Whether his act of changing lanes is an "accident" depends on what he knows about its consequences. If the driver makes the lane change, but does not bother to look in his rear view mirror or to check his blind spot, and collides with another car, that is surely a covered "accident." He should have known what could happen, which is an "accident."

On the other hand, if the driver engages in the same intentional act, but before switching lanes sees his mortal enemy next to him and knowing he is there still changes lanes, that is not an "accident." Not only was the act intentional but the consequences were known and indeed intended.

Similarly, assume the same hypothetical but the lane change is made at rush hour in a heavily congested urban area and the lanes are filled with traffic. Then not only is the act intentional, but the driver can be said to have known to a "substantial probability" that the consequence of his action would be a collision. Again, the act would not be covered.

However, with global warming, while the act of emitting carbon dioxide was intentional, the consequence was not known or at least not known to a substantial probability. Therefore, there should have been coverage. In sum, the Virginia Supreme Court in *AES* got it wrong.

LOCALITY OF HARM: INSURANCE AND CLIMATE CHANGE IN THE 21ST CENTURY

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This article focuses on how climate change has, and will continue to, alter the insurance industry. The article explores the impact of climate change on the insurance industry's ability to predict losses accurately as well as how actors who contribute to climate change must be held accountable. In answering these questions the article explores the laws and regulatory systems pertaining to insurance and environmental law in the U.S., the European Union, China and the Middle East and determines that some of the laws and regulatory systems in place are inadequate. The article calls for the development of a comprehensive legal structure to address climate change risk and warns that a failure to enact such a structure may leave the insurance industry unable to deal with catastrophic loss from climate change related risk.

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I. INTRODUCTION

The current shifts in the global economy are the most significant in more than half a century. Adding to this economic uncertainty is an increasing recognition of the profound changes that human activity has on weather patterns, biodiversity, and other life-sustaining systems. In this context, the importance of establishing more efficient mechanisms of insurance and environmental law cannot be overstated.

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Vital to the ability of insurance companies to do their job is the ability to calculate, reasonably accurately, the risks society faces. Climate change undermines this ability not only in the obvious example of predicting increasingly erratic and destructive storm patterns to which historic data becomes decreasingly relevant, but also in what way policyholders and market participants may be held to account for the role they have played in contributing to climate change and its associated losses. On both international and domestic scales, the laws pertaining to environmental protection and liability are drastically underdeveloped when we take into account the economic effect that climate change will have in both developed and developing countries.

The shortcomings of the regulatory systems related to the insurance and environmental fields will prove to be incredibly and increasingly costly if they are not addressed immediately. In the insurance field, strides have been made to overcome the problems related to the oversight of cross-sector and cross-border enterprises by sector- and jurisdiction-specific regulatory bodies. These developments have been most notable in the European Union, and in the EU-based models being instituted in the Middle East and China. The United States holds to its state-based system while making tentative steps towards a heightened role for Federal regulation and increased harmonization of state regulatory models. In the environmental arena the situation is dire, and this will eventually have its effect on the insurance industry, which will find itself unable to analyse effectively the risks it faces in light of the lack of a mature and comprehensive legal structure pertaining to the source of those risks. Without such a structure, the industry faces a high level of litigation risk as the courts fill the gap left by inactive legislatures.

For the insurance industry to be able to spread risk in the future effectively, the reality of world-wide climate change needs to be accepted at the social, government, and industry levels if it is to be adequately understood and responded to. Mechanisms need to be set in place specifically to deal with what is likely to become the most major issue that the insurance industry has ever managed – climate-change related catastrophic risk.

II. UNDERAPPRECIATED UNCERTAINTY

A. THE ECONOMIC CONTEXT

The inherent problem with preparing for future losses is the uncertainty in knowing what form they will take and how large they will be.[1] Two particularly major forms of risk can be defined as arising out of

[1] This paradigm of uncertainty, though universally applicable, is nowhere better represented that in the context of the insurance industry's response to

the economic system itself: economic bubbles, and systemic risk. These risk-factors have different but related effects.

1. Economic Bubbles

The term "economic bubble" refers to situations in which "assets and liabilities become improperly valued, and balance sheets give a false impression of the true [economic] situation. [These i]ncorrect price signals cause [a] misallocation of resources."[2] Whereas economic uncertainty results from a recognised lack of knowledge, bubbles are the result of false knowledge. When it becomes apparent that a bubble exists, and because the true value of the subject assets and liabilities are unknown, ambient uncertainty must be increased through the added factor of the realisation of the actual mistake of certainty – bubbles remind us that even when we think we know something well, we may be very wrong indeed.

2. Panic Ripples

This recognition of mistake despite relative certainty causes fear-based magnifying panic-responses that accelerate ripples of actual value correction that take place throughout the markets. This effect is well known in the depository banking context as a "run on the banks" and is largely the reason the Federal Deposit Insurance Corporation (FDIC)[3] exists – to help alleviate the insecurity depositors feel when faced with the worry that their bank may fail and their deposits may disappear if they do

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climate change. *See* Michael Hawker, *Climate Change and the Global Insurance Industry*, 32 GENEVA PAPERS RISK & INS. 22, 25 (2007) ("A changing, less predictable climate has the potential to reduce [insurers'] capacity to calculate, price and spread … weather-related risk. … Historical records will become an increasingly less reliable guide to future weather risk, as greenhouse gas concentrations rise.").

[2] ZURICH FINANCIAL SERVICES, DEALING WITH THE UNEXPECTED, 4 (2008) (*quoting* ANDREW FARLOW, BUBBLES AND EMERGING MARKET CRISES 1 (Oxford Analytica 2003)). *See also* DOUGLAS J. ELLIOTT, GREG FELDBERG, & ANDREAS LEHNERT, THE HISTORY OF CYCLICAL MACROPRUDENTIAL POLICY IN THE UNITED STATES (May 15, 2013) (providing an excellent survey of economic bubbles, their effects, and regulatory responses since the First World War), *available at* http://www.federalreserve.gov/pubs/feds/2013/201329/201329abs.html.

[3] Established as part of the Banking Act of 1933 in response to the bank runs that took place in the context of the Great Depression. FDIC: The First Fifty Years—A History of the FDIC 1933–1983, *available at* http://www.fdic.gov/bank/analytical/firstfifty/chapter3.html.

not withdraw them immediately. In a more general context, these response ripples can result in misguided policy decisions.[4]

3. Regional Effects

Another effect can take place when bubbles are particularly concentrated regionally. Given the right overall circumstances, the bursting of a regional bubble can instigate material shifts of economic influence in the global economy. An example of this can be seen in the fallout from the 2007–2009 financial crisis, in which the US and the EU were harder hit than China. The regional concentration of the repercussions of the U.S. housing bubble has helped China's economic rise by weakening China's major economic competitors.[5]

B. SYSTEMIC RISK

Systemic risk refers to the extent to which interconnectedness (of otherwise separate aspects of the overall economy) allows the fallout of a particular crisis to spread.[6] An example of this is the spreading of loss from the U.S. housing bubble throughout the general world economy, even to parts of the global economy far removed from any direct relation to the housing bubble. This systemic mechanism is essentially the result of the mutual reliance that exists within a closed system. The more the various parts of that closed system are connected, and not somehow compartmentalised, the greater the systemic risk. Illustrations of this

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[4] As has been posited was the case in the context of the 1990–1994 recession that followed an asset-price bubble in Japan. *See* Adam S. Posen, *It Takes More than a Bubble to Become Japan*, THE PETERSON INST. FOR INT'L ECON., Oct. 2003 (arguing that Japanese monetary and fiscal austerity measures were sufficient to undermine the 1995–1996 economic recovery) (working paper), *available at* http://www.iie.com/publications/wp/03-9.pdf.

[5] This is not to say that China, as a major world exporter and holder of foreign treasury bonds, has not been hit by the weakening of the markets to which it sells its goods. At the time of writing, China's economy continues to grow at almost double digit pace (only dropping below 9% in 2012). The economies of its major western competitors are faring less well (US 2008–2012 growth ranged from a low of -3.1 (in 2009) to a high of 2.4% (in 2010); German 2008–2012 growth ranged between a low of -5.1 (in 2009) and a high of 4.2% (in 2010). *See* THE WORLD BANK, GDP GROWTH (ANNUAL %), *available at* http://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG.

[6] *See generally* Douglas J. Elliot, *Regulating Systemically Important Financial Institutions That Are Not Banks,* THE BROOKINGS INSTITUTION (May 9, 2013) (discussing in particular the designation of Systemically Important Financial Institutions under the 2010 Dodd-Frank Act), *available at* http://www.brookings.edu/research/papers/2013/05/09-regulating-financial-institutions-elliott.

concept can be found in ship design, and in the U.S. Glass-Steagall Act of 1933.

1. Compartmentalization in Ships

The compartmentalization that is built into the structure of ships is a perfect illustration of systemic risk prevention. In naval vessels, the space within the hull is divided into many watertight compartments. When damage occurs to a particular part of the hull some compartments may become flooded, but other compartments do not – provided enough buoyancy remains to keep the ship afloat, it can reach port for repairs. In the case of bulk carriers, ships are designed to counter what is called the "free surface effect", the tendency of liquids or other loose matter to slosh about when affected by movement.[7] Where a ship is sailing in heavy seas, the unimpeded movement of large volumes of liquids (stored in the ship's hold) has a tendency to increase with the roll of the vessel. The momentum-weight of the dynamic flow of liquid in large un-compartmentalized spaces creates feedback loops of extreme roll that prevent the vessel from properly righting itself. This eventually causes the vessel to capsize.

2. Compartmentalization in Banking

For the purposes of this paper, the more directly pertinent example of compartmentalization is the Banking Act of 1933, commonly referred to as the Glass-Steagall Act. The ability of financial institutions to simultaneously offer both commercial and investment banking services between 1913 and 1933 was largely blamed for the financial collapse of the late 1920s.[8] There is a commonly held (though admittedly much disputed) belief that this arrangement allowed overly risky activities by depository banks – the failure of these overly risky activities ultimately led to the separation of commercial banking and securities trading with the 1933 Banking Act.[9]

For sixty-six years, this separation (according to risk category) remained the rule. It prevented, at least in theory, the possibility of *contagion,* the crossing over of loss-risk from the higher-stakes activity of

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[7] Ships generally must make sure that particular compartments are full to prevent the catastrophic movement of goods in heavy seas. *See generally* MARINE ENGINEER WORLD, *available at* http://www.free-marine.com/i8freesurface.htm.

[8] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-09-216, FINANCIAL REGULATION: A FRAMEWORK FOR CRAFTING AND ASSESSING PROPOSALS TO MODERNIZE THE OUTDATED U.S. FINANCIAL REGULATORY SYSTEM 8–10, 14 (Jan. 8, 2009), *available at* http://www.gao.gov/assets/290/284691.pdf.

[9] *Id.*

securities trading to the more secure activities of depository institutions. It was, however, an embattled sixty-six years – during that period, the restriction on banking activities was significantly weakened and was ultimately repealed with the Gramm-Leach-Blyley Act of 1999, which opened up the possibility for the three branches of financial services to exist under one roof.[10]

3. Financial Crisis: 2007–2009

The question of to what extent the de-compartmentalization of financial services brought about or contributed to the 2007–2009 financial crisis is, in some quarters, hotly disputed. What cannot be disputed is that certain unregulated actions of financial companies, when allowed to seep through a highly interconnected international financial system like a virus, not only caused the crisis but perpetuated and exacerbated it.

4. Necessity for Effective Risk Management

The following quote from Zurich Financial Services[11] precedes Zurich's discussion of economic bubbles and systemic risk. It suggests, in the face of growing complexity, the importance of establishing and instituting effective risk management structures to mitigate potential losses:

> Global business is growing in complexity, as are the number and types of risks and opportunities that companies face. Extreme events that cannot be fully predicted or understood until they occur, such as terrorist attacks or natural disasters, will continue to confound us. While it is unlikely that we will ever be able to anticipate such extreme events precisely, we can mitigate their effects

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[10] A full history of financial services regulation in the United States is beyond the scope of this paper. For such a history, *see id.* at 5–48. Note that the history this GAO Report provides covers the period from the founding of the United States through January 2009, and so while covering the financial services issues related to the 2007–2009 crisis, it does not incorporate the changes made in 2010 with the enactment of the Dodd-Frank Wall Street Reform and Consumer Protection Act. A comprehensive discussion of the Dodd-Frank Act has been produced by the Congressional Research Service. *See* CONG RESEARCH SERV., R41350, THE DODD-FRANK WALL STREET REFORM AND CONSUMER PROTECTION ACT: ISSUES AND SUMMARY (2010), *available at* http://assets.opencrs.com/rpts/R41350_20100729.pdf.

[11] Zurich Financial Services is one of the world's leading providers of insurance products, offering services in more than 170 countries. *See Who We Are*, ZURICH FINANCIAL SERVICES, *available at* http://www.zurich.com/aboutus/ataglance/whoweare.

> by trying to identify them in advance, and ensuring that robust risk management structures are in place to absorb such events when they occur.[12]

The lack of "robust risk management structures" became apparent in the aftermath of the eruption of the Icelandic volcano, Eyjafjallajökull, in 2010. The eruption caused massive business interruption losses, many of which were not covered due to the fact that they resulted from the grounding of aircraft rather than from damage to aircraft as was required for coverage under the relevant business interruption insurance policies. While pointing out that the volcano seems to have been forgotten almost as suddenly as the eruption occurred, Munich Re discusses several lessons to be learned from the event. These reasons include that:

> Instead of mounting a concerted European response, the individual national air traffic safety authorities reacted in different ways. Coordination between countries was poor and there was no central European authority. … [Further,] contingency planning in the private and the public sector appears to be inadequate where incidents last more than three days. [13]

This last point, regarding contingency planning, is the most alarming. What would happen, Munich Re asks, if the eruption had continued for months or years? As we know from the aftermath of Hurricane Katrina in New Orleans, we are not nearly so prepared for large catastrophic events as we like to think we are.[14]

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[12] ZURICH FINANCIAL SERVICES, *supra* note 2, at 4.

[13] TOPICS GEO, MUNICH RE, NATURAL CATASTROPHES 2010 : ANALYSES, ASSESSMENTS, POSITIONS 5 (2011), *available at* http://www.munichre.com/publications/302-06735_en.pdf.

[14] Another interesting example of this problem is far less dramatic. In New York, in August 2003, the power went out. As New Yorkers did not know at the time, due to the widespread reliance on cell phones and other electronic mechanisms that had ceased to work, the blackout stretched right up into Canada and as far to the west as Ohio and Michigan. It was the second largest blackout in history and affected as many as fifty-five million people. The blackout was caused by a power surge, rather than by a storm or terrorist attack, but it immediately made clear to what extent we rely on a very fragile system. Bridges connecting Manhattan to the mainland were blocked with cars, refrigerators had shut down, trains stopped running. The weather was hot and outdoor gatherings appeared in the streets of drummers and intrigued, chatting people. But had the blackout continued, once the food and water in the shops started to run out due to panic buying or even looting, once the refrigerated food started to rot in the heat – the picture would have become very different very quickly. Along similar lines,

5. The Insurance Context

When taking the above risk factors into account, and considering the interconnected nature of modern human endeavour, it is clear that without robust economic and environmental management and regulatory systems it will be impossible to avoid consequences that will be seriously detrimental to our ability to sustain a manner of living commensurate with the standards we have come to expect.[15] Among the particular systems that are most in need of overhaul are insurance and environment. The reason these particular systems are important is not just because they are themselves seriously deficient in terms of their adequacy and efficiency; they are important because their modernization is vital to provoking modernization in other systems, most particularly – the business systems that make up the overall economy, and overall patterns of public consumption.

6. Society's Risk Manager

The importance of insurance in the global economy can hardly be overstated – it is an industry that is fundamental to the security that both individuals and companies require in order to operate effectively.[16] In the

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Munich Re suggests its readers consider the potential result of a "supraregional power failure or collapse of the worldwide web lasting several weeks[?] The consequences for our networked world, with its dependence on technology and lack of preparation, would be devastating." *Id*. at 7.

[15] *See* Sean B. Hecht, *Climate Change and the Transformation of Risk: Insurance Matters*, 55 UCLA L. REV. 1559 (2008) ("If our society is to survive climate change without significant human costs, we must develop robust institutions and practices to manage these risks.").

[16] *See* PATRICK LIEDTKE, INSURANCE AS A REGULATORY OBJECT, THE FUTURE OF INSURANCE REGULATION AND SUPERVISION: A GLOBAL PERSPECTIVE 7–9 (Patrick M. Liedtke & Jan Monkiewicz eds., The Geneva Association, 2011) ("The importance of the insurance industry for an economy can only in part be measured by the number of its employees in a given country, the assets under management, or its contribution to the national GDP. It actually plays a more fundamental role in the workings of a modern society, being a necessary precondition for many activities that would not take place were it not for insurance. Insurance is a key component of economic development and an important driver for growth…. Today, in all advanced and emerging markets, insurance plays a key role in the efficient and sustainable development of the economy…. It is often the precondition for (economic) action, facilitates new ventures and is intertwined with the most basic human needs and aspirations. The availability of insurance has important positive effects and externalities that go far beyond the purely financial. It is not only a tool for addressing the immediate risk assessment and risk

context of climate change, the insurance industry, as "our society's primary financial risk manager",[17] will be vital to the success of humanity's uninterrupted economic well-being – "If insurers do not rise to the challenge of climate change, there could be a serious financial and social crisis on a global scale."[18]

C. CLIMATE CHANGE AND INSURANCE

1. Underwriting and Investment Risks

In light of the importance of the insurance industry going forward, it must be understood what undermining factors may prevent its useful employment. Insurers are subject to the risks of climate change both in their underwriting and investment capacities. On the underwriting side, where damages occur to policyholders the insurer must bear the brunt of the costs in claims. On the investment side, where companies or other sectors are affected by climate change, they may not generate the return on capital that insurers, as investors, are expecting.[19]

The underwriting and investment sides[20] of insurance companies are interlinked in the sense that when investment returns are good, the insurance company may lower its rates to make them more affordable or competitive (subject in the US to regulatory rate requirements). Likewise, in years when losses are relatively high,[21] the insurer can rely on

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management challenges before us; it can also be a powerful mechanism to discover and incentivize the right behavior.").

[17] *See* Hecht, *supra* note 15 at 1561–62 (Climate change poses risks that are unprecedented in the short time span of industrialized society; some of the risks are startlingly uncertain in nature and degree and have financial consequences to business and individuals. Because insurers play a central role in helping our global economy to manage risk and to make business and personal financial ventures viable, their participation in solving the climate change problem is essential).

[18] *Id.* at 1561.

[19] *See* Andrew Dlugolecki, *Climate Change and the Insurance Sector*, THE GENEVA PAPERS ON RISK AND INSURANCE 33, 73 (2008). *See also* INST. OF INT'L FIN., THE IMPLICATIONS OF FINANCIAL REFORM FOR THE INSURANCE INDUSTRY, 17–20 (2011) (pointing out insurance investment uncertainty in light of Basel III banking reforms), *available at* http://www.oliverwyman.com/implications-of-financial-regulatory-reform-for-the-insurance-industry.htm#.UfFpLRa_AfE.

[20] For a good discussion of insurance company balance sheet considerations, *see generally* INST. OF INT'L FIN., *supra* note 19.

[21] For insurers, a major issue with climate change is the shrinking of "return periods" – the amount of time between incidences of certain events (e.g. 100-year storms). *See* Dlugolecki, *supra* note 19, at 77 ("When return periods shrink, there are five important implications for insurers. (a) Historical models of costs are inapplicable, because the scale and frequency of events moves outside the zone of

investment returns to make up for underwriting losses. If an insurer is unable to rely on investment income, then its prices must increase on its policies to make up the surplus required to meet regulatory requirements; but this creates a "hardening" of insurance markets – an increased difficulty for consumers to procure insurance or to be able to afford it in the event it is available.

2. Risk Coverage Limitations

The ability of insurers to cover the risks entailed in climate change is at this stage uncertain.[22] This is not necessarily because of any inherent fault in the industry itself; rather, it is due to imperfections in internal company ability and external regulatory response.

3. Insurability

For a risk to be "insurable", the insurer must be able to handle the risk without undermining the solvency of the company. The risk must be determinable and quantifiable. In addition, the risk must be able to be offset within a diversified portfolio of other risks, and it must not be overly subject to the problems of adverse selection and moral hazard.[23]

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historical experience. … (b) Risks are incorrectly rated, because the probability of an extreme loss is assessed too low. … (c) Exposures are too high, because the maximum probable loss is underestimated. … (d) Claims-handling capacity is too low, because the scale (extent and intensity) of destruction in new extreme events is beyond experience. … (e) Credit ratings are too generous, because the probability of a serious depletion of capital from a disaster is underestimated.").

[22] *See* Hawker, *supra* note 1, at 25 ("Climate change is expected to bring increased damage costs as well as increased variability. Increased variability has a cost; it means that additional capital needs to be set aside to ensure that insurers continue to be able to pay claims during the "hard times". Insurers will look for ways to manage this increasing variability and, therefore, the availability and affordability of reinsurance as well as other risk transfer mechanisms will become increasingly important."). *See also* Dlugolecki, *supra* note 19, at 78 ("The entire capital of the global insurance industry is around 700 billion USD. Perhaps 200 billion USD is earmarked for catastrophe…. This provides security for only 25 per cent of today's economic losses from extreme events…. From a variety of sources, it is estimated that the annual cost of weather damage on average is probably in the range 200–300 billion USD currently. By 2030, this may rise to between 850–1,350 billion USD (in 2006 values). … This is a *four-fold increase* on today's level in real terms. Over the same period, world economic product is projected to grow by a factor of 2.5-3 in real growth."). *See also* Hecht, *supra* note 15, at 1565–68 (describing the factors that establish the insurability of a risk, and how some types of risk challenge the core principles of insurability).

[23] *See* Hecht, *supra* note 15, at 1565.

In the climate context, each of these insurability factors presents particular challenges. The potential losses are large enough to threaten the solvency of even the largest insurers. There are issues of massive uncertainty, such as the size and frequency of loss events, and the way such loss events will be handled in the coming years as regulatory systems and legal systems change to take account of the shifting risk landscape; this increased uncertainty must be paid for, but insurers are limited in what they can charge. For the pooling of risk to work, it is necessary that the risks be diversified, if not in kind then in location; but the nature of climate risk potentially entails a very high level of correlation, especially when the subsequent effects of large-scale events are taken into account. Finally, the climate arena is subject to massive issues of moral hazard.[24]

4. Rate Regulations

The ability of insurers to cover climate risks is deeply affected by the regulatory system that sets the guidelines by which insurers must act. Insurers ideally price their policies at a rate that actuarially reflects the risk; but that price might be, for many, unaffordable. Large rate increases can cause a negative economic/political reaction, and since insurers in the US, for example, are generally subject to rate regulation,[25] the state insurance commissioner may simply disallow the increase.

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[24] These issues of moral hazard are discussed throughout this paper, they include, *inter alia*, by government, business, and/or public entities: the development of high-risk coastal areas, forced under-pricing of insurance by supervisory dictate, the subsidized development of various industries that return immediate or short term profits and long term environmental and/or social costs, the avoidance of immediate mitigation in favour of later adaptation as a means of avoiding immediate cost impositions, the passing of risk from the local to the distant in terms of geographic location and/or temporal existence, the resulting consumption patterns of all of the above, etc. In all of these cases, the lack of a perceived proximate locality of harm allow the displacement of a sense of immediate responsibility as would cause a shift of policy and action towards a more localized bearing of costs.

[25] Rate regulation under state law pertains to "regulated" insurance entities. These are, in general, entities that write policies for customers that, in the eyes of public policy, require a degree of state-based protection. Certain other types of insurance relationships can be distinguished on the basis of the mutual sophistication of the parties – for example, reinsurance contracts are subject to less regulation, as these exist only between insurers and reinsurers. "Non-admitted insurers" are also subject to a lesser degree of regulation as they tend to write only special lines of insurance required by parties who are deemed able to adequately fend for themselves in the market. However, even reinsurers and non-admitted insurers are subject to insurability factors as they must be able to procure rates that both cover their risks and are affordable, even if these rates are market-based as opposed to regulation-based.

The inability to charge risk-appropriate rates can be highly dangerous to an insurer's ability to sustain its solvency and insurers may in such cases seek to stop writing certain lines. Regulators generally will attempt to prevent a dearth of available insurance, and one way they do so is by disallowing an insurer to leave a particular market on the threat that if the insurer does so, the commissioner will discontinue the insurer's license to write any line of insurance in the state.[26] For major multi-line insurers this can be a significant threat and the result of it is a long-term loss for everyone involved – it means, for example, that high-risk coastal insurance must ultimately be subsidized by lower-risk policyholders and by taxpayers in general where government backstops must be set in place in the absence of adequate insurance company presence.[27]

5. Economic Distortion

The inability for insurers to charge actuarially sound premiums is one of the most egregious examples of market distortion through understandable, but unsound, public policy. The ultimate result is two-fold: first, it results in the undermining of the industry's capacity to influence the economic decisions of government, business, and society on the basis of a "true-cost" calculation of risk; second (and stemming from the first), it promotes the ability for the development of unsustainable

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[26] In some U.S. states, the barriers to insurers' ability to exit markets is mandated by the state legislatures, in others the barrier is legislated to be governed by the discretion of insurance commissioners.

[27] *See* Ins. Info. Inst., *Catastrophes: Insurance Issues* 1, 12–13 (Aug. 2013) *available at* http://www.iii.org/issues_updates/catastrophes-insurance-issues.html. ("The growth and concentration of property values in hurricane-prone areas has pushed to the forefront of public policy debates the issue of coastal development and hidden insurance subsidies. Subsidies exist in various aspects of the property insurance transaction. First, they exist where rates for property insurance are no longer commensurate with risk because it is politically unpalatable to raise rates to actuarially justified levels. Second, there are subsidies in the pooling arrangements that were set up to make sure people living along the coast can obtain property insurance. When these pools have insufficient funds to pay claims, the shortfall is picked up by insurance companies, which may then pass the cost on to all property insurance policyholders in the state through explicit policy surcharges, as in Florida, or indirectly in the form of higher property insurance rates. Third, the federal flood insurance program has paid out millions of dollars to rebuild structures in high-risk zones known as repetitive loss properties, where the cost of claims over the years may have totaled much more than the home was worth. This has contributed to the program's deficit and to continued building in high-risk areas.").

infrastructure on the basis of subsidization propelled by short-term cost/benefit considerations.[28]

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[28] As described earlier in the paper, one of the major factors in the increasing cost of natural catastrophes is the continued development of high-risk areas. The Gulf-Coast of the US is the prime example of this phenomenon. Instead of incentivizing in-land development, and despite the exposure of coastal areas to increasingly powerful and frequent storm events, subsidized coastal development continues. Of course, it hardly need be said that a significant portion of tax revenue, in Florida for example, comes from coastal developers and tourism-related businesses. Although these businesses may be able to afford increased insurance rates (though they would certainly vehemently fight against any such increase), the workers the businesses employ very likely would not be able to afford rate increases, nor would smaller businesses in the area. The short-term cost of moving significant housing and business infrastructure in-land would be significant, and this economic cost would be in addition to the political cost that would inevitably be borne by any Governor who would suggest such an idea. There are significant long-term detriments to this type of behaviour. On the business front, the long-term detriment can be found in the economic upheaval of establishing business enterprises on an unsustainable model of cost-externalisation. The longevity of this model is limited by the fact that business can only be subsidized so long as the funds exist to subsidize it. In other words, the subsidization of an economically unsound business enterprise is a luxury that must be supported. Where money is cheap and the true-costs of the maintenance of the enterprise remain avoided, this sort of subsidization is possible; but where risks increase, where general economic circumstances are tighter, and where heightened potential for incurred liability all lead to costs that cannot be externalized, the business model will falter and the resulting vacuum will undermine the overall business environment through decreased investor confidence and general market instability. On the political front, the detriment can be found in the undermining of the credibility of government. To the extent a government, for political reasons or for reasons of economic short-sightedness, allows the entrenchment of unsustainable infrastructure it has failed to uphold its duty to the tax-paying public who ultimately will have to foot the bill of loss that is beyond the ability of insurers to pay, the cost of the reorganization and restructuring of infrastructure required in the event of an inability to sustain the current infrastructure, the increased cost of insurance in the event rates are allowed to be raised, the subsidization of the ultimate inefficiency of unsustainable and externalized costs in the event rates are not allowed to be raised, and the eventual insurance market failure in the event it is no longer in insurers' interest to stay in the market even if this means losing their ability to write other lines of insurance in the state in question. *See* Hawker, *supra* note 1, at 26 ("If trends persist, impacts of climate change in the US will inevitably result in more insurance claims and increased costs, in turn leading to higher premiums and deductibles and broader coverage restrictions. … [C]limate stresses will place more political and financial burden on federal and local governments as they assume broader exposures and become insurers of last resort."). On the public front, it means suffering the consequences of misguided development policies established by both business and by

6. Lines of Insurance Coverage at Risk

For the insurance industry, climate change will have a substantial effect not only on property/casualty lines, but also on life and health lines. On the property/casualty front, it can be expected that claims will continue to increase for property damage and for business interruption arising from events including increasingly volatile storm systems, flooding, earthquakes and wildfires in developed areas.[29] On the life/health front, claims will increase in relation to infectious and respiratory diseases, heat stress, pollution, and malnutrition-related disorders – this increase will make life and health insurance more expensive to underwrite.[30] On the liability front, duties of defence and indemnity will be triggered in the event of claims brought by third-parties.[31] The inadequate planning of companies may be also be grounds for redress in business interruption claims which insurers will also be required to defend. Finally, on the professional liability front, directors and officers may face claims of failure to disclose material facts in relation to their company's risk exposure where climate change is concerned, or on grounds of failure to address climate risks, and ultimately for a breach of their fiduciary duties in protecting the company from climate risks.

7. Global Coverage Problem

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government leading to heightened levels of unemployment, decreased public services, and higher relative-cost of living.

[29] Hecht, *supra* note 15, at 1574–75.

[30] *See id.* at 1575–76 (Infectious diseases expected to increase include: malaria due to increases and changes in mosquito breeding grounds – malaria currently kills over 3,000 children each day; West Nile virus in Europe and the US – which can cause death and neurological impairment; and Lyme disease – which can cause permanent damage to the nervous system, the musculoskeletal system and the heart. Respiratory diseases expected to increase include: asthma, allergies, and other problems related to increased pollen allergens, increased airborne particulate matter from smog, mold, wildfires, and ozone pollution. Heat stress is expected to increase cardiovascular problems, deaths from dehydration, and heat stroke – "over 52,000 people are estimated to have perished in the 2003 heat wave" in Europe.).

[31] *See id*. at 1577–78 ("[N]uisance claims against greenhouse gas emitters have already alleged injury from the direct and indirect effects of climate change, and other similar lawsuits may follow. These claims are likely to be covered under either commercial general liability or environmental liability insurance policies. Negligence, products liability, and other tort theories may also lead to significant defence costs, and possibly indemnity costs . . . for insurers whose policyholders may have contributed to climate change or have not planned adequately for climate change's impacts.").

Considering the global nature of modern risks, their enormity,[32] and the extent to which they affect all aspects of contemporary living models, "[i]ntegrated prevention on all levels is essential….loss prevention programmes must be implemented on a local, regional, national and international level, in both the private and public sector."[33] But successful loss prevention requires widespread awareness of risk, "[t]his is where the insurance industry can make a valuable contribution, be it through professional risk expertise or suitable insurance products providing financial safety for new or residual risks."[34]

The lack of adequate insurance and government systems was painfully apparent in the context of the Haiti earthquake of January 12, 2010 (the most devastating seismic catastrophe since 1976). Due largely to "the precarious condition of society in general," very little of the damage was insured.[35] One of the key benefits of a developed insurance sector is the incentive effect that insurance pricing can have on government-instigated building regulations and on the organizational influence that insurance can have on construction processes in general.[36] However, in developing countries like Haiti, there is little money available to develop, let alone support an on-going insurance mechanism. In these cases it is vital that international development organizations play a role in supporting the creation of catastrophe reinsurance facilities (such as the Caribbean Catastrophe Reinsurance Facility[37]) and microinsurance mechanisms.[38]

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[32] *See* TOPICS GEO, MUNICH RE *supra* note 13, at 16. ("The earthquakes in Chile and New Zealand were the first natural catastrophes in recent times to have caused an insured loss of several billion US dollars outside the highly developed insurance markets of the USA, Japan and Europe.").

[33] *Id.* at 7.

[34] *Id*.

[35] *Id.* at 16.

[36] However, *see* Hecht, *supra* note 15, at 1587 (discussing the limitations of pricing incentives by insurance companies: "Despite the incentives that the insurance industry appears to have to make climate risk more manageable, there is a significant market failure that limits insurers' motivation to do so through their product pricing. A stable climate, like clean air or other similar common resources that cannot be owned, is a public good. The benefits of insurers' contributions to this public good cannot be internalized through the operation of the insurance market. Moreover, insurers in particular will collectively benefit from a stable climate because of their high exposure to climate-related risk and uncertainty. But no individual insurer can reap the benefits of its incremental contribution to reducing climate risk.").

[37] *See Catastrophes: Insurance Issues*, *supra* note 27, at 6 ("Established in 2007, the CCRIF is an insurance pool that covers hurricanes and earthquakes for its 16 Caribbean member nations and their territories.").

[38] *See id.* (discussing the program that has been set up in Haiti: "A syndicate, which includes a reinsurer, a global development and relief agency and a microfinance distribution institution, will offer parametric coverage to businesses

These stop-gaps can assist in easing the risk faced by societies in an already precarious position, which in turn can help those communities develop into viable markets that can eventually support their own insurance needs, thus contributing to the pooling of international risks and the lowering the overall price of insurance.[39]

III. THE STATE OF PLAY

To the extent that the international regulation of insurance can assist the international management of risk, it is necessary to understand what changes must be made for it to do so most effectively. Due mainly to local public policy concerns, insurance regulation remains a very fragmented area of law; however, for the last ten years, changes have been taking place towards greater efficiency through harmonization and increased systemic security. Considering the increasing intensity of the economic and climactic uncertainty we face, and taking into account the central role the international insurance industry plays in stabilizing our experience of that uncertainty, it is of the utmost importance that the systems that govern international insurance be as efficient as possible – this means modernization to account for the nature of modern insurance enterprises and the risks they face.[40]

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that have taken out small loans with the finance company. Parametric coverage is based on a claim settlement process that takes into account the known and 'observable characteristics' of various types of disasters, such as the potential damage that a crop would sustain in a 150 mph wind in a certain part of the country. By not having to rely on individual claims adjusters to decide the amount of damage, claims can be settled quickly, thus allowing the claimant fast access to funds that might be needed to keep the business going. The premium will equal 6 percent of the business's total loss.").

[39] The harsh effects of climate change on developing countries will not just affect those countries: "The most serious impacts for Europe [from climate change] may be those that occur elsewhere. One important risk is a potential surge in refugees from climatic impacts in North Africa, where drought is expected to be more frequent. Another is that there could be supply chain disruption due to events in coastal regions in China . . . [, which are] vulnerable to typhoons, erratic river flow, and sea-level rise." Dlugolecki, *supra* note 19, at 73.

[40] *See* INST. OF INT'L FIN., *supra* note 19, at 2 (discussing current international financial reform and the importance of understanding the insurance business model in the context of overhauling banking and insurance regulation; "Each industry must be regulated separately to ensure that the specific risk profiles of firms are addressed. However, it is also necessary to adopt a comprehensive cross-sectoral perspective on regulation to ensure that unintended effects of regulation do not create additional risks. The developing concepts of macroprudential regulation and the increasing coordination provided through the FSB should go a long way to achieving these goals, if pursued in the right spirit.").

A. MODERNIZATION OF REGULATION: THE SOLVENCY CONTEXT

The greatest steps towards modernization are being made where no prior regimes exist. Specifically, the international sphere has the benefit of being able to forge ahead more or less from scratch. The EU, similarly, has the benefit of being a relatively new governmental system.

1. IAIS

A comprehensive system of regulation (that will more closely match the interconnected cross-border and cross-sector enterprises that the regulatory systems are in charge of supervising) is being developed by the IAIS in ComFrame. ComFrame's group-wide supervisors and supervisory colleges is a large step in this direction, giving internationally-based guidance and leadership to different regional and national systems. Already IAIS Principles are being employed in jurisdictions such as the Middle East, which is fast developing a regional system of its own along the lines of the European Solvency II initiative.

2. European Union

In the EU, major structural changes have been taking place in the regulation of financial services over the last ten years. The beginning of this process preceded the 2007–2009 financial crisis, but that event continues to have a strong influence on the process. Although the new European System of Financial Supervision (ESFS) is now in place, much of the most recent restructuring surrounding Solvency II is still in play and subject to amendment. It remains to be seen exactly what form many provisions will take, but the ultimate focus is to implement a harmonized system of risk-based supervision that takes into account the entirety of the cross-sector and cross-border risk carried by financial services enterprises. It also remains to be seen to what extent the changes in EU law will affect the laws of other countries, particularly in light of the institution of the EU "equivalence" concept.

3. United States

The US retains a diversified domestic regulatory structure. Although it too has a unifying body (in the form of the NAIC), that body does not have actual authority over the many jurisdictions its membership represents.[41] The NAIC has been working to harmonize the law in the US

[41] The International Monetary Fund, in May 2010, reported that the US insurance regulatory system is compliant on 28 of the IAIS's core insurance principles. It did not match international standards in three areas: insulation of

with international regulatory developments, and in effect generally provides principles of risk-based solvency regulation that are in practice attuned with those of the IAIS and the EU.[42] The differences, however,

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insurance regulators from political pressure, failure to assess group-wide financial conditions, and lack of cooperation and information between state and federal authorities in the life insurance sector to prevent money laundering. *See* Ins. Info. Inst., *Insolvencies/Guaranty Funds* (Sept. 2013), *available at* http://www.iii.org/issues_updates/insolvencies-guaranty-funds.html.

[42] This result is consistent with historical precedent - it has been largely the risk of Federal pre-emption of state insurance regulation that has spurred the NAIC to push for greater harmonization and consideration of ways by which to interrelate with international supervisors. The consequence of this for the NAIC is that (with every step towards harmonization of law in the US) it decreases its own reason to exist. Modern IAIGs are global enterprises that require a global approach to market entry and solvency regulation. The maintenance of the state-based system, as applied to IAIGs, is inefficient and outdated and needs to be pre-empted by federal regulation that will be better able, through a bottom-sensitive top-down approach, to regulate IAIGs effectively, and act as a single voice regarding the US market alongside bodies such as EIOPA in Europe. The conflict of interest arguments that the NAIC has leveled against the notion of the FIO addressing questions of whether the federal government should play a larger role in the insurance area may all too easily be leveled at itself - can a system be restructured by a governing body that would itself have to be discarded in the process? The answer is usually not. However, despite differences, the US is adopting more robust own-risk assessment requirements, further refining group supervision concepts and the modernization of reinsurance regulatory provisions, and aligning itself with the EU as well as the IAIS and those jurisdictions that are basing their regimes on IAIS principles. While harmonizing developments are needed in the US, the increasing harmonization of law undermines one of the key tenets that uphold the State system - the regulatory laboratories that the state systems have been said to embody. Another key argument towards the maintenance of a State-based system is the ability for policyholders to have more direct access to insurance regulators, and that, were the system to be centralized in the Federal government in Washington D.C., then this access would be diminished. However, with State-regulators increasingly beholden to an NAIC under pressure to harmonize regulatory law, policyholders are already one step removed from the actual source of regulation and, unlike the Federal government, the NAIC is a non-governmental body that is neither accountable to policyholders, nor directly to voters. Any increase in the power of the NAIC to develop and apply law through the states directly contradicts the principle of policyholder protection to the extent the power of state regulators is in practice subjected to the NAIC. The international sector has the advantage of playing in a (more) clear field. Like the NAIC, it may not, except through formal treaty or agreement between national governments, proscribe law to be implemented by national (or, in the case of the NAIC, State) officials. It may only recommend systems and principles that should be adopted on the weight of the expertise of those involved in the process. Thus, also like the NAIC, its principles are more along the lines of model laws. The difference lies in the starting-point interests inherent in each body. The NAIC has

between the US and the EU systems are such that the US, currently, is unlikely to achieve "equivalent" status if that requires U.S. regulators adopt a solvency regime virtually identical to Solvency II. If the US is alternatively granted *transitional* status, the date by which the US will have to achieve "equivalent status," should it wish to do so, will be set back as late as 2018.[43]

4. Effective Systemic Oversight Bodies

Symbolically at least, the most important developments have occurred with the establishment of the Financial Stability Board by the G20, the European Systemic Risk Board by the EU, and the Financial Stability Oversight Council in the US. These organizations are all focused on overseeing financial systems as a whole and thus complement individual sector supervision in much the same way the Group-Wide Supervisors of ComFrame supplement the supervision of the solo-supervisors in the supervisory colleges. The creation of these bodies suggests a meaningful move by governmental organizations to take into account, more effectively, the business reality of modern financial enterprises.

B. MODERNIZATION IN THE INSOLVENCY CONTEXT

Entailed in catastrophic risk is the possibility of insurance company failure. For this reason it is important that the insolvency context not be neglected in the modernization process.[44]

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an inherent interest in protecting the system that allows its existence and influence—the state-based system. Therefore, the NAIC's proposals are always founded on the continued regulation by the states of the business of insurance. The international sector does not have this concern, and thus has focused on not only establishing principles, but also on systems of interaction that embody the principles they attempt to establish. It has the luxury of considering the question—if the best possible regulatory regime were to be created from scratch, what would it look like? One of the requirements of progression is that the possibility exists for reinvention.

[43] It may be possible for U.S. regulators to convince EU regulators within such a long time period that the systems developed in the US are functionally equivalent to the processes adopted in the EU, even if the approach uses different tools to arrive at a common objective. One of the problems with the US gaining equivalent status within the EU is that the view persists, outside the US, that modernization is taking place less quickly in the US, and although the establishment of the Federal Insurance Office is a step in the right direction, it is one that is far too small when considering the opportunity that the 2007–2009 financial crisis provided for a long-overdue overhaul of the U.S. state-based insurance regulatory system.

[44] *See* INST. OF INT'L FIN, *supra* note 19, at 9 ("The failure of an insurer may … have serious consequences. The resolution of a cross-border insurance group

1. Jurisdictional Protectionism

Although international frameworks increasingly apply to insurance solvency regulations and requirements, they still fall short in the event of an insurer's insolvency. National, jurisdiction-based, public interest concerns take over in this context and international (and interstate) agreements defer to resolutions under national law.

Some noteworthy progress has been made. The supervisory structures set in place in IAIS's ComFrame, to oversee the solvency of IAIGs and the pre-resolution crisis management of IAIGs, should greatly help in the resolution process. Supervisors will be more used to working with one another and this familiarity, ideally, will breed trust, which should spill over into the resolution context. However, the resolution of a company, especially an insurance company, is a sensitive affair that entails long-crystalized instincts on the part of particular jurisdictions to protect domestic interests. In the insolvency context, the incentive of those who hold the assets of the troubled company to cooperate with the company decreases.[45] This protectionist instinct will not be fully rectified by increased supervisory cooperation in the solvency context, but it may be alleviated on the basis of the comity and reciprocity that will likely develop through cooperation.

2. Sources of Complexity

All large cross-border insolvencies are relatively complex. In the insurance area, certain factors come into play to increase that complexity. Three major issues stand out, the nature of the business that must be wound down, the public policy implications involved in the insurance arena, and the structure of cross-border proceedings.

3. Nature of Business

In the corporate arena, assets and liabilities are often more straightforward and more immediately ascertainable than those in the insurance context. Barring, for example, long-term environmental damages

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may pose challenges which arise from differences in legal environments and potential conflicts of interest between regulatory authorities defending their national interests. The latter may result in litigation that increases both the cost of resolution and legal uncertainty for policyholders.").

[45] Including reinsurers who may hold payables that the estate could use to pay-off claims, and regulators and other authorities who may want to make sure that what reserves they have control over remain in their jurisdiction so that domestic policyholders are more likely to be covered.

that may be attributable to a corporation, most of the typical corporation's assets and liabilities can be determined with relative ease. Insurance company liabilities, on the other hand, often take many years to manifest. The company has contracted to cover certain risks that may or may not ever materialise, and are certainly by no means necessarily ascertainable at the time of the winding-up proceedings.

4. Public Policy Implications

To a much greater extent than in the general corporate arena, insurance has enormous public policy implications. These include the fact that insureds have contracted for the future coverage of potential claims, that they have paid premiums for such coverage, and the implications of that coverage not being available in the event it is needed. With the exception of concerns such as loss of company-funded pensions, general corporate insolvency simply does not normally entail such loaded public implications. For this reason, the business of insurance is far more tightly and directly regulated than general corporate activity. But this regulatory structure, created on foundations of strong public policy concerns, brings its own complexities.

5. Cross Border Considerations

In the cross-border insolvency context, there has always been a degree of difficulty where the collection of assets into the bankruptcy estate is concerned. This difficulty is heightened in the insurance context. This is due to the increasing complexity of multinational insurance enterprises, the insurance entity-based regulatory structure, the protectionism afforded insurance by territorial-based regulatory bodies and courts, and the fact that such bodies and courts are not always in the best position to manage the complexities of the proceeding.[46] Where difficult issues (such as the

[46] *See* James W. Schacht & Lynne Prescott Hepler, *Insolvencies In-Depth Series (Part 2): Analyzing the Life Cycle of an Insolvency*, LRP Publications (Feb. 1 2007), *available at* http://www.riskandinsurance.com/story.jsp?storyId=13404529. ("Unlike the United Kingdom, Bermuda and other countries, the United States does not have licensed insolvency practitioners who must be appointed to administer a receivership estate … Winding up the affairs of insolvent insurers of the recent past and likely the future is a business and management function not well-suited for government. When insolvencies were modest affairs, there was no need to question the government's role, but, today, insolvencies are often large, complex and national, and in some cases international. This makes the two primary functions of estate administration [marshaling assets, and approving and fixing claims,] anything but simple and straightforward … The United States has yet to develop an effective means of accelerating the slow and expensive evaluation process for long-tail claims." Further, "[t]he receivership proceeding is

marshalling of international assets) are handled badly, the result can be expensive litigation and delay. Reinsurance recoverables are very often the largest value in the estate, but reinsurance is a global business and reinsurers are unlikely to be based in the same jurisdiction as the authority in charge of the winding-up proceeding. Negative experiences with authorities over the winding-up of insurers can cause bad relations to develop between the company and its reinsurers.[47] Further, different structures of law and proceeding can hamper efforts towards a harmonized approach.[48]

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under the oversight of the court; however, the court is ill-equipped to perform effective oversight … most courts have neither the time, nor the resources, nor the expertise, to examine data and information to evaluate performance and hold a receiver accountable. There are no common standards governing the accountability of receivers to the courts, creditors or the public. Lack of information hampers the ability of stakeholders to monitor and encourage efficient management.").

[47] For example, in the winding-up of Mission Insurance Company, the California Insurance Department found itself in a very awkward position in its relations to the mainly foreign reinsurers, who held the bulk of the estate's potential assets. "The reluctance of Mission's reinsurers to pay reinsurance balances alleged due now resulted in reinsurance recoverables being the fastest growing asset on the company's balance sheet. While the cause of this nonpayment is open to debate, and was the subject of litigation, in part it was the unexpected level of losses being reported to reinsurers. To some extent, the nonpayment was also caused by the public complaints about the behavior of Mission's reinsurers and the subsequent drawing down of letters of credit held by Mission, which created a very adversarial relationship between Mission and its reinsurers and retrocessionaires, particularly those outside the United States. This 'uncommercial behavior' would impact other U.S. receiverships. Nevertheless, and perhaps more importantly, these circumstances put the insurance department at odds with the reinsurers. This conflict would remain when the insurance commissioner put on the receiver's hat." Furthermore, "[t]he dissention between Mission and its reinsurers not only continued but worsened as the liquidation process continued, at least in part due to the, at best, 'unconventional' positions taken by the receiver." James W. Schacht and Lynne Prescott Hepler, *Insolvencies In-Depth Series (Part 3): One Long, Long Mission*, LRP Publications (Mar. 1 2007), *available at* http://www.riskandinsurance.com/story.jsp?storyId=13403894.

[48] Even in related systems, such as the UK and Australia, difficulties can arise, such as in the *HIH Casualty and General Ins. Ltd. v. McGarth* case, "In proceedings involving HIH Casualty and General Insurance Ltd., which collapsed in March 2001, the English Chancery court held that, in an English liquidation of a foreign insurer, English courts may not direct the Joint Provisional Liquidator to transfer funds for distribution in the principal liquidation if the foreign and English distribution schemes are not substantially the same. After the declaration of insolvency by the New South Wales Supreme Court, winding-up petitions against the companies were presented to the English High Court, Queen's Bench Division, because the insurers conducted business in several countries, including England. Australian liquidators and the Joint Provisional Liquidators (JPL) appointed by the

6. Harmonization of International Processes

Complete harmonization of law pertaining to the resolution of insurance enterprises has been achieved in neither the US nor the EU. Each region consists of a collection of 'sovereign' states with similar though divergent law.

7. United States

Through the 2007 NAIC Insurer Receivership Model Act (and the 1939 Uniform Insurer Liquidation Act and the 1997 Rehabilitation and Liquidation Model Act), attempts have been made to unify the law in the United States, but not one of these Acts has been enacted by every state, and even if all states enacted the Model Act, there is no necessity that any of those states would enact it word-for-word, nor that they would apply it in the same way.

Reciprocity provisions exist in all three of the above-listed Acts, but as not one of them has been adopted by all U.S. jurisdictions, decisions as to whether to recognise proceedings in another state, let alone another country, remain grounded in the discretion of the State Commissioners. That being said, states do generally take the importance of comity and reciprocity very seriously,[49] through recognition of foreign proceedings states are more likely to garner similar respect in return.[50] This application

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English court proposed that the English assets be kept in a separate fund for distribution in accordance with English insolvency law. Some Australian creditors objected to the proposed scheme, and argued instead that the Australian court should decide distribution of assets in accordance with Australian law. The Australian Liquidators demanded that the JPLs pay them the assets after deduction for costs and expenses. The court refused to direct or authorize the JPLs to remit the assets collected by them to the Australian Liquidators unless there could be a means of ensuring that those assets could be distributed as if in an English liquidation, and held that in case of default the assets would be distributed in accordance with English law." Semaya, *Insurer Insolvencies: Looking Back and Forging Ahead,* Reinsurance Law & Practice 2006: New Legal & Business Developments in a Changing Global Environment, 89 PLI/Comm 207, 284 (2006).

[49] *See, e.g.*, Hall v. Michael Bello Ins. Agency, Inc., 880 A.2d 451, 453–55 (N.J. Super. Ct. App. Div. 2005); Aon Risk Servs, Inc. of Georgia v. Commercial & Military Sys. Co., Inc., 270 Ga. App. 510 (2004); Home Ins. Co. v. Montgomery Cnty Comm'n, 902 So.2d 677 (Ala. 2004); All Star Adver. Agency, Inc. v. Reliance Ins. Co., 898 So.2d 369 (La. 2005).

[50] *See Hall*, 880 A.2d 451 at 453–55 (even though, unlike New Jersey, Texas had not adopted the UILA, the New Jersey Superior Court decided to recognize the Texas resolution proceedings pertaining to the insolvency of the Highlands Insurance Company, and refused to ignore the stay that had been instituted in that

of comity falls short of the Constitutional full faith and credit standard, and is rather a doctrine "of practice, convenience, and expediency…. Comity persuades; but it does not command…. It demands of no one that he shall abdicate his individual judgment, but only that deference shall be paid to the judgments of other co-ordinate tribunals."[51]

The adoption, by all states, of the same law (at this point probably the Model Act) would further reciprocity, at least between the States, and would decrease the uncertainty of current discretion-based comity. For the foreseeable future, however, each State retains power over insurer assets located within their jurisdiction even in the event of insolvency proceedings elsewhere, particularly where those proceedings are taking place in another country.

8. European Union

The EU regulatory framework is far more equivalent to the U.S. framework in the insolvency context than in the solvency context. In the EU, the law adheres to national interests in the area of insurance insolvency just as does the law in the US adhere to state interests. In both jurisdictions this prevents regulatory harmonization, and the relative certainty such harmonization entails. The EU does benefit from a layer of certainty that the US cannot claim. It replaces the more uncertain (common law based) comity and reciprocity of U.S. state courts with a statutory mandate requiring recognition of the home-state jurisdiction's resolution law and mechanisms. This home-state jurisdiction is easy to discern as it is based on the EU "passport" system that requires an insurer to be licensed by only one EU jurisdiction. To the extent that U.S. common law principles of comity and reciprocity generally produce the same effect as the EU Directive on the Reorganisation and Winding-Up of Insurance Undertakings (i.e., the recognition of home state jurisdiction), insurance company considerations end up in the same place – that is, national (or state) resolution law applies.

C. IAIGS AND THE LAW

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proceeding.); *see also Aly v. E.S. Sutton Realty*, 822 A.2d 615, 620 (2003) ("[T]he Commissioner voices a concern that our refusal to honor the Pennsylvania stay would be shortsighted, arguing that were we to now do so, the courts of other states might in the future do likewise and refuse to honor a similar stay order issued by our courts should one of our domestic insurers face rehabilitation.").

[51] *Aly*, 822 A.2d 615 at 619 (quoting Mast, Foos & Co. v. Stover Mfg. Co., 177 U.S. 485, 488–89 (1900) in the context of discussing whether to recognize the stay instituted in the ongoing Legion Insurance Company proceedings then taking place in Pennsylvania).

U.S. state-based regulation is a stumbling block in the international regulatory arena – the arena in which IAIGs play – and this is important because it is there that international concerns regarding systemic efficiency play out. The difference in state law becomes in this context a risk liability through the regulatory inefficiencies and uncertainties it entails.

The recent crisis taught us that it is simply not a sustainable position to continue to supervise financial institutions as if the fiction of the corporate form maintains total relevance in the cross-border cross-sector enterprise context. For the inherent risk of these enterprises to be fully accounted for, equivalent supervisory bodies (ones that can cast the scope of their perspective across both borders and sectors) need to be in place, and must be properly empowered to act as regulators. State-based protectionism of oversight thus has no place in this particular context – there is no way the average insurance department can properly, and completely, comprehend the intricacies of the more complex businesses for which they have responsibility. Indeed, it is quite impossible for even the managers in charge of the more complex enterprises to fully comprehend the extent of the intricacies of their own businesses let alone the networks within which their businesses exist.[52]

It is certainly a mistake to consider regulatory systems as, by definition, adverse to business interests. It may, however, fairly be said that to the extent regulatory systems constrain business interests in ways those interests should not be constrained, they are adverse to business interests – for example, by adding costs and imposing extraneous requirements that are neither conducive to the regulatory purpose of protecting policyholders, nor to the regulatory purpose of maintaining the solvency of insurance companies.[53] Maintaining a closer relationship with

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[52] This might be considered a cousin of the uncertainty principle of quantum mechanics – the extent of the complexity of factors involved, generally heightened with the increasing size and extent of a given enterprise, means that previously unknown factors will always appear to affect the enterprise at any or all of its various levels of operation, and will cause response mechanisms within the business that likewise are unknowable in the absolute. Risk management is therefore precisely what it claims to be—not the total removal of risk, which would be (particularly in a market system) impossible, but the management of inevitable risk by way of understanding (to as great an extent as possible) potential influencing factors and their respective probabilities.

[53] Regulatory systems should be a check only on the dangerous practices of companies – those practices that (through misguided internal policy or through failures of prudential governance) in fact generate risks that violate established public policy (the extent to which a system will look to protect the solvency of an insurance company must be considered a matter of policy – in a market system, some failure is expected and allowed.) Internal governance is the major consideration here. Where necessary and proper internal checks and balances are not in place, serious mistakes can be made. In such instances, supervisors should

regulators of increased caliber would entail extra costs; however, these extra costs would be more than made up for with the savings that would be gained from substantially decreased comparative regulatory due-diligence, licensing, and filing costs. In the insolvency context this streamlining of regulation holds an even greater importance. In the insolvency context, barring the application of guaranty funds – an inherently inefficient though necessary mechanism – the potential for policyholders not having the coverage for which they contracted is highly likely. Here, the estate's administrative costs, related to litigation between jurisdictions in attempting to draw assets into the estate, can be considerable. With increased uniformity of law, and structures in place to streamline assets into an estate, costs will be lowered and a greater possibility of policyholder and creditor protection can be gained.

There is an increasing weight of risk inherent in the financial markets today, and insurance companies are tied into those markets – they rely on those markets for their investment of premiums. There is the unknown factor of future risks related to climate change and catastrophic damage, but there are also the risks of increased social unrest, and the heightened business risk that such unrest can bring about. There is every sign that these factors will increase rather than slow in the foreseeable future. Therefore, it is of the greatest importance that the insurance regulatory systems of the world be as capable and efficient in their structure and practice as possible if they are to spread risk efficiently, which is vital to societal, political, and economic stability.

IV. LOCALITY OF HARM

The magnitude of the risks humanity faces is increasing dramatically, and with the development that is taking place in countries like China, India, and Brazil, we can expect to see the costliness of risk that has so far only been relevant to Japan, the EU, and the US, spread to other parts of the world as well. The global repercussions of this increasing risk for the insurance industry and for society in general are enormous. Consider this Swiss Re appraisal of catastrophic losses in 2010:

> Natural catastrophes and man-made disasters claimed nearly 304[,]000 victims and resulted in economic losses of close to USD 218bn in 2010. The cost to insurers was

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take on that role; but to do so they must be able to understand the entirety of what they are dealing with just as well as, if not better than, the management of the company itself. This is a lofty goal, and yet a necessary one; but it is not a goal that can possibly be reached without the removal of all possible extraneous regulatory hurdles and requirements. Regulators must be able to focus on what is actually important.

> more than USD 43bn. In terms of insured losses, 2010 ranks as the seventh highest year since 1970, when *sigma* began collecting catastrophe data. Compared to 2009, insured losses were more than 60% higher in 2010, but still below 2005, the year that insured losses soared after Hurricanes Katrina, Wilma and Rita struck the US.
>
> In 2010, 304 catastrophic events occurred, consisting of 167 natural catastrophes and 137 man-made disasters.[54]
>
> …
>
> …[T]he number of fatalities and insured losses from earthquakes are rising because population growth and higher population density, especially in urban areas, exposes more people to a single damaging earthquake. Many of the rapidly growing urban areas with high population densities are located in seismically active areas. Due to this, the probability for earthquakes with high death toll continuously increases, although the seismic threat itself remains unchanged.[55]

The above figures are somewhat misleading, but only in the sense that we were lucky the losses were as low as they were. The reason we can consider these almost record-level losses low is that there was very little hurricane damage in 2010. As Munich Re points out, this was not for a lack of hurricane activity, just that, fortunately, they did not touch land.[56] Indeed, it was the fifth consecutive year that a major hurricane did not make landfall. The lesson to be reminded of from this is that there are things we can control and other things we cannot. We cannot assume that nature, every year, will spare us from having to face a year like 2010 without a major U.S. city-devastating hurricane to add to the mix of earthquakes, harsh winter storms, volcanic eruption, tornadoes, cyclones, typhoons, floods, tropical storms, and landslides that we did experience in 2010.[57]

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[54] The most recorded per year since Swiss Re started compiling data.

[55] Lucia Bevere et al., *Natural Catastrophes and Man-Made Disasters in 2010: A Year of Devastating and Costly Events,* SIGMA, no. 1, 2011, *available at* http://media.swissre.com/documents/sigma1_2011_en.pdf.

[56] "The 2010 hurricane season was one of the most active since reliable records were first kept. That it should nevertheless have proved so benign can only be described as a stroke of good luck. Hurricane Earl, which at times reached Category 4 on the Saffir-Simpson Hurricane Scale, passed within a few hundred kilometres of the eastern seaboard of the USA. Had it moved just a little further west, it could have caused immense damage and losses in and around New York and the New England states." MUNICH RE, *supra* note 13, at 11.

[57] *See* SIGMA, *supra* note 55, at 6–8.

Indeed, in 2011, this lesson was proved. Economic losses as a result of natural catastrophes and man-made disasters were the highest ever recorded at over USD 370 billion while insurance losses stood at USD 116 billion.[58] The difference between these costs highlights the difficulty faced by those who, while suffering the consequences of climate change, are not in a position to protect themselves from it. There is another important perspective to be taken into account – even though less than a third of economic losses were insured, the amount of insured losses was the second highest Swiss Re has recorded since it started gauging in 1970.[59] Once again, these loss figures were spared the addition of major hurricane losses in the US.[60]

So far, despite massive losses in the last decade, the reinsurance market has withstood; but this has not been without strain.[61] Questions have arisen regarding alternate methods of spreading risk. Such considerations have, for obvious reasons, looked to the capital markets and the development of insurance-linked securities and special-purpose vehicles,[62] which allow the hedging of insurance and reinsurance climate-related risks.

A. ADAPTATION AND MITIGATION

Active responses to climate change can take two forms: adaptation and mitigation, each with limited capacities. Many changes are already taking place in the environment and these changes will continue to take

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[58] Lucia Bevere et al., *Natural Catastrophes and Man-Made Disasters in 2011: Historic Losses Surface from Record Earthquakes and Floods,* SIGMA, no. 2, 2012, at 2, 4–5, *available at* http://media.swissre.com/documents/sigma2_2012_en.pdf.

[59] *Id.* at 2, 5.

[60] *Id.* at 5.

[61] *See* Hecht, *supra* note 15, at 1583–85 (discussing the role of reinsurance and other risk transfer instruments in helping insurers cope with climate change).

[62] *See* Christopher Kampa, *Alternative Risk Transfer: The Convergence of The Insurance and Capital Markets Part II*, INS. STUD. INST. 1, 2–3 (2010), http://www.insurancestudies.org/wp-content/uploads/2010/07/ISI_Insurance-Convergence-Series-Part-II.pdf. "A basic catastrophe bond structure involves an insurance or reinsurance company ('sponsoring company') issuing a bond security through a Special Purpose Vehicle ('SPV"'). The sponsoring company enters into a reinsurance contract and pays premiums on the reinsurance to the SPV. The SPV issues the bond to investors with a defined trigger that specifies the situations where the investor would lose principal. The SPV holds funds received from the bond offering in a trust that invests the funds into Treasury securities and/or other highly rated assets. Investors, mostly institutions, typically receive a spread over LIBOR. The sponsoring company collects part of or the entire bond principal when the covered catastrophic event occurs, thus reducing or wiping out returns to the investors." (citation omitted).

place and will accelerate, regardless of any mitigation measures that may be instituted.[63] In light of this, adaptation measures are unavoidable, and the reason to mitigate rests in the economic and social necessity of limiting the effects of climate change so that we are able to continue to adapt without suffering the failure of our supporting systems.

1. Adaptation

The ability to adapt is limited by available means such as "a society's productive base, including natural and man-made capital assets, social networks and entitlements, human capital and institutions, governance, national income, health and technology."[64] Our capacity to adapt can only consist of removing climate risks to the extent allowed by our available means of adaptation.

2. Mitigation

If we wish to limit our need to adapt, we must mitigate future risks. One of the principle arguments against mitigation is based on humanity's well-established adaptive potential including the ability to adapt sufficiently to create the ability to more effectively mitigate in the future. This argument takes particular strength from advances in scientific understanding and our ability to solve problems through advances in technology – it argues that we will discover the necessary technology to adequately mitigate the problems we may face.

3. Mitigation and Producers

As the Intergovernmental Panel on Climate Change ("IPCC") states, "[n]o single technology can provide all of the mitigation potential in any sector. The economic mitigation potential, which is generally greater than the market mitigation potential, can only be achieved when adequate policies are in place and barriers removed."[65] Without adequate policies in place to spark mitigating processes, the processes will be delayed too long to be sufficiently successful. This construct is in the process of being demonstrated. In the most "sophisticated" private market economies in the world, mitigating processes have already been delayed for what have

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[63] Lenny Bernstein et al., *Climate Change 2007: Synthesis Report, Summary for Policymakers*, INTERGOVERNMENTAL PANEL ON CLIMATE CHANGE 14 (2007), http://www.ipcc.ch/pdf/assessment-report/ar4/syr/ar4_syr_spm.pdf [hereinafter IPCC].

[64] *Id.*

[65] *Id.*

proven to be crucial decades.[66] This delay is largely a result of the difficulty of shifting long-established and entrenched economic superstructures for which the maintenance of the profitable[67] status quo is more attractive than embracing the risks of substantial change.[68]

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[66] Modern economies that are based on high levels of increasing consumption fuelled by credit and the resulting debt require the constant growth of economy for their perpetuation. In order to fuel this consumption, inefficiencies such as "planned obsolescence" are built-in to productive processes—without adequate consideration of the repercussions of waste we specifically design products to prematurely fail in order increase production to secure the profit of continued consumption. *See* The Lightbulb Conspiracy: The Untold Story of Planned Obsolescence, Synopsis, http://www.media314.cat/eng/docu_24.html, a multiple international award-winning 2010 documentary film by Cosima Dannoritzer ("A long time ago, consumer goods were built to last. Then, in the 1920s, a group of businessmen realized that the longer their products lasted, the less money they made. Thus was born Planned Obsolescence, the deliberate reduction of a product's life span to increase sales. And ever since, manufacturers have designed their products in order to make them fail."). Financial companies benefit from the interest gained from the credit they deliver to companies so that companies can produce; energy and chemical industries profit from the production and delivery of the goods as well as their packaging, manufacturing and shipping companies profit from the sale and delivery of the goods; financial companies profit again from the credit they provide the consumers of the goods. There is little incentive to limit production so long as the total costs of the process can be subsidized by the externalization of the damage the process causes to the natural environment. These costs are now proving to be very large indeed.

[67] It should be noted here that where energy companies are concerned, this "profitable status quo" is only profitable for the enterprise concerned. When true costs are taken into account, traditional power generation is not so profitable as it has been presented as being: "With or without a price on carbon, nuclear power *and* big fossil-fueled power plants simply cost far more than 'micropower' generation (renewables except big hydropower, plus cogenerating electricity with useful heat) or saving electricity through efficient use." Amory Lovins, *On Proliferation, Climate, and Oil: Solving for Pattern*, FOREIGN POLICY (Jan. 21, 2010), http://www.foreignpolicy.com/articles/2010/01/21/a_roadmap_to_our_energy_future.

[68] This construct is particularly evident in the energy industry. For example, in the context of discussing the oil and gas subsidy battles of 2011, one scholar wrote, "Defenders of oil and gas industry tax breaks are clearly finding it harder to maintain support for tax and other provisions for a mature, highly profitable industry whose incumbency essentially locks in U.S. economic vulnerability and energy dependency and inhibits the emergence of alternative energy sourcing. The sheer cost of these provisions is one issue, given that the fossil fuel sector reeled in more than $72 billion in subsidies in a seven-year period in the 2000s, compared to the $29 billion received by the renewables sector . . . [a]dding to the imbalance is the fact that while most of the largest subsidies to fossil fuel production are written into the U.S. Tax Code as permanent provisions, many subsidies for renewables are time-limited, implemented through energy bills, with expiration dates that

4. Mitigation and Government

To the extent that markets are liable to delay on systemically important reforms, it becomes necessary that they be sparked to action by government-imposed policy. Such policies may include "integrating climate policies in wider development policies, regulations and standards, taxes and charges, tradable permits, financial incentives, voluntary agreements, information instruments, and research, development and demonstration…."[69] Although these mechanisms are within the power of government to impose, they can be difficult to institute where the political process is highly influenced by the very industries that would suffer a diminishment of profits as a result.

5. Mitigation and Consumers/Managers

To the extent government policy is not instituted because of the existence of political/regulatory capture, other mitigation methods may be employed. For example, the consumer base can affect the market through changing the nature of market demand; or, as shareholders or management in the commercial enterprises themselves, through the management practices of the organizations they own or run.[70]

B. CONSUMER SOCIETY

A problem with relying on consumer demand and management responsibility for imposition of mitigation is the establishment of the knowledge and incentive required to spark the imposition. The reason this is a problem is that modern consumer societies, especially the US (long the world's largest producer of GHGs), have established prevalent media structures that are largely funded through advertisements by the very companies that might potentially suffer through decreased demand.[71] To

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continually create uncertainty for the industry and undercut deal-flow and deployment." Mark Muro, *Rationalize and Reform the Energy Subsidy Mess: It's Time*, THE BROOKINGS INSTITUTION, (June 27, 2011), *http://www.brookings.edu/opinions/2011/0627_energy_subsidies_muro.*

[69] IPCC, *supra* note 63, at 18.

[70] *Id.*

[71] *See* THE CENTURY OF THE SELF (BBC Four 2002) (an award-winning documentary film by Adam Curtis, focusing on how Edward Bernays, a pioneer in the field of public relations and propaganda, employed the psychological understanding developed by his uncle Sigmund Freud to influence the way corporations and governments analyse markets and populations; and, further, on how that knowledge has been used to influence consumers and voting populations).

the extent the average member of society is more likely to be influenced by one of these media outlets than by other sources, changes in lifestyle priorities are unlikely to shift sufficiently to cause a material difference in the mitigation of climate damage.

1. Costs as Incentives

Where general purchasing influence fails to change management approaches, changes may still take place on the basis of management's appraisal of the company's "reputational risk". This is the risk that a company faces when its market activities fall afoul of customer expectations regarding corporate practices.[72] But this too requires a consuming public that has developed a moral position that a company may infringe upon. Further, it requires the transparency to allow the information to reach the public, and it requires that the public be sufficiently invested in the issue to respond in such a way as to actually cause a change in corporate behaviour.[73]

2. Externalization of Costs

Given the current state of advanced market economies, it can logically be argued that (where information regarding the cost of consumption is freely and easily available, and has been considered by the consumer) the desire for the consumed product must outweigh any concern over the cost of the process by which that product came into being – if it did not, then changes would necessarily take place. In this construct, we are talking about externalized costs (whether environmental or human), as the consumer will assume that all internalized costs are being paid for. An externalized cost will only be addressed once it grows to the extent that it

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[72] *See* Charles Durhigg & David Barboza, *In China, Human Costs Are Built Into an iPad*, N.Y. TIMES, Jan. 25, 2012, for an example of how a large percentage of Apple customers expected Apple to carefully monitor their factories to guard against exploitation of the factory workforce, and how questionable practices, by western standards, came to light after a New York Times article exposed round the clock hours and barracks living-conditions at the Foxconn Technology plant in Chengdu, China.

[73] Consider that allegations and publicity surrounding the use of sweatshops in Southeast Asia have repeatedly plagued the sports merchandiser Nike since the 1970s, despite some actions of the company to respond. This ongoing controversy has not prevented Nike from remaining a world market-leader in its industry. Ultimately, the plight of distant workers is likely not a sufficiently *local* problem to spark action from a wider section of Nike's customer base.

becomes a sufficiently *local* problem for the consumer. For a problem to be local, it must be psychologically local.[74]

The market has mechanisms to prevent the localization of externalized cost – a significant one is information disparity. Savings from externalized cost may not necessarily or entirely be passed on to the consumer. Externalized costs, by definition, lower the internalized production costs of an enterprise. This saving allows the potential for lower market costs; but to the extent the savings are not passed on to the consumer, they become the profits of the enterprise. Increased profits mean more money for management and shareholders, and the greater possibility of attracting new capital for growth. On this basis, there is a built-in systemic incentive to both save on production costs and to pass on as little of those savings as possible to the consumer.[75] To take complete advantage of this information disparity, enterprises rely on maintaining it to the extent possible. It will rarely be the Apples or Nikes of the world that will voluntarily submit (to the public) information regarding in what ways they save costs through externalization, such information would invite calls for lower market prices for products, and in the event sufficient concern for human wellbeing (or environmental responsibility) were brought into play, might invite calls for costly corporate governance reforms.

The result of this pattern is the situation we currently face in the environmental arena – the return of 150 years of externalized costs related to highly damaging industrial and market practices. We must now begin to pay for those costs. Fortunately, we have well-established systems of international political interrelation, technology advancement, and finance, which have the potential to be employed to adapt to climate change and mitigate further climate change.[76] Unfortunately, so far, these systems are

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[74] It may be assumed that physical locality, in general, suggests psychological locality. The human cost of sweatshops becomes a psychologically local issue for unrelated consumers in another part of the world when sufficient light is shed on the living conditions of the workers to trigger an empathetic response in consumers of the products made in those sweatshops. But the response need not be in the context of a direct relationship between producer and consumer. An example of an indirect response would be where the environmental cost of Japanese nuclear energy policy causes a local issue for California when radiated waste, water or air arrives in California as a result of failed generators at a coastal nuclear power plant built in a location exposed to the possibility of damage from earthquakes and tsunamis; this physical exposure to the risks of nuclear energy production may effect consumer policy positions on local nuclear energy production.

[75] It hardly need be stated here that collusion in this incentive underlies the existence of anti-trust laws.

[76] *See* IPCC, *supra* note 63, at 18 ("Many options for reducing global GHG emissions through international cooperation exist. There is *high agreement* and *much evidence* that notable achievements of the [United Nations Framework Convention on Climate Change] and its Kyoto Protocol are the establishment of a

outdated and/or have not been employed effectively, and have as a result to a large extent actually hindered progress towards sufficient adaptation and mitigation.[77]

3. Reducing Future Vulnerability

Regardless of past successes and failures in addressing these issues, in moving forward, it is clear that international government, commercial, and public policy will need to be consciously and directly focused towards reducing vulnerability to the changes we will face. Since the 2001 Third Assessment Report, the 2007 IPCC understanding of the risks facing both natural and human systems is that they have in large part increased.[78] It is now clear that both adaptive and mitigating actions will

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global response to climate change, stimulation of an array of national policies, and the creation of an international carbon market and new institutional mechanisms that may provide the foundation for future mitigation efforts. . . . Greater cooperative efforts and expansion of market mechanisms will help to reduce global costs for achieving a given level of mitigation, or will improve environmental effectiveness. Efforts can include diverse elements such as emissions targets; sectoral, local, sub-national and regional actions; [research development and demonstration] programmes; adopting common policies; implementing development-oriented actions; or expanding financing instruments.").

[77] These hindrances may be in many forms, including: the protection of national sovereignty and protection of established internal industry (whether on the basis of protection of jobs, or on the basis of protection of vested interests), the protection of established technology by impeding the advancement of new potentially superseding technology by potential competitors, and the protection of financial interests in the profitability of established systems.

[78] *See* IPCC, *supra* note 63, at 19 ("There is new and stronger evidence of observed impacts of climate change on unique and vulnerable systems (such as polar and high mountain communities and ecosystems), with increasing levels of adverse impacts as temperatures increase further. An increasing risk of species extinction [(20–30% of species assessed)] and coral reef damage is projected with higher confidence than in the [Third Assessment Report (TAR)] as warming proceeds . . . Confidence has increased that [an increase] in global mean temperature . . . poses significant risks to many unique and threatened . . . biodiversity hotspots . . . There is now higher confidence in the projected increases in droughts, heat waves and floods, as well as in their adverse impacts . . . Compared to the TAR, initial net market-based benefits from climate change are projected to peak at a lower magnitude of warming, while damages would be higher for larger magnitudes of warming. The net costs of impacts of increased warming are projected to increase over time . . . There is better understanding that in the TAR that the risk of additional contributions to sea level rise from both the Greenland and possibly Antarctic ice sheets may be larger than projected by ice sheet models . . . .").

need to be taken for an effective response.[79] While adaptation will be necessary, "[u]nmitigated climate change would, in the long term, be *likely to exceed the capacity of natural, managed and human systems to adapt.* … Early mitigation actions would avoid further locking in [of] carbon intensive infrastructure and reduce climate change and associated adaptation needs."[80] Our strongest asset in this process will be the maturity and sophistication of our market and regulatory systems,[81] but "[w]ithout substantial investment flows and effective technology transfer, it may be difficult to achieve emission reduction at a significant scale."[82] In light of past experience, neither government action, nor market forces can solve the problem alone – they will have to rely on one another within a balanced framework, but that framework will be very difficult to achieve without a major upheaval of perspective.

4. Localizing the Cost of Inaction

Establishing a balanced framework means, on one front, pressuring markets and government to accept and respond to the extent of the cost of inaction. If this is to take place, the current information disparity (between the voting populace and business) needs to be addressed to trigger a more localized understanding of the risks. To wait for the actual local experience of the risks to manifest will mean massively increased and likely unmanageable costs will manifest.[83] The voting populace will need to pressure government to install policies that will incentivize the shifting of the overall economy in a more sustainable direction. In addition, the voting

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[79] *Id.* ("There is *high confidence* that neither adaptation nor mitigation alone can avoid all climate change impacts; however, they can complement each other and together can significantly reduce the risks of climate change . . . Mitigation efforts and investments over the next two to three decades will have a large impact on opportunities to achieve lower stabilization levels. Delayed emission reductions significantly constrain the opportunities to achieve lower stabilization levels and increase the risk of more severe climate change impacts.").

[80] *Id.* (emphasis added).

[81] *Id.* at 20. "There is a *high agreement* and *much evidence* that all stabilization levels assessed can be achieved by deployment of a portfolio of technologies that are either currently available or expected to be commercialized in coming decades, assuming appropriate and effective incentives are in place for their development, acquisition, deployment and diffusion and addressing related barriers."

[82] *Id.*

[83] *Id.* at 22. "Choices about the scale and timing of GHG mitigation involve balancing the economic costs of more rapid emission reductions now against the corresponding medium-term and long-term climate risks of delay."

populace, as market consumers, needs to make clear that a sustainable economic structure is desired.[84]

C. FREEDOM TO ACT

Humanity faces very real and costly events in the coming decades. Our preference for adaptation (such as building higher sea-walls, changing the building codes for coastal structures or structures at risk from earthquakes) is not surprising – it is the equivalent of reactive medical treatment as opposed to preventative behaviour. Reactive behaviour is fine so long as a fund exists to pay for it. Where funds do not exist (such as in developing countries), or where they are diminished (such as currently in the US or EU), it becomes necessary to consider alternatives.

1. Self-Interest as Incentive

Unlike adaptation, mitigation requires actual fundamental change in behaviour and systems – it requires we take a long hard look at the circumstances that gave rise to these issues we face. This is not an easy thing to do as it requires changes in well-established patterns of behaviour, and habits are particularly hard to change where they are systemically reinforced by surroundings.[85] However, mitigating climate change need not be costly if it is done in a considered and sensible way:

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[84] That being said, it is unfair to place all of the weight on consumers. Where a market is structured to favor certain established infrastructures, and where real alternatives are practically non-existent because of market forces beyond the scope of the person at the fuel pump, it is not fair to hold that person (say 95% of the population) to account for the perpetuation of the inefficiencies in the overall system.

[85] Antony Froggatt & Glada Lahn, *Sustainable Energy Security: Strategic Risks and Opportunities for Business*, LLOYDS 360° RISK INSIGHT, Sept. 13, 2012 at 20, *available at* http://www.lloyds.com/news-and-insight/riskinsight/reports/energy-security/energy-security ("In spite of broad international agreement on the importance of inventing and deploying technologies at scale to meet energy and climate security goals, progress has been too slow. Uncertainties around domestic and international regulations and pricing structure can stall investment, discourage collaborative projects and generally dampen investor confidence. For example, inconsistent policies have entrenched a pattern of boom and bust in the renewable energy and efficiency industries in many parts of the world, including the US. Enacting policies and freeing up the necessary finance for technological transformation is even harder in the context of the global financial crisis and volatile energy prices.").

> Business experience proves climate protection is *not costly but profitable,* because saving fuel costs less than buying fuel. Changing the conversation to profits, jobs, and competitive advantage sweetens the politics, melting resistance faster than glaciers. Whether you care most about security, prosperity, or environment, and whatever you think about climate science, you'll favor exactly the same energy choices: focusing on outcomes, not motives, can forge broad consensus. … The climate conversation gets vastly easier and less necessary when it's shifted from shared sacrifice to informed self-interest.[86]

In the context of alleviating stress-based paralysis, the above quote perhaps understates the difficulties and complexities of restructuring energy sourcing where that restructuring has been described as "the third industrial revolution [that] will challenge all aspects of energy services: from energy sources and storage; to user-technologies, such as lighting, vehicles and electric motors; and infrastructure."[87]

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[86] Amory Lovins, *On Proliferation, Climate, and Oil: Solving for Pattern,* Foreign Policy, January 21, 2010, at 1, *available at* http://www.foreignpolicy.com/articles/2010/01/21/a_roadmap_to_our_energy_future.

[87] LLOYDS 360° RISK INSIGHT, *supra* note 85, at 20. "There is now widespread acknowledgement that we are in a 'transition' period heading towards less-polluting, more-sustainable forms of energy. Yet there are a variety of views as to what this involves, the duration, and to what extent hydrocarbons should be part of the energy mix. Added to this is the uncertainty around what will replace them. This involves scaling up new technologies and introducing completely different energy delivery systems." *Id.* at 8. "Recoverable reserves of natural gas are enough to meet world demand for heat, power and petrochemical uses to at least 2030 . . . . But production equal to that of two Russia's would need to come on-stream by then just to make up for the decline in existing fields. Over half of conventional natural gas resources are concentrated in three countries Russia, Iran and Qatar, and there are political, geological and technological obstacles that may restrict international supplies in the short to medium term." *Id.* at 12. "Even before we reach peak oil, we could witness an oil supply crunch because of increased Asian demand. Major new investment in energy takes 10–15 years from the initial investment to the first production, and to date we have not seen the amount of new projects that would supply the projected increase in demand." *Id.* at 13–14. "The costs, environmental impact and security implications of [unconventional fossil fuel] options [(such as heavy oil, oil sands, and tar sands)] differ and are at the centre of fierce debates about the trade-offs between climate and energy security . . . [T]he energy input (usually in gas) needed to get the oil out is around three times as much as for conventional oil. It also takes three barrels of water to produce each barrel of oil, most of that being too toxic to return to the rivers. Emissions from shale oil are likely to be higher and those from coal to liquids are at least double the levels of those from conventional oil-based fuel. Gas to liquids would produce

2. Affected Sectors and Types of Risk

Three general business sectors dominate global energy use: manufacturing, household consumption and transport.[88] The risks these sectors face can be broken down into short-term operational and supply chain (changes in prices paid for energy affect global competitiveness; disruption of electricity supply can cause operational failures and restart costs), financial and regulatory (uncertainty over potential changes in regulatory treatment undercuts security in investment), longer-term operational and supply chain (risk of regional carbon pricing in developed countries for energy intensive industries such as cement and steel), and reputational (public scrutiny of government, business, and other institutional emissions profiles).[89]

Energy companies also face risks that fall into the following categories: regulatory and environmental, financial and investment, technology, physical and operational, and reputational. As regards regulatory and environmental, energy companies face two key challenges: "how to adapt to a resource constrained and low-carbon world and how to deliver the non-traditional energy sources that are being encouraged by government policy."[90] Due to the "common good" nature of the environment as a whole, it is not clear at this stage how the economic costs of pollution of the environment will be attributed in the future.[91] Also, even though renewable energy targets have been set in place in many countries around the world, the binding nature of these targets is unclear, and for that reason the extent of the need for the continued provision of traditional energy sources is also unclear.[92] But "Government implementation of 'investment grade' energy policy will reduce these risks and give investors confidence in the longevity and breadth of the proposed policies. To achieve this it is necessary to establish long term policy targets and incentives that remove ambiguities and ensure that all aspects of energy policy and investment are addressed."[93]

Financial and investment risks are similar to regulatory risks in that they are greatly affected by the extent to which consistency in policy can be relied upon. However, they are also greatly affected by the even greater whims of the market itself. For significant shifts in energy infrastructure,

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emissions some 10% to 15% higher than those from conventional petrol or diesel." *Id.* at 14.

[88] *Id.* at 25.

[89] *Id.* at 25–30.

[90] *Id.* at 31.

[91] *Id.* at 31–32.

[92] *Id.* at 32.

[93] *Id.*

there must be significant investment – but investment follows market conditions. Thus, "[i]n the last decade [2000-2010], high energy prices have led to great surges in investment … in renewable energy technologies worldwide. But many projects were stalled, cancelled or became unprofitable when the price fell. … The uncertainties of price fluctuations are amplified by variations in the carbon price and the uncertainties over which sectors it will affect."[94]

Technology risks likewise are exacerbated by uncertainty in policy going forward; for this reason, many businesses have delayed investment in new technology that may be made uncompetitive in the event policy does not prove to support it.[95]

Political and operational risks refer to the issues involved in finding new sources of energy in harder-to-access locations where easier-to-access energy is depleted or made less accessible for political reasons.[96] Infrastructure investments are put at risk by changing climate patterns, such as increased storms at sea or on coasts, or the drying up of rivers required for the cooling of power stations.[97]

Finally, as regards reputational risk, share prices can be substantially affected by public perception of a company's operations – where companies operate in increasingly sensitive environments, the results of failures are increasingly damaging for the company's reputation and economic situation.[98]

3. Prospects

The risks described above pertain both to investment in next-generation energy technology, and to the maintenance of current generation technology. Ultimately though, the risks of not investing in next-generation technology are greater and the business opportunities of early investment

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[94] *Id*.

[95] "New technologies and processes must be developed, piloted and scaled up, yet incentives to drive their innovation and deployment at the scale and necessary pace often lack long-term political commitment." *Id.* at 33.

[96] *Id.* at 33–34.

[97] *Id.* at 34.

[98] "Operating in more difficult terrains increases the risk of accidents which have human, environmental and economic consequences. The economic consequences relate to the costs of remediation, compensation and the potential impact of reputational damage on the company's share prices. The pressure to invest in areas with unclear legal frameworks and governance challenges will continue to expose companies to accusations of collusion in human rights abuses or corruption." *Id.* at 35. However, the fact that accidents such as the Exxon Valdez and the BP Gulf Spill does not prevent discussion, for example, of the opening up of the Alaskan Wildlife Refuge to drilling represents the extent to which we are reliant on oil under the current system.

are growing. "The threat of man-made climate change and supply security concerns is challenging the relative competitiveness of fossil fuels in terms of cost, environmental impact, energy output and access."[99] As the realities of climate change become more localized, governments and companies will increasingly realize that "[r]enewable energy solutions can help diversify the energy portfolio of many businesses, bringing added price and supply security in the long-term while adding to a company's sustainability profile." Even if companies don't get on board as quickly as they might, the specter of the repercussions of global average temperatures rising by 2°C above pre-industrial levels will force "a transformation in the way we live and the way governments regulate our activities, particularly in relation to industry, transport and buildings."[100]

Such government action is likely necessary to instigate a full-fledged movement of industry towards mitigation measures. But this action will have to take place on an international level. As Lloyd's of London points out:

> Despite great expectations, the Copenhagen Summit in December 2009 did not lead to a binding international treaty on [GHG] emission reductions. . . . The outcome is seen by many in the private sector as a missed opportunity. Without clearer and stronger domestic policies in key markets, it is unclear whether there are sufficient drivers for large-scale renewable investment and deployment. … [But pure domestic action, such as through border measures, are problematic.] Unilateral action to impose border tax adjustment outside any global climate agreement is likely to prompt trade-related retaliatory actions, undermining the global trading system. …
>
> To achieve the 2°C target . . . countries and markets must stimulate opportunities in low-carbon and energy-efficient investments across the globe and generate $30trn of investment in the next two decades. . . . Only strong policy incentives will promote renewable energy activity under existing market conditions. This is often described as a 'market failure' in need of market mechanisms or policies that factor in the environmental cost of higher emitting fuels or subsidize cleaner ones, as a public good. Lack of confidence in the binding nature of national renewable energy targets or incentive mechanisms has

[99] *Id.* at 17.
[100] *Id*.

> hampered the growth of the sector. But where there is political will, investments are taking place.[101]

Even in the absence of determined government action, there is still the possibility that companies can make a difference. Particularly where companies intelligently collaborate, they have the potential, through innovation, to create the conditions that allow the profitability of new ventures. This dynamic is called "game-changing strategy",[102] and it should be encouraged to the extent possible both by governments (through enabling legislation) and by support-industries such as finance and insurance.

D. LOCALITY OF HARM

A major issue in both the insurance and environmental arenas, where the updating of systems-regulation and mechanisms of mitigation and adaptation is concerned, is a perceived non-locality of harm.

"Locality of harm" is the *objective* proximity of harm to an entity. A given entity's perception of the locality of harm is the measure of risk to which the entity perceives itself to be exposed – this is the *subjective* proximity of harm, the entity's risk exposure, or vulnerability. If the proximity of harm is calculated to be distant, then the behaviour producing the risk will not change.[103]

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[101] Antony Froggatt & Glada Lahn, *Sustainable Energy Security: Strategic Risks and Opportunities for Business*, LLOYDS 360° RISK INSIGHT, Sept. 13, 2012 at 18, *available at* http://www.lloyds.com/news-and-insight/riskinsight/reports/energy-security/energy-security

[102] *Id.* at 36.

[103] The subjective proximity of harm will always be different from the objective proximity of harm. This is due to the inevitable discrepancy between perception and reality. In some cases, there may be an over-abundance of caution and risk-aversion, and in such cases the locality of harm will be deemed closer than it truly is. On the opposite end of the spectrum is the case in which the locality of harm is deemed further away than it truly is and behaviour may be taken that increases the level of harm on the basis of the underestimation of the magnitude of that harm. Where harm is underestimated, and continuing behaviour increases that harm, the result can be catastrophic, such as was the case with the financial crisis of 2007–2009, and such remains the case to the extent the underlying problems that gave rise to the 2007–2009 crisis have not been fixed. Underestimation of the locality of harm can take place for various reasons. *See, e.g.,* Hecht, *supra* note 15, at 1591–92 (discussing possible explanations for a lack of demand for first-party catastrophic risk insurance). "[There are] several possible explanations for this behavior. First, limits on time and other resources . . . . Second, people may be motivated to choose not to think about outcomes that are scary or negative. Third,

In the following quote, Patrick Liedtke[104] highlights a scenario in which locality of harm issues appear – he argues against the rash development of new regulatory models in response to crises:

> [W]hat is unsettling is that many reform projects apply a perceived urgency that appears to sacrifice too readily methodical analytics and careful investigation for quick action. In the quest for solving the problems at hand, rapid action is desired and the time for meticulous examination seems too long-winded and politically inopportune. This is a shame. Regulation, especially if it is comprehensive and meant to stand the test of time, needs a proper gestation period and enough time for appropriate consideration and thorough discussion.[105]

Change necessarily entails uncertainty and risk. Where the instigator of change is something that is perceived as negative or harmful or where the necessary result of confronting a given issue is perceived as involving hardship, the inherent psychological avoidance of uncertainty is exacerbated by the inherent desire to avoid difficulty to the extent reasonably possible – the linking of these two creates inertia.[106] In the case of climate change, the required changes are extreme precisely because they

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people may assume that if a situation is terrible enough, someone else will bail them out. Fourth, perceived or real budget constraints . . . . Fifth, people's view of insurance as an investment rather than as a hedge against loss . . . . And finally, consumer myopia, a tendency to ignore any costs or benefits with a time horizon over approximately one year . . . ." *Id*.

[104] Patrick Liedtke is the former Secretary General of The Geneva Association and former Editor-in-Chief of The Geneva Papers. He is one of the world's foremost authorities on the international regulation of insurance. INSTITUTE FOR THE STUDY OF LABOR, http://www.iza.org/en/webcontent/personnel/photos/index_html?key=162 (last visited Oct. 9, 2013).

[105] Patrick Liedtke, *Rules of Engagement: Global Regulatory Reforms and the Insurance Industry,* 36 THE GENEVA PAPERS 325, 326 (2001), http://www.palgrave-journals.com/gpp/journal/v36/n3/pdf/gpp201116a.pdf.

[106] *See* Stephen M. Gardiner, *A Perfect Moral Storm: Climate Change, Intergenerational Ethics and the Problem of Moral Corruption,* 15 ENVIRONMENTAL VALUES 397, 402 (2006) ("[A]ction on climate change is likely to raise serious, and perhaps uncomfortable, questions about who we are and what we want to be. …[T]his suggests a *status quo* bias in the face of uncertainty. Contemplating change is often uncomfortable; contemplating basic change may be unnerving, even distressing. Since the social ramifications of action appear to be large, perspicuous and concrete, but those of inaction appear uncertain, elusive and indeterminate, it is easy to see why uncertainty might exacerbate social inertia."), http://xa.yimg.com/kq/groups/21093100/1401045316/name/Gardner_Perfect_Moral_Storm.pdf.

have already been avoided for so long, and one of the factors that made climate change easy to ignore is the fact that most people simply have not seen the results of it in a sufficiently threatening form.[107]

1. Exploiting Uncertainty

Interests that would maintain the status quo, for the time being at least,[108] are able to reinforce avoidance through appeals that rest on the uncertainty inherent in climate science.[109] This approach fails to admit that all knowledge is uncertain and that the basis of the western scientific tradition rests on an appreciation of uncertainty. Science is constantly called to consider and reconsider extant knowledge, to update and correct the canon of empirical knowledge.

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[107] *See* Hecht, *supra* note 15, at 1586 ("On the demand side, cognitive biases cause individuals and risk managers to treat many catastrophic risks as trivial if their probability is perceived as below a certain threshold amount, and to place an extremely high discount rate on contingent events.")

[108] *See* Dlugolecki, *supra* note 19, at 84 ("Despite the gravity of the threats, the will to act is weak. There are powerful lobbies ranged against mitigation. The chain of accountability in asset management is confused and priorities are short term. Politicians fear to act, because making energy cleaner, or constraining consumerism are potentially vote-losing. Insurers themselves have been reluctant to become involved. In the face of scientific uncertainty and political antagonism, American insurers have been very reluctant to commit themselves…."); *see also* Hecht, *supra* note 15, at 1586 ("On the supply side, collective action issues, perverse incentives provided by regulation, uncertainty aversion, and concerns about short-term profits all tend to hinder the development and deployment of products that will help to solve climate change-related problems."); *Id.* at 1589 ("High transaction costs also tend to favor existing modes of doing business over innovation. Insurers typically benefit from large economies of scale and put large amounts of capital at risk. The transaction costs of adapting business practices are especially likely to affect insurance lines that aggregate risk from a very large number of policyholders. This phenomenon may explain, in part, the increased willingness of [certain] large surplus [lines] insurers and reinsurers, [those] which engage in fewer transactions overall, to explore taking on climate change more aggressively. Finally, insurers, most of which are publicly-traded companies, may have incentives to be concerned with short-term profits rather than risks that may materialize over the long term.").

[109] *See* Justin Gillis, *Clouds' Effect on Climate Change is Last Bastion for Dissenters,* N.Y. TIMES (Apr. 30, 2012) (discussing the passionate embrace by climate change skeptics in industry and government of the MIT climate scientist Richard Lindzen, who, standing largely alone on the basis of research (that has been so discredited by other climate scientists that he had to go to Korea in order to publish his findings in a journal) holds to a theory that it is not necessary and would be wasteful to make any political moves on climate change risks), *available at* http://www.nytimes.com/2012/05/01/science/earth/clouds-effect-on-climate-change-is-last-bastion-for-dissenters.html.

Where policy involves large expenses of finite capital politicians rightly seek a degree of certainty in their decisions. Climate change is an area that brings this problem into acute focus.[110] Huge economic interests are involved; society must choose whether or not to fundamentally restructure long-standing and deeply entrenched systems of economy. To make the necessary changes, massive legal shifts must be made that will affect hundreds of millions of people, huge shifts of investment must be made to fund new enterprises aligned with speculative models.

Understanding is never complete and to require (for public policy decisions to be made where hundreds of trillions of dollars are at stake along with the well-being of all future generations of humanity and the survival of countless other life-organisms) certainty greater than 97% of working climate scientists is unreasonable. Inaction in the face of such certainty represents gross negligence on the part of public servants in their duties to the public in a representative democracy.[111]

2. The Precautionary Principle

In modern international environmental law, the acceptance of uncertainty (matched with recognition of the duties of public servants) is embodied in what is called the "precautionary principle". As laid out in *Principle 15* of the United Nations *Rio Declaration on Environment and Development (1992),* the principle states:

> In order to protect the environment, the precautionary approach shall be widely applied by States according to their capabilities. *Where there are threats of serious or irreversible damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradation.*[112]

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[110] "For decades, a small group of scientific dissenters has been trying to shoot holes in the prevailing science of climate change, offering one reason after another why the outlook simply must be wrong. Over time, nearly every one of their arguments has been knocked down by accumulating evidence, and polls say 97 per cent of working climate scientists now see global warming as a serious risk." *Id.*

[111] "Gross negligence" is "[a] conscious, voluntary act or omission in reckless disregard of a legal duty and of the consequences to another party". BLACK'S LAW DICTIONARY 1062 (8th ed. 2004). Gross negligence is the opposite of "diligence", which entails care and caution, traits that are the very least that should be expected of any public servant in the exercise of his duties to the public. *Id.* at 488.

[112] United Nations Conference on Environment and Development, Rio de Janeiro, Braz., June 3–14, 1992, *Rio Declaration on Environment and Development*, U.N. DOC. A/CONF.151/5/Rev.1 (Aug. 12, 1992) *reprinted in* 31 I.L.M. 874, 879 (1992) (emphasis added).

Principles require adherence to an abstract (the *spirit* of the law), it does not matter what form of action is taken, so long as the action falls within the guidance or meaning of the principle. By way of contrast, rules-based law requires adherence to specific mechanisms or guidelines. Rules-based law encourages creativity in how to profitably undermine the *spirit* of the law while *technically* adhering to the law.

The precautionary principle is thus inherently vague – it leaves policymakers to determine its application. Determinations may include questions such as: What degree of protection is required? What measure of capability should be employed when deciding the extent of actions expected of states? What exactly constitutes serious or irreversible damage? What level of certainty is required for action? What are cost-effective measures? What does environmental degradation mean? These questions may be asked out of honest concern for how to apply the principle, or they may be asked so as to undermine the possibility of establishing what the principle seeks to establish through the creation of uncertainty-based inertia.

3. The Desire for Particularity

Both forms of question contain a fundamental flaw – they apply a rules-based paradigm of thought in a principle-based environment.[113] The requirements of the precautionary principle are perfectly clear if one considers the meaning of the principle in its true context. The true context of the principle is one in which the intent of the principle and what it represents is *actually and inherently* understood. When the principle is approached with this understanding the answers to the questions are integrally answered in the context of upholding the principle. This last statement is admittedly enigmatic in the context of a legal/business policy paper. We are used to, and generally require, a far greater degree of particularity – consider this statement:

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[113] Two examples illustrate this problem of applying a certain paradigm of thought in a fundamentally inconsistent context. The first is Zeno's paradox of motion, set out in the 4th Century BC. This paradox describes how in order for an arrow to reach its target it must first reach the mid-point between the bow and the target, but once it has reached that mid-point, it must then reach the next mid-point between the first mid-point and the target before it can reach the target, and so on. Ultimately the arrow spends an eternity reaching the next mid-point and can never actually reach the target. The second is the application of classical mechanics at the quantum level of matter. In both of these cases the logical problems that result are due to a misapplication of a paradigm of rules on the basis of an assumption of the universal relevance of those rules to all potential states.

> To assure efficiency and sustainability, the dialogue about the risks associated with new technologies must be improved and conducted at a more granular level. Only when sufficient granularity in the discussion of risks related to each new technology is achieved can appropriate risk management solutions and appropriate public policies (where necessary) be devised. Risks must be identified, categorized and analysed with respect to the cause of loss in developing economically efficient solutions that are also reasonable, responsible and responsive. If risk is not appropriately characterized, inappropriate policy solutions result, which ignore relevant market forces, create the potential for long-term dependency, foster economic inefficiency and aggravate the risk of environmental harm – all of which are unsustainable conditions. . . . Many approaches to risk analysis are possible. The key is to assure that the appropriate analysis is used for the technology under discussion, and the analysis itself is comprehensive and granular. Only when risks are parsed and defined appropriately can one determine what mechanisms are most effective and economically efficient to manage such risks.[114]

The above quote captures the requirement for specificity in analysis and comprehension of complex issues if they are to be effectively solved. The quote does not, however, represent a more fundamental concern, the question of whether the discussion at the granular level can possibly satisfy the underlying issue that prevents the ability for market participants to intuitively comprehend the requirement set in place by the precautionary principle, or the governing impetus for which the principle stands – which is, quite simply, "intent".[115]

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[114] Lindene Patton, *Beyond Rising Sea Levels: The Importance of the Insurance Asset in the Process of Accelerating Delivery of New Technology to Market to Combat Climate Change*, THE EUROPEAN BUSINESS REVIEW (2008) (Lindene Patton is Chief Climate Product Officer for Zurich Financial Services), *available at* http://www.zurich.com/internet/main/SiteCollectionDocuments/insight/NewtechnologyPatton.pdf.

[115] Consider the five-stage UK Civil Service formula for progressively preventing Cabinet Ministers from achieving anything during their time in office between general elections: "1. 'The administration is in its early months and there's an awful lot to do at once.' 2. 'Something ought to be done, but is this the right way to achieve it?' 3. 'The idea is good, but the time is not ripe.' 4. 'The proposal has run into technical, logistic and legal difficulties which are being sorted out.' 5. 'Never refer to the matter or reply to the Minister's notes. By the time he taxes you with it face to face you should be able to say it looks unlikely if

Where faced with the extreme repercussions that climate change provides, the seeking of particular answers prior to action generally causes unsustainable delay. To attempt to completely understand the various factors involved at the granular level is a futile exercise, and the adherence to this perspective leads to an impossible position – the discarding of the principle until the granular repercussions have been discerned – but this would effectively undermine the very basis of incentive that the discovery of granular answers requires. In other words, in certain circumstances action must be taken before all of the questions are answered, and in the course of acting the answers that are required are inherently discerned.

The above discussion should not be taken to suggest that a granular understanding of risk is not required in the creation of the concrete mechanisms to adapt to and mitigate any given risk.[116] What it does suggest is that, *to the extent the abstract requirement of the precautionary principle is not intuitively understood, a problem exists that will undermine the possibility for the granular understanding to develop.* Further, unless a factor of focused intent is harnessed to govern, even where a granular understanding may develop it will constantly be left open to countering arguments relying on alternative granular evidence, or interpretations of evidence, derived from the ever-present measure of uncertainty.

V. MANAGED EVOLUTION

As the pressures of climate change increase, if the global insurance system does not develop the necessary internal structures to spread risk as efficiently as possible, two possible outcomes will emerge: insurers will become insolvent due to not being allowed to charge adequate premiums, or they will have to leave markets due to the markets being unable to afford the actuarially-true premiums. Simultaneously, to the extent government, corporate, and investment policy allows an increasing wealth gap in the US or elsewhere in the developed world, increasingly few individuals will be

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anything can be done until after the election.'" *Yes, Minister: Big Brother,* at 14:34–15:41 (BBC television broadcast Mar. 17, 1980) (the *Yes, Minister* series and its sequel, the *Yes, Prime Minister* series, ran on BBC between 1980–1984 and 1986–1988 respectively – the script, written by Jonathan Lynn, was noted for its brilliantly insightful satire of the relationship between the permanent Civil Service and elected government ministers, often focusing on the creation of inertia in government action), *available at* http://www.free-tv-video-online.me/player/tudou.php?id=03ewO032bXg.

[116] *See* Hecht, *supra* note 15, at 1587 (discussing pricing in the context of climate change and insurance supply, and ultimately shedding light upon the necessary link between a demonstrable granular understanding of risk and the ability to employ that understanding as a price signal). As indicated by Sean Hecht, "where actuarial risk is not correlated with climate-friendly behavior, it is far more difficult to justify incorporating climate concerns into policy pricing." *Id*.

able to afford insurance causing a feedback loop to develop that will further exacerbate the problem.

When we consider the sensitivity of modern infrastructure it becomes very clear that we have been, particularly over the last forty years, sailing directly towards a perfect storm. It is the admitted intention of this paper to highlight the urgency of the matter.[117] Regulatory systems certainly do need "proper gestation period[s] and enough time for appropriate consideration and thorough discussion,"[118] but the appropriate consideration in an ideal system should be on-going and engaged in by academics, private policy/research institutions, industry, and public regulators on an on-going basis.

The current European system of insurance regulation is perhaps the best example of considered regulatory evolution.[119] While the regulations of Solvency I are still in place, Solvency II has been developed and is being tested, and (in response to those tests) is being adjusted prior to implementation. This process of evolution should not end with the implementation of Solvency II in 2016, but should ideally continue after Solvency II is implemented. The reason for this is obvious: the business market that Solvency II will regulate is in a state of constant change. A regulatory system must take this into account, and through the International

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[117] On a similar note, this exasperated Op-Ed, by the Director of NASA's Goddard Institute for Space Studies, should be required reading in every classroom across the country today: James Hansen, Op-Ed., *Game Over for the Climate,* N.Y. Times, May 9, 2012, (describing in detail the *dangerous* insanity of Canada's plans to exploit the oil in its vast tar sands reserves) *available at* http://www.nytimes.com/2012/05/10/opinion/game-over-for-the climate.html?nl=todaysheadlines&emc=edit_th_20120510.

[118] *See* Liedtke, *supra* note 105, at 326.

[119] Solvency II is not a perfect system. Concerns have been made regarding the level of complexity that the system has developed over the course of the several Impact Assessments that have been incorporated into the process of implementation to analyse the possible macroeconomic and financial repercussions of the legislation. Other concerns have been raised pertaining to the potential for changes that have been made to Solvency II to actually increase the possibility of systemic risk embedding itself into the insurance industry. *See* Philipp Keller, *Solvency II and Incentives for Systemic Risk Exposures,* 54 PROGRES (The Geneva Association, Geneva, Switz.) Dec. 2011, at 1, 2–8 (arguing that the main objective of Solvency II is policyholder protection, but also that protecting policyholders might not always be consistent with objectives of sustaining market stability or other macro-economic aims; and discussing "changes that were introduced to Solvency II that lower technical provisions, that are not consistent with an economic valuation standard, changes that could lead to an increased exposure to banking and sovereign risks, and changes to the structure of Solvency II, namely from the reliance on the standard formula and on governance requirements which introduce other specific risks . . . [which] bear the risk that the insurance industry will become increasingly exposed to systemic risk.").

Association of Insurance Supervisors (IAIS), the Financial Stability Oversight Council (FSOC) in the US, and the European Systemic Risk Board (ESRB) in the EU, international regulatory systems are now learning to take a more inclusive, business-reality based view of the objects of their oversight. By setting in place mechanisms by which regulatory systems can incorporate evolution, the opportunity for market-failures to surprise regulatory systems will be diminished.

The United States system can reasonably be considered an example of the failure of a system to instil this principle of managed evolution into its regulatory mechanisms. The financial crisis provided a great deal of urgency that would have, ideally, been employed to more significantly overhaul the financial services sector. Even though in that instance the main causes of concern were not in the insurance area, it was nevertheless an excellent opportunity to create a more simplified structure of regulation across the financial services spectrum, one that would more closely match the modern requirements of the global economy.[120]

Making unconsidered but systemically important changes in the midst of a crisis constitutes bad planning.[121] Fundamental structural changes must be made to the systems of environmental and insurance

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[120] The opportunity was largely lost, and now we see quite clearly the importance of substantial impetus – now, the public will, the public perception of urgent need, is gone and very little of material substance has changed. Another opportunity will not present itself except in the event of another crisis, which will certainly come and will very likely be significantly worse than the last because it will be a crisis that will very likely strike when economic and political systems are already weak and underfunded.

[121] This is of course the situation we are currently in, and it is not to be envied: "The additional challenge and complexity of the actual situation is that policymakers are faced with a volatile economic and market environment. Uncertainty rules—uncertainty stemming from several distinct sources: the continued lack of a full resolution to the European sovereign debt crisis, fiscal constraint and political infighting in the US, dwindling effective options remaining to the [U.S. Federal Reserve] and European Central Bank (ECB), disappointing economic data, and unknown implications from regulatory reforms. Erratic markets reflect this uncertainty: investors worldwide have little sense of how economies will develop. We face a severe crisis of faith in economic policy, undermining business confidence. In times [of great uncertainty] like these, it becomes even more critical that policy be appropriate and credible. . . . The industry is at a critical time to reflect on the process of regulatory reform." Philippe Brahin, *Regulatory Reforms in an Uncertain Environment,* 54 PROGRES (The Geneva Association, Geneva, Switz.) Dec. 2011, at 21, 22. But though the industry is a critical time to reflect on the process of regulatory reform, it is also the worst time to reflect on the process; going forward, it will be vital to precisely consider the reform that is needed in advance so that it is not necessary to consider it amidst such insecurity as currently exists. In other words, preventative action is generally a far less disruptive course than reactive action.

regulatory law in the expectation of crises, not in the midst of them. The two must take place simultaneously and will require the participation of government, business, and the voting/consuming public.

A. STRUCTURAL INVESTMENT

We must concentrate on helping dedicated insurance industry players to conduct their business more efficiently, we must increase the ability for a wider segment of the general population to achieve an economic position in which they can afford insurance at actuarially-accurate rates, and we must save money where we can by understanding more carefully the value of money and the relationship of its investment to long-term considerations. If we do not achieve all three of the above, the losses that will result from increasingly devastating weather events, affecting increased worldwide development, will deplete the surpluses of the industry and make insurance unaffordable if even available.

It must be recalled that even where losses are insured and the pain of the loss has been spread, even though there is benefit to be had for local businesses in rebuilding, *the overall economy has still suffered a loss.* It is not sufficient that the proceeds of policies are used to rebuild in exactly the same place where the loss occurred with adaptation to future events in mind. Consider, for example, the development that is currently taking place in Southeast Asia and Indonesia, the historical prevalence of 9.0 earthquakes in the region. In March 2011 this problem came into sharp focus with the tsunami that struck northeastern Japan, a stark "reminder that secondary loss elements, such as tsunamis, can be a crucial loss driver in an earthquake event."[122]

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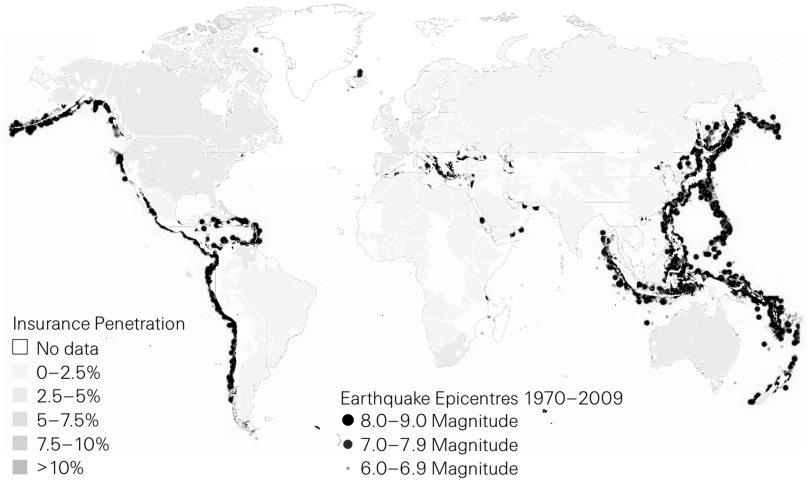
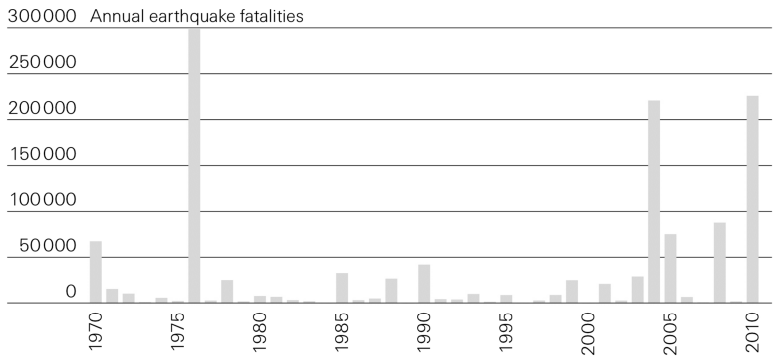
[122] Lucia Bevere et al., *Natural Catastrophes and Man-Made Disasters in 2011: Historic Losses Surface from Record Earthquakes and Floods,* SIGMA, no. 2, 2012, at 1, 7, *available at* http://media.swissre.com/documents/sigma2_2012_en.pdf.

Historical Epicenters with a Moment Magnitude of 6 or Higher:[123]



Source: Swiss Re CatNet
http://www.nxtbook.fr/webapp/nxt/CatNet-Guide/Geoportal/index.php#/0

Now consider the next graphic, and the result that on-going consistent growth will produce in the fatality statistics.
Comparison of Annual Fatalities Due to Earthquakes since 1970:[124]



Source: Swiss Re Economic Research & Consulting

To consider the matter coldly, from a purely economic perspective, it does not matter so much that people have died – what matters more is the

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[123] Lucia Bevere et al., *Natural Catastrophes and Man-Made Disasters in 2010: A Year of Devastating and Costly Events,* SIGMA, no. 1, 2011, at 1, 11 fig.7, *available at* http://media.swissre.com/documents/sigma1_2011_en.pdf.

[124] *Id.* at 9 fig.4.

disruption that will take place when highly populated coastal areas are devastated, when governments must respond to millions of people in trouble, when the population is burdened with the psychological scars of their neighbours having been killed, their small businesses, their fields and livelihoods devastated. These are massive costs.[125]

Whether the situation is looked at in terms of morality or in terms of economics, the magnitude of the risk that our growth patterns create when considered in light of climate change is disturbing. The money spent in response to preventable loss from catastrophic events is economic value that has not been used for other purposes, for relocation of infrastructure, for education, for research and development of next-generation technology. Economic buying power is finite – with every dollar we spend we are forming our future experience. Responding to catastrophes is expensive. Instead of using our creativity to come up with ingenious methods of avoiding facing the problem, we must work to develop methods by which we can bring down the price of insurance, so that it is affordable even in situations of greater risk.

1. Making Insurance Affordable

There are ways of decreasing the price of insurance that make sense, and many others that seem attractive in the short term, but prove not to make sense when looked at more carefully. Subsidization by un-like risk-holders does not make sense. Local, jealous protection of regulation does not make sense. Forcing insurers to stay in markets while disallowing them to charge actuarially sound rates does not make sense.[126] Allowing the continuation of industrial and other living practices that provoke climate change does not make sense. Preventing international and enforceable

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[125] The insured losses from the 2011 flooding in Thailand were unprecedented. Though different in cause from coastal damage from earthquakes, the flooding produced a similar result. Many companies had moved production facilities to Thailand, including Japanese firms that had moved facilities in response to tsunami damage in Japan; these large businesses are generally insured. The owners of residential homes and small businesses in an area the size of Switzerland were not so fortunate, only about 1% of them held flood insurance – they lost everything. *See id.* at 12–16.

[126] "Regulators have generally sided with the financial interests of affected policyholders in situations where affordability or availability of insurance is threatened, limiting insurers' ability to charge purely risk-based premiums." Hecht, *supra* note 15, at 1607. "Regulators may indeed have a significant role to play in the attempting to change their regulatory structure to promote incentives to properly incorporate risk. If they do not do so, they will not only sacrifice the long-term health of the insurance industry, but may impede opportunities to help address climate change where insurers' interests are aligned with climate-friendly practices."). *Id.* at 1609–10.

systems of environmental cooperation from gaining momentum does not make sense.

What would make sense would be to gather together as an international community and conclude a global agreement on a world environmental organization that can harmonize, systematize, and streamline global approaches to environmental protection, adaptation and mitigation policies, and liability structures[127] with biting enforcement mechanisms. Also, to harmonize the law pertaining to the international spreading of risk, the regulation of IAIGs, and the mechanisms by which insurance regulators from all over the world determine and vouch for the solvency of complex enterprises so that like-risks can be more easily and efficiently be pooled on a global basis. And finally, to incentivize the building and spreading of sustainable wealth models so that a greater numbers of people are more securely able to afford insurance. The insurance industry can and should help in this process.[128]

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[127] *Id.* at 1598–99 ("[T]he current ambiguity in legal liability regimes relating to responsibility for climate change will continue to pose a challenge to insurers who attempt to consider climate change-related liability risks in their underwriting.").

[128] *See* Dlugolecki, *supra* note 19, at 88 ("Insurers have a duty as ubiquitous players in the economy and society to help to shape climate policies in a responsible and effective way. With their expertise in risk management, and their responsibilities as custodians of future wealth they are uniquely placed, but in general they have been dilatory in this task."). *See also* Hecht, *supra* note 15, at 1587, 1613–14, 1616 ("[I]nsurers . . . should be motivated to take significant actions aimed at reducing overall societal greenhouse gas emissions and increasing adaptive capacity. These actions will reduce overall uncertainty and other barriers to insurability, by reducing insurers' potential exposure to catastrophic risks in excess of their capacity as well as the potential for property/casualty and liability claims in excess of current pricing structures. It will also allow insurers to price their products at marketable rates, giving them wider potential markets of policyholders . . . [Further t]he insurance industry in particular has significant potential to influence the behaviour of other market actors through its contracting. . . . Firms with significant market power can use contracts and other instruments to achieve broader environmental goals, complementing and in some cases substituting for government regulation . . . In light of its market power, influence, and incentives, the insurance industry is a potentially powerful instrument of private governance to address climate change. The industry wields enormous market power internationally by serving as a facilitator of new ventures and spreader of risk for new and existing ventures. Its contracts affect individuals and businesses around the globe. And consumers of insurance are often beholden to insurers' unilateral decisions about the pricing and the availability of insurance products . . . [But, insurers cannot do it alone,] the public sector must work together with the insurance industry . . . to develop partnerships and regulatory relationships that promote sound climate policy while benefitting insurers and policyholders. . . . Unless and until these challenges are overcome, the insurance

2. Foundations for Action

Without a perception of proximate locality of harm, responsive action is impossible due to a lack of incentive. The problem with presenting doomsday scenarios is that they can have a tendency to cause people to feel the problem is just *too much* to consider. Solutions help alleviate the stress of facing problems, they allow confidence that the problem is something that can be managed. That being said, it is dangerous to require absolute certainty in the choosing of solutions – there are very good reasons to expend attention, energy and resources on overwhelming problems prior to the existence of certain solutions.

First, sometimes problems can *only* be managed if they are addressed. The overwhelming problem of climate change is precisely of this nature. The optimistic avoidance argument that we will be able to solve climate change problems through future technology is problematic – while it is the case that human beings have proved remarkably ingenious and effective in solving pressing problems, the difference between the climate issue and other issues is that there is much more at stake with the climate than was the case in any previous problem modern mankind, as a whole, has faced. In the context of climate change delay on the basis of a future quick-fix is too much of a gamble, it places on the line the lives of too many people (and other life-forms) who have not had adequate opportunity to be informed and heard.

A second reason to act despite overwhelming odds would be that it is the *right* thing to do – *irrespective* of whether or not a solution is *in fact* possible, action should be taken anyway. This argument rests in a notion of duty – duty to others, duty to nature and the earth, duty to our descendants, and perhaps most importantly, duty to ourselves. By not acting we undermine our own credibility, our own ability to look into a mirror and feel truly proud and satisfied with the way we spend our days, with the choices we make. This concept refers to a certain heroic element in the human spirit, it is one that comes through in adversity and fights for what is right regardless of apparent futility.[129] On this basis alone, we should feel

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industry will have limited ability to help society address climate change through its products.").

[129] Consider these words from the speech given by Prime Minister Winston Churchill to the House of Commons on August 20, 1940:

> What a cataract of disaster has poured out upon us . . . . The trustful Dutch overwhelmed; their beloved and respected Sovereign driven into exile; the peaceful city of Rotterdam the scene of a massacre as hideous and brutal as anything in the Thirty Years' War. Belgium invaded and beaten down; our own fine Expeditionary Force, which King Leopold called to his rescue, cut off and almost captured, escaping as it seemed only

ashamed of our inaction, and should act to prevent the continued support of unsustainable enterprises.

Such sentiments, while noble, generally hold little weight in the cold reality of international politics, business and economics.[130] Luckily, a third reason for acting against overwhelming odds in the climate area is that it is, *given the right circumstances,* economically profitable to do so.[131]

> by a miracle and with the loss of all its equipment; our Ally, France, out; Italy in against us; all France in the power of the enemy, all its arsenals and vast masses of military material converted or convertible to the enemy's use; a puppet Government set up at Vichy which may at any moment be forced to become our foe; the whole Western seaboard of Europe from the North Cape to the Spanish frontier in German hands; all the ports, all the air-fields on this immense front, employed against us as potential springboards of invasion. Moreover, the German air power, numerically so far outstripping ours, has been brought so close to our Island that what we used to dread greatly has come to pass and the hostile bombers not only reach our shores in a few minutes and from many directions, but can be escorted by their fighting aircraft. .
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> . . .
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> . . . The British nation and the British Empire finding themselves alone, stood undismayed against disaster. No one flinched or wavered; nay, some who formerly thought of peace, now think only of war. Our people are united and resolved, as they have never been before. *Death and ruin have become small things compared with the shame of defeat or failure in duty*.

Prime Minister Winston Churchill, "The Few" Address at the House of Commons (Aug. 20, 1940) (emphasis added).

[130] "Britain should always be on the side of law and justice, so long as we don't allow it to affect our foreign policy*." Yes, Prime Minister: A Real Partnership* (BBC television broadcast Feb. 6, 1986), *available at* http://www.veoh.com/watch/v21039982Jw546Dc4?h1=Yes+Prime+Minister+1.5+-+A+Real+Partnership (the Yes, Minister series and its sequel, the *Yes, Prime Minister* series, ran on BBC between 1980–1984 and 1986–1988 respectively–the script, written by Jonathan Lynn, was noted for its brilliantly insightful satire of the relationship between the permanent Civil Service and elected government ministers, often focusing on the difference between the importance publicly placed on principles such as law and justice, and the extent to which such principles fail to guide public policy in actual practice where economic or business concerns are raised).

[131] Aside from the profitability of a new industrial revolution in next-generation technologies:

> [T]here is much analysis and evidence to show that "green sectors" such as building retrofits and renewable energy have the

3. "ESG" Factors

In October 2009, the United Nations Environment Program Finance Initiative (UNEP-FI) published a report by its Insurance Working Group,[132] called *The State of Sustainable Insurance: Understanding and Integrating Environmental, Social and Governance Factors in Insurance:*

> prospect of leading the global economic recovery while addressing major environmental crises, and doing so with better returns to capital than "brown" development or a "spending spree". . . . Falling employment and income levels are the destabilizing social consequences of the economic crisis. Maintaining and creating jobs and income levels is vital for social stability as well as for restoring aggregate demand to start and underpin economic recovery. Many green sectors have higher employment leverage per unit investment than less green alternatives. There are also very significant opportunities to create employment in green sectors as part of short-term stimulus packages. . . . We believe that there is a unique historical opportunity now to create the basis of a new Green Economy that is able to allocate natural capital and financial capital in a far more effective and efficient manner into the foreseeable future.

U.N. ENV'T PROGRAMME, GLOBAL GREEN NEW DEAL: POLICY BRIEF 1, 4 (Mar. 2009), *available at* http://www.unep.org/pdf/A_Global_Green_New_Deal_Policy_Brief.pdf. *See* U.N. ENV'T PROGRAMME FIN. INITIATIVE, THE GLOBAL STATE OF SUSTAINABLE INSURANCE: UNDERSTANDING AND INTEGRATING ENVIRONMENTAL, SOCIAL AND GOVERNANCE FACTORS IN INSURANCE 1, 13–14, 35–40 (Oct. 2009), *available at* http://www.unepfi.org/fileadmin/documents/global-state-of-sustainableinsurance.pdf (describing how proper management of Environmental, Social and Governance factors potentially enhances insurance company earnings and long-term company value via avoided loss and new product offerings); *see also* GLOBAL GREEN NEW DEAL: POLICY BRIEF *supra*, at 19–29 (describing the advantages to such an approach as applied to specific industry sectors such as building, energy, transport, freshwater, ecological infrastructure, and agriculture, there are specific profitability factors from which the insurance industry in particular stands to gain).

[132] U.N. ENV'T PROGRAMME FIN. INITIATIVE, *supra* note 131, at 9. Although UNEP is an entirely underfunded and largely overlooked limb of the United Nations framework, the significance of its Finance Initiative Working Groups should not be overlooked. The Insurance Working Group membership includes over 200 financial institutions, including some of the world's largest banks and insurers. Initially it was hoped UNEP-FI's membership would represent a larger share of the banking/insurance world, but interest diminished in light of uncertainty over liability and reputational concerns. This is particularly unfortunate as regards potential insurer membership – as this paper argues, greater certainty regarding liability exposure for insurers would increase their ability to assist in manifesting behavioral change in markets such as would decrease and make more

> We believe that through the systematic integration of material [Environmental, Social and Governance (ESG)] factors into core insurance processes, insurance companies – along with the individuals and entities they protect and the entities that they invest in – will be able to sustain their economic activities and play their roles in the creation of a more sustainable global economy that invests in real and inclusive long-term growth, genuine prosperity and job creation, in line with UNEPs Green Economy Initiative and the broad objectives of its 'Global Green New Deal'[, which includes making] a major contribution to reviving the world economy, saving and creating jobs, and protecting vulnerable groups.[133]

In the preparation of its report, UNEP conducted a comprehensive survey[134] of the insurance industry in regards to the role of ESG factors in their underwriting and investment practices. ESG risk factors are broken down into sub-factors by UNEP as follows: Environmental – climate change, biodiversity loss & ecosystem degradation, water management, pollution; Social – financial inclusion, human rights, emerging manmade health risks, ageing populations; and Governance – regulations, disclosure, ethics & principles, alignment of interests.

Five key findings were made by the report. First, "ESG factors influence underwriting, and have varying degrees of impact across lines of insurance"; second, "Proper management of ESG factors potentially enhances insurance company earnings and long-term company value via avoided loss and new product offerings"; third, "Given their assessment of ESG risks, underwriters judge the societal response for many ESG factors as underdeveloped"; fourth, "The evolution of ESG factors in developing regions is different, but there are aspects common globally"; and fifth, "Active promotion and adoption of integrated ESG risk management and financing is needed".[135]

As regards the first of the above thematic findings, the report points out that "in a data-driven industry, the absence of a substantial track record in utilising ESG factors as a performance predictor or risk quality was noted as a barrier to both the development of new products and further

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manageable the overall risks to which society and economies are exposed through climate-related issues.

[133] *Id.*

[134] Resulting in "nearly 2,700 pages of data from 60 territories worldwide and from respondents with over 3,800 years of cumulative insurance experience." *Id.* at 12.

[135] *Id.* at 13–17.

integration of ESG criteria into formal underwriting guidelines."[136] With more concerted study, the relationship between ESG factors and the overall risk exposure of companies will become increasingly apparent. Insurers, going forward, will need to take more conscious account of this area, not only in terms of how particular climate change related repercussions will affect particular lines – like ageing populations and life insurance for example – but also in terms of the overall and developing reputational-risk faced by insureds in light of their treatment of ESG factors.[137]

As regards the second of the above thematic findings, the report points out that the development of new insurance products has been challenging.[138] Because these risks fall into a new category, and therefore historical exposure data is largely non-existent, the product development process relies to some extent on legal and regulatory frameworks. On this basis, inter-governmental action could help by establishing a more effective infrastructure of international environmental law, as well as harmonization of domestic environmental law, to help crystallise these ESG risk-factors into a more economically measurable state through reporting and liability mechanisms. Without such mechanisms in place, if the insurance industry wants to develop new products, it must accept an additional regulatory risk burden that will make the products more expensive, and thus less viable.

As regards the third of the above thematic findings, the report points out that there exists a disconnect between industry assessments of ESG-related risks, and the apparent societal response to those risks. The insurance industry, as an entity, is the world's most expert risk analyst. It is expertise in this area that makes the on-going provision of insurance possible. It cannot be surprising that those who specialize in the area would see new risk-factors earlier than others. Whereas in the public sphere there is a marked inattentiveness to climate change related risks, the results of UNEP-FI's survey found that "underwriters judged ESG risks to have significant loss potential. . . ."[139]

In light of this, to return to the question of establishing systems to crystalize risk-factors into economic models, the report asks "whether a regulatory or legal framework is a precondition of insurability, or whether

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[136] *Id.* at 13. One area of particular difficulty in this context is the natural commons. "[M]ost biodiversity and ecosystem benefits are largely public goods with no price, and are therefore rarely detected by our traditional economic compass." *Id*. at 33. *But see* U.N. ENV'T PROGRAMME FIN. INITIATIVE, THE NCD ROADMAP: IMPLEMENTING THE FOUR COMMITMENTS OF THE NATURAL CAPITAL DECLARATION, 31–34 (May 2013), *available at* http://www.unepfi.org/fileadmin/documents/ncd_roadmap.pdf (marking the beginning of Phase II of efforts under the Natural Capital Declaration, an initiative of signatory financial institutions to include natural capital on balance sheets).

[137] U.N. ENV'T PROGRAMME FIN. INITIATIVE, *supra* note 131, at 13.

[138] *Id*.

[139] *Id.* at 14.

it is simply one of many important issues that influence the underwriting process."[140] In response to its question, the report points out:

> The insurance industry perspective reflected in the survey results suggests that ESG risks may be 'outrunning' the development of prudential regulatory or legal frameworks. This is significant because it is a fact that the insurance industry is highly regulated, and the survey statistics reveal that *regulations* is the number one factor influencing underwriting, and the number one factor in terms of risk severity.[141]

Here the report makes clear its view that where industry must lead the way in a dynamic market, there must be in place an equally dynamic framework by which to guide that industry response.[142] Without such a framework, it is particularly difficult for insurers in the context of emerging risks as it is not clear to what extent they may be held liable for claims made for losses based on those risks. For an insurer to take on a risk, it is important that it is able to charge an appropriate premium, and important that it not be unduly expected to pay claims outside of the risk it has taken on in the event of unknown liabilities arising.[143]

As regards the fourth of the above thematic findings, the major difference between developed and developing countries is in the extent of insurance penetration—there is not necessarily such a difference where incorporation of ESG factors are involved. As regards the fifth of the above thematic findings—that active promotion and adoption of integrated ESG risk management and financing is needed – the report breaks down its findings into five critical required actions:

> 1. Working together within a fragmented insurance industry structure on how to achieve collective industry action on ESG factors. . . . 2. Creating enhanced forums for

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[140] *Id*.

[141] *Id*.

[142] *Id.* at 14–15.

[143] *See id*. (referring to insurer hesitancy in joining UNEP-F1 as a result of liability uncertainty). Note that the insurance industry suffered major damage as a result of the irresponsible practices of its insureds in the case of asbestos. Tort liability for asbestosis almost bankrupted Lloyd's of London, one of the most important markets for the spreading of risk in the world. Frameworks for the more effective understanding and measurement of ESG factors have begun to be developed both in the insurance industry (with the ClimateWise Principles) and in the investment industry (with the UN-backed Principles for Responsible Investment). ClimateWise is an insurance industry project launched by Charles, Prince of Wales.

> dialogue on ESG factors within the insurance industry, and between the industry and its stakeholders. . . . 3. Embedding material ESG factors in underwriting guidelines, and building the appropriate skill sets. . . . 4. Addressing ESG communication gaps and barriers within insurance companies. . . . 5. Recognizing and respecting divergent interests on ESG factors. . . .[144]

In regards to divergent interests, the report makes a particular point about legacy issues, and their potential effect on insurer openness to environmental concerns. Legacy issues are:

> [P]otential loss exposures arising from policies issued in the past where new theories of litigation might trigger a claims payment never contemplated at the time the policy was underwritten. . . . Potential legacy issues could be . . . liability risks associated with the failure to act on climate change. Not all conversations on ESG issues are 'safe' or 'comfortable' for insurance companies as they can touch not just the coverage to be offered in the future, but also the potential reinterpretation of policies issued in the past. Without addressing these structural issues, it will be difficult to seize the benefits arising from a public-private partnership in response to the universe of largely long-term and systemic risks inherent in many ESG factors.[145]

On the basis of these themes, the UNEP-FI report makes recommendations specific to insurance companies, the insurance industry, and regulatory systems and stakeholders:

Regarding insurance companies, UNEP-FI suggests the integrating of ESG risk factors into company-wide policy and insurance processes including: a clear mandate and strategy at Board and senior management levels; the provision of ESG education, training, tools and information for

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[144] *Id.* at 16–17. In regard to critical action 3, note that "as skilled as underwriters are, the reality is that many ESG factors entail enhanced skill sets, involve regulatory and legal challenges, and require greater knowledge and exposure data in order for the risks to be properly underwritten." *Id.* at 16. In regard to critical action 4, note that "communication gaps or barriers that exist between underwriters and investment managers [is an example of how] organisational silos can impede ESG integration." *Id.* In regard to critical action 5, note that "enhanced forums . . . will be a useful means of identifying those areas of common ground to be seized for mutual benefit, as well as those areas of clearly divergent interests to be more effectively managed once defined." *Id.*

[145] *Id*. at 17.

employees; the review of formal underwriting guidelines to integrate ESG factors; consideration of the potential for ESG-related products; the assessment and monitoring of both direct (within the company itself) and indirect (insurance, reinsurance, and investment portfolios, as well as supply chain) ESG performance; and the transparent disclosure of direct and indirect ESG performance.[146]

Regarding the overall industry, UNEP-FI suggests that "the insurance industry should develop and adopt a set of 'Principles for Sustainable Insurance' focused on ESG factors, tailored to the insurance business, grounded on risks and opportunities, and in line with the goals of sustainable development. These principles can provide the global sustainability framework through which the industry can work together to address, among others, the major challenges" outlined by the five thematic findings described above.[147]

Regarding the regulatory and stakeholder level, UNEP-FI suggests: that policymakers and regulators should establish and maintain prudential frameworks relating to ESG factors; that civil society institutions, through self-education, should help the insurance industry in becoming more sustainable and should support the provision of ESG-related products and services; and that the academic community should advance research in related areas.[148]

> In order to sustain the long-term economic health and resilience of the insurance industry – and unleash its immense capacity to tackle ESG factors as risk managers, risk carriers and institutional investors – material ESG factors must be systemically integrated into underwriting guidelines and product development, and other core insurance processes such as investment management, claims management and sales & marketing. . . . [T]he societal response to managing the global, long-term and systemic risks posed by many ESG factors is underdeveloped. [The development of] 'Principles for Sustainable Insurance' . . . can act as a dynamic best practice framework, pool information and resources, inform regulators and policymakers, create a global sustainability forum for the industry and its stakeholders, foster inclusiveness across markets, drive innovative solutions, and accelerate collective action on global sustainability challenges.[149]

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[146] *Id.*
[147] *Id.* at 17–18.
[148] *Id.* at 18.
[149] *Id.*

4. The ClimateWise Principles

The ClimateWise Principles[150] are an example of an industry-led approach to taking ESG factors further into account in the absence of a government-imposed framework.[151] The Principles were launched by Charles, Prince of Wales, in September 2007 on the basis of his understanding of the social and economic importance of insurance in our society.[152] The Principles are to: 1. Lead in Risk Analysis; 2. Inform Public-Policymaking; 3. Support Climate Awareness Amongst Insurance Customers; 4. Incorporate Climate Change into Investment Strategies; 5. Reduce the Environmental Impact of Business; and 6. Report and Be Accountable.

By its second year, this initiative had grown from 16 original insurance company members to over 40 from Africa, Asia, Europe, and North America. Most prominent in its membership however (as is the case with the UNEP-FI Industry Working Group) are large European insurers. The underlying reality that this imbalance reflects is perhaps well-demonstrated in the below excerpt from the Executive Summary of PricewaterhouseCoopers' independent review:

> Overall, *ClimateWise members have maintained the high levels of compliance seen in the 2010 Independent Review, with average compliance across all the principles standing*

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[150] *See* CLIMATEWISE, THE CLIMATEWISE PRINCIPLES, http://www.climatewise.org.uk/storage/The%20ClimateWise%20Principles.pdf (last visited Oct. 14, 2013).

[151] As a matter of transparency, the ClimateWise Initiative members agreed that they would publish an annual statement detailing what actions they have taken to comply with the ClimateWise Principles. *See* CLIMATEWISE, CLIMATEWISE PRINCIPLES: THE FOURTH INDEPENDENT REVIEW 2011, http://www.climatewise.org.uk/storage/fourthyearreview2011/ClimateWise%20Fourth%20Year%20Review%20-%20Summary%20Version.pdf (last visited Oct. 14, 2013); CLIMATEWISE, CLIMATEWISE PRINCIPLES: THE FIFTH INDEPENDENT REVIEW 2012, http://www.climatewise.org.uk/storage/_website-2012/fifth-anniversary-review-and-summit/ClimateWise%205th%20Year%20Review%202012%20-%20Executive%20Summary.pdf (last visited Oct. 14, 2013).

[152] For more than thirty years, the Prince of Wales has been advocating a more sustainable and responsible manner of living, in terms of both human-built environments and natural environments. For decades, his ideas on these topics have been dismissed, if not ridiculed, as eccentric in the press and many segments of the government and public. The ClimateWise project is just one of many such projects that the Prince has launched. His battles in fighting for principles of sustainable living and applied concepts of sustainable development directly highlight the regrettably inadequate and/or misguided attention given to maintaining basically healthy human and natural environments.

> *at 88%*.... Posting [] growth in compliance in this reporting period was always going to be difficult against the backdrop of the external market challenges. Therefore maintaining compliance at just under 90% can be seen as something of a strong performance. It is also key to point out that members of ClimateWise, in signing up to the principles and reporting against them, are indicative of a section of the industry that is more advanced in addressing climate risk. In September 2011, Ceres released a report entitled 'Climate Risk Disclosure: Evaluating Insurer Responses to the NAIC Climate Disclosure Survey'. *While clearly focussed on the North American market, the report concluded* "while the NAIC survey revealed a broad consensus among insurers that climate change will have an effect on extreme weather events, *only 11 of the 88 companies reported having formal climate risk management policies in place, and more than 60% of the respondents reported have no dedicated management approach for assessing climate risk."* In contrast, the level of compliance across the ClimateWise Principles demonstrates that, for most members, activities supporting management and assessment of climate risk are well established.[153]

The above excerpt demonstrates the different approach taken in Europe to the climate change issue. Problems related to climate change are too large for individual insurers or regions to tackle alone – it is of the utmost importance for the US insurance industry, public, and government to follow suit. The actions of a single insurer (or even a single group of insurers) will not have a sufficient effect in influencing global industry or governmental/social policy towards a more responsible approach to the magnitude of the concerns the society faces; second, the embracing of ESG factors by a single insurer (or group of insurers if they do not have sufficient bargaining power to force a shift in global industry) can place that/those insurer/s at a competitive disadvantage in the short-term, and potentially prevent them from realizing the benefit of their action in the mid- to long-term. By acting together, and by thinking of mid- to long-term interests, insurers can pool their collective bargaining power in the overall markets. The driving push of insurers will help to spur their counterparties in the process.

5. The Principles for Responsible Investment

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[153] CLIMATEWISE PRINCIPLES: THE FOURTH INDEPENDENT REVIEW 2011, *supra* note 151, at 6 (emphasis added).

On the investor side, a similar initiative to ClimateWise is the Principles for Responsible Investment (PRI).[154] PRI was founded in 2005 on the invitation by the UN Secretary General to institutional investors to develop, in cooperation with the UNEP-FI and the UN Global Compact, a set of principles upholding and promoting the ESG concept in the investment arena. The Principles are: 1. We will incorporate ESG issues into investment analysis and decision-making processes; 2. We will be active owners and incorporate ESG issues into our ownership policies and practices; 3. We will seek appropriate disclosure on ESG issues by the entities in which we invest; 4. We will promote acceptance and implementation of the Principles within the investment industry; 5. We will work together to enhance our effectiveness in implementing the Principles; 6. We will each report on our activities and progress towards implementing the Principles.[155]

The PRI initiative is organized principally into four Work Streams. These are: Implementation Support, Academic Network, Principles for Investors in Inclusive Finance, and PRI Country Networks.

Implementation Support breaks down into nine subcategories related to different areas of investment activity: listed equity, fixed income, private equity, property, hedge funds, commodities, infrastructure, small and resource-constrained signatories, and investing with impact.[156] The PRI Academic Network "is a unique research community established to support the work of the PRI through research on responsible investing. It fosters a network of scholars, practitioners, policymakers and students interested in responsible investment issues [and provides] a global platform to deliver high-quality and accessible academic research to PRI signatory organizations. . . ."[157] The Principles for Investors in Inclusive Finance (PIIF) provides a framework for "expanding access to affordable and responsible financial products and services by poor and vulnerable populations. . . . A wide range of financial products and services are incorporated within the remit of inclusive finance including savings, credit, insurance, remittances, and payments."[158] PRI Local Networks have been set up in Brazil, South Africa, Korea, Japan and Australia in order to

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[154] *See* PRI ASS'N, PRINCIPLES FOR RESPONSIBLE INVESTMENT, *available at* http://www.unpri.org/ (last visited Oct. 14, 2013).

[155] *See* PRI ASS'N, THE SIX PRINCIPLES, *available at* http://www.unpri.org/about-pri/the-six-principles/ (last visited Oct. 14, 2013).

[156] *See* PRI ASS'N, IMPLEMENTATION SUPPORT, *available at* http://www.unpri.org/areas-of-work/implementation-support/ (last visited Oct. 14, 2013).

[157] PRI ASS'N, ACADEMIC NETWORK, http://www.unpri.org/areas-of-work/about-an/?option=com_content&view=category&layout=blog&id=43&Itemid=100065 (last visited Oct. 14, 2013).

[158] PRI ASS'N, WHAT IS INCLUSIVE FINANCE? *Available at* http://www.unpri.org/areas-of-work/piif/what-is-inclusive-finance/ (last visited Oct. 14, 2013).

provide the following opportunities for investors in those countries: "support implementation of the Principles in a local context; provide a platform for signatories to share ideas and best practices [as well as to create a networking and collaboration space]; consolidate understanding of common challenges with a focus on local/regional issues; encourage [more] signatories to get involved in global PRI activities; raise awareness about responsible investment and [to] recruit new signatories; engage with local companies and policy makers collectively on specific ESG issues; and provide [information] to the PRI Secretariat on the issues and challenges facing local signatories."[159]

Another noteworthy Work Stream is the Engagement Clearinghouse, which "provides signatories with a forum to share information about collaborative engagement activities they are conducting, or would like to conduct." [160] The PRI, through the Engagement Clearinghouse, is able to combine the bargaining powers of its members in order to influence corporate performance on ESG issues, and "seek changes in company behaviour, policy or systematic conditions."[161] Through acting collectively, investors are also able to avoid the problem of the positive externalisation of the costs of monitoring individual companies – by pooling resources, signatories can share both the costs of monitoring, and the benefits of that monitoring.[162]

Like ClimateWise, the PRI is an example of private enterprises acting where governments have failed to act. By joining together, companies have the opportunity to simulate regulated conditions – they

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[159] PRI ASS'N, NETWORKS, *available at* http://www.unpri.org/areas-of-work/networks/ (last visited Oct. 14, 2013).

[160] THE ORG. FOR ECON. CO-OPERATION AND DEV., CORPORATE GOVERNANCE: THE ROLE OF INSTITUTIONAL INVESTORS IN PROMOTING GOOD CORPORATE GOVERNANCE 39 (2011). Examples of collaborative efforts include: The CEO Water Mandate (improving corporate practices in regards to water usage); the Engagement on UN Global Compact Reporting (highlighting both good and bad practice in compliance with the Global Compact); Engagements with companies on Carbon Disclosure Project data; an Investor Statement calling for a global arms trade agreement; an Investor Statement in support of human rights principles; a Pilot Project on responsible business in conflict-affected and high risk areas; the Sudan Engagement Group (to consider investments in companies with operations in Sudan); and an initiative in regards to sustainable stock exchanges (looking to improve stock exchange ESG disclosure requirements).

[161] *Id.*

[162] PRINCIPLES FOR RESPONSIBLE INV. & UN ENV'T PROGRAMME FIN. INITIATIVE, UNIVERSAL OWNERSHIP: WHY ENVIRONMENTAL EXTERNALITIES MATTER TO INSTITUTIONAL INVESTORS 46 (2011), *available at* http://www.unepfi.org/fileadmin/documents/universal_ownership_full.pdf.

[162] THE INT'L INTEGRATED REPORTING COUNCIL, THE IIRC, *available at* http://www.theiirc.org/the-iirc/ (last visited Oct. 14, 2013).

create a level playing field out of mutual long-term interest. These self-instigated actions are admirable; but they are also telling. To the extent that businesses, with pressure (if not mandates) to produce investor profits in the short-term, are willing to forego short-term profits in order to take into account longer-term sustainability considerations, they put our political systems to shame. That seems a strong statement, but unlike business enterprises, governmental systems in the West are representative governments with a duty, ultimately, to protect the interests of citizens against exploitation by others (assuming an accepted degree of exploitation necessarily exists in a free market system). Businesses have no duty to anyone (except their shareholders) beyond a general duty that if they break the law they must pay a penalty for the injury.

The companies that have engaged themselves in these private schemes have done so willingly and ideally out of a sense of duty, or at the least out of economic intelligence in recognizing that thinking only of short-term profits is not a sustainable business model. But even this recognition must be said to involve a sense of duty – a duty to those who will come later, there is simply no other basis for the decision to forgo present returns for future returns when those future returns will very likely reward others long after current decision-makers have left their posts.

6. Integrated Reporting

One final noteworthy effort currently underway is in the area of corporate reporting. The International Integrated Reporting Council is "a global coalition of regulators, investors, companies, standard setters, the accounting profession and NGOs."[163] The IIRC's mission is to create "*the* globally accepted International <IR> Framework that elicits from organizations material information about their strategy, governance, performance and prospects in a clear, concise and comparable format. The Framework will underpin and accelerate the evolution of corporate reporting, reflecting developments in financial, governance, management commentary and sustainability reporting. . . . Our vision is . . . [to enable] informed decision-making that leads to efficient capital allocation and the creation and preservation of value . . . towards the advancement of a more sustainable global economy." [164] Integrated reporting is a process that results in a periodic integrated report that constitutes "a concise communication about how an organization's strategy, governance, performance and prospects lead to the *creation of value over the short, medium and long term*[through enhancing] accountability and stewardship with respect to *the broad base of capitals* (financial, manufactured, human,

[163] *Id.*
[164] *Id.*

intellectual, natural, and social and relationship) and *promote understanding of the interdependencies* between them."[165]

The IIRC has recognized that the traditional factors taken into account in financial reports are insufficient to give a complete picture of an organization's situation. Many factors that are not easily reported in traditional financial reports are taking on increasing importance, and a new structure of accounting, reporting, and comparison is required. IIRC is now working with the International Accounting Standards Board (IASB)[166] to develop these concepts into an integrated corporate reporting framework.[167]

B. OBSTACLES TO ACTION

As alluded to above, the overall reluctance to face the issue of climate change through the establishment of effective and sufficient frameworks brings about litigation risk – the risk of the application of the legal system as a means of redressing issues that have not been resolved by legislative action.

1. Attribution Uncertainty

The application of liability, even in well-established legal systems involving well-established areas of law, involves significant uncertainty. Where the law is immature (i.e. liability resulting from climate change) the risk for companies and insurers increases dramatically. Climate change is a "risk-multiplier" – it has the potential to increase pre-existing risks by a factor determined by the severity of the change and the vulnerability of affected institutions. Liability risk is also a risk-multiplier in that it has the potential to significantly agitate an already unstable economic/social situation. In the absence of legislative frameworks, people and institutions turn to the courts to redress the wrongs they suffer. The attribution structure of liability related to climate change is not only unsettled, it is largely undetermined at its base. Companies and insurers both have reason to fear that climate liability could produce a similar magnitude of losses that asbestos and tobacco litigation brought about in the 1970s-1990s.

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[165] THE INT'L INTEGRATED REPORTING COUNCIL, ABOUT <IR> (2013), http://www.theiirc.org/about. (emphasis added).

[166] The IASB is the standard setting body of the International Financial Reporting Standards (IFRS) Foundation. PARLIAMENTARY COMMISSION FOR BANKING STANDARDS, WRITTEN EVIDENCE SUBMITTED BY THE INTERNATIONAL ACCOUNTING STANDARDS BOARD, *available at* http://www.publications.parliament.uk/pa/jt201314/jtselect/jtpcbs/27/27ix_we_h10.htm (last visited Oct. 14, 2013).

[167] INT'L FINANCIAL REPORTING STANDARDS, press release, IASB AND IIRC FORMALISE COOPERATION ON WORK TO DEVELOP INTEGRATED CORPORATE REPORTING FRAMEWORK, (Feb. 7, 2013), http://www.ifrs.org/Alerts/PressRelease/Documents/2013/IASB-IIRC-MoU-February-2013.pdf.

Ideally, liability should be determined in a controlled and considered manner so as to avoid unnecessary upset to the insurance industry.[168] To allow climate change liability to pass to the insurance industry in the absence of *specific* policy coverage would be to indulge a massive moral hazard problem in unsustainable industry while causing valuable insurance resources to be depleted. Risk-takers should bear the costs of the risks they take and should, if they choose to do so, pass those costs on to their shareholders and customers. Economic efficiency of the sort required to tackle the massive complexities of the current and future economic environment will only be harnessed through a transparent and actualized true-cost model. The same principle holds for liability. Distortions in cost attribution through subsidies, whether those are apparent subsidies (e.g. tax breaks for certain industries or legislated incentives), or non-apparent subsidies (e.g. the externalization of the costs of environmental harm to the public commons), should *only be made as a corrective of pre-existing market failure,* and should only be made *very carefully* with *long-term development repercussions* foremost in mind. In light of this, to the extent that industries and their shareholders have profited by reaping the benefits of their business model while externalising the true costs, they should be required (whether through legislative or judicial action) to recompense those who have been harmed. Conceptually this is at the very least a matter of basic equity, but although it should hardly be controversial the application of the concept is highly complicated.

The attribution of liability for climate change faces significant legal hurdles but steps are being made. In the business sector, awareness of potential for climate change liability is increasing. Simultaneous to this is

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[168] "The courts may be waiting to see if federal and state legislatures take firm action to address climate change issues through new statutory laws…. If clear action is not taken soon, courts may be willing to open the door to private litigation claims that could cost corporate defendants many millions – if not billions – of dollars." Kevin Haroff, *Climate Change Litigation in the United States, in* LIABILITY FOR CLIMATE CHANGE? EXPERTS' VIEWS ON A POTENTIAL EMERGING RISK 6 (Munich Re 2010) *available at* www.munichre.com/publications/302-05493_en.pdf. By approaching the issue through legislative means, the possibility exists for the weight of liability for climate damages to fall where they should, on the companies that have produced the damages. If the issue is dealt with through the courts, insurers will at the least have to contribute significant funds to defense costs, and will potentially be subject to liability costs that they should not be required to bear unless the policies they wrote specifically covered those risks and the risks were factored into the premiums the insurance companies received for covering the risks. This would unnecessarily and inequitably undermine the ability of insurers to insure future risks – increasing the ability for insurers to underwrite future climate risks must be established as a top public policy concern considering the threats society will face in the coming years.

an increase in awareness of the various mechanisms by which companies may be held to account for their climate change related risk management programs and responses. As general awareness among company shareholders grows, so will the potential for fiduciary suits for breaches of duties of care in cases where the management of the company carelessly disregards known risks regarding climate issues resulting in loss.[169] Such losses may be actual losses in litigation, or losses due to a failure to mitigate company risk, or failure to adapt to a changing climate (business, regulatory, or environmental), or losses based on reputational damage arising as a result of company policy. The SEC has moved to take risk management further into account and on this basis publicly-listed companies may be subject to liability for failure to adequately account for risk in securities filings under U.S. securities laws.[170] In addition, institutional investors have moved to pressure companies into making their climate risk exposure and management more apparent.[171]

2. Problems of Attribution

The problems of attribution in the climate context start with the question of whether climate change is anthropogenic. Current scientific knowledge has put this question to rest and as time passes it will be increasingly difficult for defendants to successfully defend on this point. The next questions refer to issues of justiciability and standing.

Justiciability is defined by Black's Law Dictionary as, "The quality or state of being appropriate or suitable for adjudication by a court."[172] Due to the complexity of climate change related issues, the special scientific knowledge required for a considered determination of the issues, and the public policy concerns involved, courts have considered climate change to be more appropriately handled by legislative action.[173]

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[169] *See* Christina Ross, Evan Mills, & Sean B. Hecht, *Limiting Liability in the Greenhouse: Insurance Related Risk Management Strategies in the Context of Global Climate Change*, 26 A STAN. ENVTL. L. J. 251, 263–273 (2007).

[170] *See id.* at 266–270.

[171] *See* CARBON DISCLOSURE PROJECT, CDP INVESTOR INITIATIVES, *available at* https://www.cdproject.net/en-US/WhatWeDo/Pages/investors.aspx (last visited September 27, 2013).

[172] BLACK'S LAW DICTIONARY 882 (8th ed. 2004).

[173] *See* Ina Ebert, *Legal Aspects of U.S. Claims Based on Greenhouse Gas Emissions*, *in* LIABILITY FOR CLIMATE CHANGE? EXPERTS' VIEWS ON A POTENTIAL EMERGING RISK 14 (Munich Re 2010) *available at* www.munichre.com /publications/302-05493_en.pdf (referring, for example, to the cases People of State of Cal. v. General Motors Corp. No. C06–05755 MJJ, 2007 WL 2726871 (N.D. Cal. Sept.17, 2007), Native Vill. of Kivalina v. ExxonMobil Corp., 663 F. Supp. 2d 863 (N.D. Cal. 2009)).

Standing is defined by Black's Law Dictionary as, "A party's right to make a legal claim or seek judicial enforcement of a duty or right."[174] More particularly, the basic requirements that a plaintiff must demonstrate to satisfy the standing requirement are: (1) that an "injury-in-fact" has occurred that is "actual or imminent" *and* that is "concrete and particularized"; (2) that the alleged injury is fairly traceable to actions of the defendant; and (3) that a favourable decision will redress the alleged injury.[175]

Causation is perhaps the most major hurdle in climate change litigation, both in terms of standing and in the context of common law tort claims such as negligence or public nuisance. Due to the long-standing diffusion of GHGs emitted over many years from all over the world, it is very difficult in most cases to demonstrate a sufficiently direct link between the defendant's actions and the plaintiff's harm. To argue that such a requirement is almost certainly impossible to satisfy would be in keeping with the state of the law as it stands,[176] but not necessarily with the state of the law as it could stand in the context of an unprecedented situation of realized systemic harm.

Negligence is "the failure to exercise the standard of care that a reasonably prudent person would have exercised in a similar situation; [it refers to] any conduct that falls below the legal standard established to protect others against unreasonable risk of harm, except for conduct that is intentionally, wantonly, or wilfully disregardful of others rights."[177] The elements of a negligence claim are therefore: duty, breach, causation, and harm.

The negligence standard is that of a "reasonably prudent person". It is simply not reasonably disputable that if the evidence the IPCC had uncovered by the time of its Second Assessment Report in 1995 was presented to an unbiased and uncompromised "average person in the street" that that person would consider it highly unreasonable for heavy emitters of GHGs to continue to behave in a like manner in light of the risks presented. In other words, and to reinforce the point, a "reasonable person", when faced with scientific evidence demonstrating massive environmental upheaval that promises to disrupt the lives of hundreds of millions of people and cause the decimation of entire ecosystems relied upon for

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[174] BLACK'S LAW DICTIONARY 1142 (8th ed. 2004).

[175] Lujan v. Defenders of Wildlife, 504 U.S. 555, 560–61 (1992).

[176] *See* Ebert, *supra* note 173, at 15 ("Plaintiffs would have to prove that specific defendants caused specific damage. This is not yet possible and will not be possible in the foreseeable future . . . [A]ny approach that would overcome the causation issues connected with climate litigation would have to be so radical and far-reaching that it seem highly unlikely any court would ever be willing to go down that road.").

[177] BLACK'S LAW DICTIONARY 1061 (8th ed. 2004).

medical and other research that might at some point prove vital to human development, would not consider it "prudent" to continue without significant and immediate precautionary changes.

Considering the above in the context of the demonstrable damage that climate change is already beginning to cause, heavy emitters of GHGs have been arguably guilty of negligence since the creation of the United Nations Environment Program 1972. They have almost certainly been guilty of negligence since 1986 (the year of the Montreal Protocol, when we indisputably acknowledged our ability to cause massive damage to life-sustaining natural systems). But to take the notion further, and considering the supposed sophistication of people engaged as directors and officers of large-emitter enterprises, and that of elected representatives, it would in fact be entirely reasonable to suggest that as of 1996 (the year following the publication of the IPCC Second Assessment Report), those who failed to make the necessary changes to the systems of high-emitter industries (and instead fought for or allowed its subsidisation) are guilty of having committed repeated and on-going acts of gross negligence. There can be little doubt that at some point in the future it will come to light that these segments of industry colluded with each other and with government to wilfully misinform the public as to the dangers of their actions.[178]

Western law exists as a mechanism for the peaceful and coordinated redressing of wrongs done by one to another. The principle of precedent is integral to this notion of fairness, it upholds protection from arbitrary treatment. Barring subsequent legislative acts, in a precedential system, those subject to the law may rest in the knowledge that it will be applied to them in a way that is consistent with how it was applied to others in the past. In the context of climate change liability the shortcomings of precedential system are apparent. The courts wait for the legislature, but the legislature protects and strengthens that which should have been overhauled; and where the courts should thus act in the absence of legislative action, they are bound by precedent, which effectively bars them from applying basic principles of common law to rectify an on-going and

[178] Because of the difficulties inherent in establishing common law cases alleging negligence or public nuisance, it seems likely that claims will in future focus on "non-compliance with regulations or professional duties – for instance, on failure to warn or inform; on conspiracy to mislead the public, legislation or the courts, e.g. by 'greenwashing' business activities (false claims of climate-friendliness) or by promoting scientific reports denying global warming or its partly man-made origin against better knowledge; on the sale of products that are falsely or insufficiently labeled to indicate the greenhouse gas emissions they cause; on not sufficiently considering the consequences of global warming and rising sea levels in the construction business; or on non-compliance with other climate regulations the new U.S. administration is expected to introduce in coming months or years." Ebert, *supra* note 173, at 15.

egregious systematic breach by entire industries of the duty to protect others from an unreasonable risk of harm.

Professor Richard Stewart of the New York University Law School illustrates these issues quite clearly in his argument that these problems are "insurmountable" for plaintiffs bringing suits for storm damage or flooding linked to climate change: [179]

> First, it can be argued that such an event is attributable to weather fluctuations rather than long-term climate change[, and s]econd, [that] climate change is connected to [carbon dioxide] and other greenhouse gases . . . emitted by a huge range of human activities, including deforestation and agriculture, throughout the world. These emissions mix together on a global scale, making it impossible to fix individual responsibility. Moreover, climate change is driven by current atmospheric GHG concentrations, which are due to emissions over decades. Sorting out issues of causal responsibility and apportioning liability fairly among millions or billions of emitters pose nearly insuperable problems.[180]

Even though Professor Stewart is quite right to point out the incredible complexity of ascertaining liability in cases like these, and even though his representation is correct as a representation of the difficulties courts have encountered, the problem is certainly not insurmountable. Viable methods are already being developed to overcome these obstacles.

C. THE PROBLEM OF THE WORST EMITTERS

One of the major reasons why material developments have been impossible is due to "the fact that the principle contributors to climate change, the [US] and China, do not perceive themselves as likely to be its principle victims. As a result, the two leading contributors lack a strong incentive to help to solve the problem."[181]

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[179] Professor Stewart rightly distinguishes these types of cases from toxic waste liability cases, for example, in which the locality of harm is more immediate and the causers of the harm more readily ascertainable. *See* Richard Stewart Interview, *Climate Liability under the Obama Presidency, in* LIABILITY FOR CLIMATE CHANGE? EXPERTS' VIEWS ON A POTENTIAL EMERGING RISK 9 (Munich Re 2010) *available at* www.munichre.com/publications/302-05493_en.pdf.

[180] *Id,*

[181] Cass R. Sunstein, *The World vs. the United States and China? The Complex Climate Change Incentives of the Leading Greenhouse Gas Emitters,* 55 U.C.L.A. L. REV. 1675, 1676–77 (2008).

For example, the ultimate failure of the 1997 Kyoto Protocol was due to a lack of incentive, in the US and in China, to ratify it.

> On the numbers as they were generated at the time, the [US] would have to spend over $300 billion to comply with the requirements of the Kyoto Protocol, and the monetized benefits, for the [US], would be about 4 percent of that amount. . . . In 1997, a unanimous Senate . . . asked [President Clinton] not to agree to limits on greenhouse gas emissions if the agreement would injure the economic interests of the [US]. . . . [T]he Senate concluded that any 'exemption for Developing Country Parties is inconsistent with the need for global action on climate change and is environmentally flawed' and indicated that it 'strongly believe[d]' that the proposals under consideration 'could result in serious harm to the [US] economy, including significant job loss, trade disadvantages, increased energy and consumer costs, or any combination thereof.' Because the developing nations were not going to agree to emissions limitations, this request effectively ensured that the [US] would not ratify the resulting agreement.. . . [The Senate] perception [was] that the [US] had far more to lose than to gain . . . There were large efforts, by the [US] above all, to convince China and other developing nations to agree to emissions limitations in the Kyoto Protocol. These efforts were unsuccessful. China did indicate its willingness to ratify the agreement, but its own decision was essentially meaningless, because the protocol imposes no obligations on China at all. In refusing to agree to emissions limitations, China made an array of equitable arguments, emphasizing its relative poverty, its relatively low per capita emissions, and the fact that the existing stock of greenhouse gas emissions is a product of the industrialized nations, which benefitted from those emissions. But there is no question that China was greatly influenced by two perceptions: it would not greatly benefit from emissions reductions, and those reductions would cost a great deal. . . . China was affected by a purely domestic cost-benefit analysis, which argued strongly against acceptance of international requirements.[182]

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[182] *Id*. at 1680–82.

D. THE PROBLEM OF DEVELOPING VS. DEVELOPED ECONOMIES

As the above quote demonstrates, one of the major problems that the development of international agreements on climate and on sustainable development faces is the problem of getting developing countries on board.

China's position in the Kyoto ratification context highlights that the problem is largely one of equity, even if in a certain sense it is a misguided notion of equity. The argument made by developing economies to developed economies is essentially: "You got to burn coal and wreck the environment so that you could develop your economy, but now that you are developed and are reaping the rewards of your development, you want to stop us from doing the same – this has less to do with protecting the environment than it does with keeping us undeveloped." And indeed, we in the western developed nations might well ask – if no one stopped us from developing in the way we did, how is it our right to now tell others that they can't do what we did, shouldn't developing countries be able to assert the right to do as we did?

The question is absurd – there is no right whatsoever for developing countries to pass through the same process developed countries passed through in order to arrive in their current state.[183] The northern hemisphere's industrialized powers began their industrial development in the 1750s. They learned by trial and error in a natural environment that still maintained, at the macro-level at least, a massive ability to absorb the pollution produced. We are not in the 18th century anymore and the natural life-sustaining systems we rely on are simply not in a position to handle the dirty industrialization of the so far unindustrialized human world.

It is not the fault of the developing world that the developed world has done material damage to the planet's ecosystems. The developing world must now suffer due to the faults of the developed world because it has to, there is no choice – it is not fair and no one can reasonably state otherwise – the developed world has seriously mismanaged its development, and now people (and millions of other life-systems – known and unknown) the world over are suffering the consequences. The answer to the issue is not for developing countries to demand to be able to commit the same errors that developed countries committed – errors of judgment

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[183] The idea is equivalent to another country pointing out that in the process of the development of the U.S. cotton industry, U.S. growers were able to use slaves, and therefore others should be allowed to do so now. Another example can be found in the nuclear weapon fuelled rivalry between India and Pakistan. Of course it is the case that the US and Russia went through a very similar process of development of arms and mutual threats – but this does not mean that others should seek to put themselves in the same position; rather, it means that others should learn from the US/USSR Cold War experience and realize that that is not a desirable path to walk down.

and action should be learned from and avoided, not knowingly repeated out of some misguided notion of equity.

So what is to be done? The first step is to comprehend that it is imperative that developing countries be given the opportunity to develop their economies, not by way of 18th century understanding, but by way of 21st century understanding. In other words, as an international community we must be imaginative and generous, we must think globally and with a long-term perspective.

E. SOLUTIONS

1. World Environment Organization

First of all it must be stated that this paper cannot reasonably argue that there is any great possibility that anything resembling the following summary blueprint will be implemented in the near future. However, this paper does argue that something consistent with this blueprint must be implemented if the material mitigation of climate change, and the creation of an internationally coherent system of sustainable development is to be accomplished.

The general guise of the following blueprint is not new.[184] What is new is the manner in which various aspects of the overall UN structure have been pieced together into a structure with increased potential for the production of a sustainable worldwide economic system that prudently acts immediately to mitigate the worst of any potential disruption, while retaining the capability to withstand the inevitable changes we will face in the coming century as a result of prior irreversible activity. The structure of the international system of UN and other international agencies, programmes, and organizations related to trade, environment, human health, and financial support and oversight must be restructured and consolidated to better and more efficiently reflect the three pillars of the Brundtland Report (economic, environmental, and social), so as to achieve

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[184] *See* Daniel C. Esty & Maria H. Ivanova, *Making International Environmental Efforts Work: The Case for a Global Environmental Organization,* YALE CTR. FOR ENVTL. LAW AND POLICY 5–10 (2001), *available at* www.environmentalgovernance.org/cms/wpcontent/uploads/docs/riopaper1_esty_ivanova.doc (discussing the rationale for a Global Environmental Organization, the necessary functions and features and design of such an organization, its benefits, and strategies for implementation); Frank Biermann, *Reforming Global Environmental Governance: The Case for a United Nations Environment Organisation (UNEO),* STAKEHOLDER FORUM 5 (Feb. 2011), *available at* http://www.stakeholderforum.org/fileadmin/files/WEO%20Biermann%20FINAL.pdf (discussing the history of debate surrounding the creation of a World Environment Organization, three models of a WEO, and the case for a UN Environment Organization).

the maximal structural efficiency, and the maximum possible information exchange, in the pursuit of global sustainable development where global issues are concerned. The resulting structure would look something like this:

- UN General Assembly
  - World Security Council (WSC)
  - World Court of Justice (WCJ)
    - World Court for Human Health (WCHH)
    - World Court for the Environment (WCE)
    - World Court for Trade Disputes (WCTD)
  - World Development Council (WDC)
    - World Development Organization (WDO)
      - World Health Organization (WHO)
      - World Environment Organization (WEO)
      - World Trade Organization (WTO)
    - World Development Finance Organization (WDFO)
      - World Development Bank (WDB)
      - World Insurance Mechanism (WIM)
        - World Catastrophic Risk Organization (WCRO)
        - World Microinsurance Organization (WMO)
  - World Financial Stability Council (WFSC)
    - World Bank for International Settlements (WBIS)
    - World Financial Stability Board (WFSB)

Three aspects of the above chart should be highlighted. First, the United Nations Environment Program (UNEP) and the World Meteorological Organization (WMO) should be merged into a World Environment Organization (WEO) with a mandate to consolidate the bureaucratic burdens and reporting requirements of all international conventions related to the protection of the natural environment, to the mitigation of climate change, and where change is inevitable, to adaptation.

Second, within the purview of a World Development Finance Organization (WDFO) there should be a World Development Bank (WDB) and a World Insurance Mechanism (WIM), which would itself consist of a World Catastrophic Risk Organization (WCRO) and a World Microinsurance Organization (WMO). The WIM would be specifically designed to licence and supervise global (re)insurers so that they can more efficiently spread catastrophic risks and develop insurance markets (in developing countries) on a global and regional basis without the inefficiencies of being subject to local regulatory and legislative risk.[185]

[185] The regulation in this context would be minimal and focused towards setting and managing entry and exit requirements, and regulation and supervision

The objective would be to streamline the ability for internationally active insurance groups to provide and develop insurance on a global basis.[186] Rather than institute mechanisms to force private insurers to provide coverage, the structure would be designed to incentivise insurers to take part so that mandatory provision of insurance would be unnecessary. Regulatory and legislative risk would be kept to a minimum through the close connection between the WDFO and the World Development Organization (WDO) (discussed further below) under the auspices of the World Development Council (WDC).

Third, the World Financial Stability Council (WCFS) would bring into its fold two pre-existing organizations: the Bank for International Settlements, and the Financial Stability Board. The Financial Stability Board was established "to coordinate at the international level the work of national financial authorities and international standard setting bodies and to develop and promote the implementation of effective regulatory, supervisory and other financial sector policies. It brings together national authorities responsible for financial stability in significant international financial centers, international financial institutions, sector-specific international groupings of regulators and supervisors, and committees of central bank experts."[187] For purposes of the WFSB, representation would

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of company solvency. Form regulation requirements would be unnecessary where the policyholder is sophisticated; and where the policyholder is unsophisticated, the WCRO would act as an intermediary allowing form supervision where necessary. Rate regulation would also be kept to a minimum – the sole requirement being that the rates charged be demonstrated as actuarially accurate to the risk covered. The scheme would be designed to create a situation in which a more robust layer of private insurance (arranged on a bi-level regional/global basis with funds held in reserve by the WDB) would decrease the need for government backstops, in which subsidization by taxpayers or policyholders with unlike risks would cease to exist except in far more extreme situations than the market has yet suffered. By setting rates at actuarially sound levels, and by avoiding unnecessary compliance costs, the industry would be able to fully manifest its potential for establishing market incentives to minimize risk of loss, while expanding the base of worldwide insureds, thus decreasing the overall cost of insurance coverage. An important question, when considering the prospect of non-subsidized insurance premiums, is what happens to those who live in high-risk areas who cannot afford accurate insurance rates. Consider for example the people who work for low wages in coastal resorts in Florida, or the small support businesses in such communities.

[186] *See The Implications of Financial Reform for the Insurance Industry,* INST. OF INT'L FIN. 5 (2011) ("In many cases, catastrophic risk cannot be efficiently insured at the national level, but instead requires very large risk pools that spread beyond national borders. Large (re)insurance groups thus play a role in global risk pooling."), *available at* http://www.oliverwyman.com/implications-of-financial-regulatory-reform-for-the-insurance-industry.htm#.UfFpLRa_AfE.

[187] *Overview,* FINANCIAL STABILITY BOARD, http://www.financialstabilityboard.org/about/overview.htm (last visited September 29, 2013).

be focused in entities such as the Financial Stability Oversight Council (FSOC) in the US, the European Systemic Risk Board (ESRB) in the EU, and equivalent organizations (which would be required for representation in the WFSB) from other regions. In each case, national or regional financial stability organizations would have to be made up of senior regulators from the three branches of the financial services: investment banking, commercial banking, and insurance; as well as senior national finance ministers. The jurisdictional oversight of the national/regional financial stability organizations would be required to employ a system of supervisory colleges to oversee cross-border/cross-sector financial services organizations on an *enterprise-wide* basis.

2. Assessment of Liability to Subsidize Innovation

As a matter of sustainable development, the World Development Organization, through its three branches, the WHO, WEO, and WTO, must have the power to establish, coordinate, and enforce measures designed to ensure a balance of interests that will specifically contribute to sustainable development on a global scale. Where current WTO agreements are contrary to, or not supportive of, measures required for the protection of the environment by the WEO, those agreements must be invalidated (or altered where possible) to take account of the conflicting requirements of environmental protection, consistent with the precautionary principle of international environmental law.[188]

In consideration of the limited capabilities of developing states to apply the precautionary principle, the World Development Bank would have to establish a fund (through assessments discussed below), which

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[188] *See* United Nations Conference on Environment and Development, Rio de Janiero, Braz., Jun. 3–14, 1992, *Rio Declaration on Environment and* Development, Principle 15, U.N. Doc. A/CONF.151/26 (Vol. I), Annex I (Aug. 12, 1992) ("In order to protect the environment, the precautionary approach shall be widely applied by States according to their capabilities. Where there are threats of serious or irreversible damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradation."). *See also* Harold Hongju Koh, *Why Transnational Law Matters*, 24 PENN ST. INT'L L. REV. 745 (2006) (As this is a matter of the application of transnational law to sovereign states, it is necessary to consider why such law should be applied, and how it can be applied to sovereign states). *But see* Jon Kyl et al., *The War of Law: How New International Law Undermines Democratic Sovereignty*, 92 FOREIGN AFF., 115 (2013) (articulating the arguments against application of transnational law in which these authors do not find the overall argument against application of transnational law convincing in light of concerns of superseding importance, but it is necessary to comprehend the sovereign constitutional/democratic issues inherent in its development where it has domestic legal repercussions).

would be employed to help finance the ability of developing states to adhere to the precautionary principle. In such cases, the investment would be made in full communication and cooperation with the WEO. The WEO would then actively advise upon and oversee the actual implementation of the investment by the developing country. The investment would have to be used to establish innovative systems of development rigorously focused towards the long-term establishment of domestically-sustainable industry. Such model systems would be designed and developed within the WEO (but would be supplemented by an established in-built competitive system in which new and innovative, cost-saving proposals from outside designers would be considered and rewarded); on this basis, the most advanced new technologies could be immediately implemented in developing countries where necessary. This methodology would immediately spur a massive increase in investment and job creation in next-generation energy and development technology.

A large portion of the funding for this system would come from the assessment of funds from high-emitter industries in return for relief from the prospect of uncontrolled liability – this controlled and regulated system would be the proverbial carrot. The proverbial stick would be the actual threat of significant attribution of liability for past action on the basis of public-nuisance, gross negligence, and (probably) conspiracy. The attribution would be unmitigated by insurance coverage unless such coverage was *specifically* contracted. This correction of past externalised harm would not only finance the building of sustainable economies and mitigation measures in both developed and developing countries, it would also fund adaptation measures where mitigation measures are too late (and where affected *vital* infrastructure cannot be moved – such adaptation would consist of the building of sea walls, the replenishment of mangrove barriers, and the rejuvenation of coral reefs, to protect major cities and population centers from flooding, as well as the strengthening of structures vulnerable to earthquakes[189] and wind zones), and adaptation measures where infrastructure can be moved (this would require the active and enforced prevention of further building in high-risk zones, and the establishment of population centers in lower risk zones linked, as necessary, to higher risk zones by appropriate weather-proof public transport systems[190]).

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[189] Note that earthquakes are not caused by anthropogenic climate change (though they may be caused by new methods of gas extraction). The reason to include adaptation to earthquake risks in this context is to ensure that insurance and public funds are saved to the greatest extent possible in circumstances where they are most needed, and where mitigation measures are insufficient.

[190] This pertains to a question previously raised. *See supra* note 185. Highly developed communities in high-risk areas must be moved out of the major risk zone to the extent the global spreading of like risk does not bring actuarially

3. Fractional Allocation

It has been vehemently argued that it is not possible to adequately gauge the contribution to the climate change by any given entity.[191] This is not necessarily the case.[192] In a report by Trucost,[193] jointly published by the UNEP Finance Initiative and the UN-backed Principles for Responsible Investment, it becomes quickly apparent that the calculation of such harms is not impossible.[194] Trucost establishes in the report that:

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accurate rates down to affordable levels. To the extent coastal businesses require on- or near-site employee living, they must pay for it – that is part of their business expense. Shifting the cost of poor community-planning to insurance companies through forcing coverage, under government-proscribed rate subsidization, in order to maintain the current structure is not economically viable when long-term costs are taken into account, nor is it equitable.

[191] "Many academic pundits have focused on the challenges facing the plaintiffs' ability to demonstrate a causal link between a specific entity's GHG emissions and a specific alleged damage. It is important to note, however, that both the activist and academic stakeholder communities have turned their focus and efforts to this matter. They seek to overcome the barriers to tort liability, creating a legal theory that would allow plaintiffs to attribute damages to a specific emission or sets of emissions by individual companies or industries." Lindene E. Patton, *Why Insurers Should Focus on Climate Risk Issues, in* LIABILITY ISSUES RELATED TO CLIMATE RISK 1, 9 (Geneva Association 2011).

[192] *See id.* at 8–9 (describing recent trends in damages calculations and the use of fractional allocation as a means of establishing liability: "Development of law providing a broader base for retroactive liability for past resource damages, combined with a general erosion of legal theorem which would hold parties to be responsible for understanding obvious risks, and a multitude of types of claims filed, suggests a broad social change in expectation of what is required as a 'social license to do business' as respects natural resources – including impacts related to GHG emissions and climate change.").

[193] "Trucost has been helping companies, investors, governments, academics and thought leaders to understand the economic consequences of natural capital dependency for over 12 years. Our industry leading data and insight enables our clients to identify natural capital dependency across companies, products, supply chains and investments; manage risk from volatile commodity prices and increasing environmental costs; and ultimately build more sustainable business models, products and brands. Key to our approach is that we not only quantify natural capital dependency, we also put a price on it, helping our clients understand environmental risk in business terms." *What We Do*, TRUCOST, http://www.trucost.com/what-we-do (last visited Sept. 29, 2013).

[194] *See* Patton, *supra* note 191, at 9 ("[Trucost] appear[s] to be patterning their arguments to overcome the 'causation' barrier by modeling the successful market share theory applied in many product liability cases and combining that with an implied assertion of the *'de minimis'* theory applied in hazardous waste cases to create a path for activist judges to find liability … attributable past, current and/or

> Medium– to large-sized publicly listed companies cause over one-third (35%) of global externalities annually.[195] The largest 3,000 public companies caused over US$ 2.15 trillion of global environmental costs in 2008, which equates to nearly 7% of their combined revenues. Other actors in the global economy, such as small and private companies, governments, other organisations and individuals contribute the remaining US$ 4.45 trillion of external costs. Five sectors account for around 60% of all externalities from the largest 3,000 listed companies. Reducing emissions in the Electricity, Oil & Gas Producers, Industrial Metals and Mining and Construction & Materials sectors would have the greatest effect on reducing carbon costs. … GHGs emitted by the listed companies and their suppliers account for over 30% (US$ 1.4 trillion) of total economy-wide carbon costs. Almost two-thirds of total costs from the 3000 companies are due to GHG emissions…. The materiality of externalities varies at a company and sector level. Assuming all environmental costs were internalised for each company, they would

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present GHG emissions."). *See also* PRINCIPLES FOR RESPONSIBLE INV. & UNITED NATIONS ENV'T PROGRAM FIN. INITIATIVE, UNIVERSAL OWNERSHIP: WHY ENVIRONMENTAL EXTERNALITIES MATTER TO INSTITUTIONAL INVESTORS 11–16 (2011), *available at* http://www.unepfi.org/fileadmin/documents/universal_ownership_full.pdf (for Trucost's methodology in evaluating the costs of greenhouse gas emission – Trucost notes the difficulties involved in evaluating these costs, but ultimately points out that "[t]he actual value of externalities is likely to be higher than in this study.").

[195]

> Business use of environmental goods and services generates environmental damage that carries significant costs. These are largely external to financial accounts. Without adequate information about environmental externalities, markets have failed to account accurately for the dependence of businesses on ecosystem services such as a stable climate and access to freshwater. . . . Environmental degradation that damages natural and human capital harms economic productivity. One way to measure business damage to the environment is to price natural resource use, waste and pollution. Damage costs from production are usually not paid in full by the companies generating them and are therefore known as "external costs" or "externalities".

PRINCIPLES FOR RESPONSIBLE INV. & UN ENV'T PROGRAM FIN. INITIATIVE, *supra* note 162, at 4, 6.

> equate to between 0.34% and over 100% of revenue. … Some 623 companies valued at US$ 7.8 trillion in the Electricity, Oil & Gas Producers, Industrial Metals and Mining, Food Producers, and Construction & Materials sectors are responsible for the majority of corporate externalities…. The five sectors account for over US$ 1.25 trillion in externalities, or 58% of external costs caused by the 3,000 companies, and 26% of the combined market capitalisation of all 3,000 companies.[196]

Serious and technically complex efforts are being made that have the potential to overcome the causation problem in attributing liability to companies for their contribution to damages resulting from climate change. Trucost went on to construct a hypothetical typical investment fund, valued at US$ 20 billion. On the basis of its models, Trucost found that "for every US$ 10 billion invested in equities in the [MSCI All Country World Index (ACWI) in 2008], an investor would be proportionally responsible for US$ 560 million of the externalities caused by the listed companies annually."[197] Hence, investment firms would also bear a very real incentive to support the restructuring effort.

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[196] *Id.* at 4, 25–27. The report goes on to describe Trucost's approach to calculating the environmental impacts of companies in the study:

> To calculate the environmental impacts of companies included in the study, disclosures were reviewed from sources including company annual reports, sustainability or corporate social responsibility reports, and websites. Calculations incorporate disclosed quantitative data on companies' actual pollutant releases and resource use. . . . Where companies do not disclose adequate data, Trucost used its environmental profiling input-output model to calculate the type and level of environmental resource use and non-product output. These calculations are based on the economic activity of any given company operating in 464 industries, using data on industry emissions derived from national and industry-compiled emissions registries. Detailed government census and survey data on resource use and pollutant releases, industry data and national economic accounts inform calculations. Trucost engages with companies, which are given the opportunity to verify their data and provide more information. Trucost's comprehensive coverage ensures that all companies within the universe are included, not just those that disclose environmental information.

Id. at 16.

[197] *Id.* at 28.

VI. CONCLUSION

The inherent deficit of insurance and government adaptation and mitigation mechanisms in much of the world, factored into already unstable developed-world systems, intensifies the need to make sure that our developed world systems are as robust as possible in the coming decades.

Many, but not all, of our developed-world systems are long-established, and this is both an asset and a liability. It is an asset in the sense that we have experienced individuals within organizations specifically focused on establishing and maintaining supervisory networks. These supervisory networks have existing relationships with the industries they oversee, and those industries are familiar with being regulated and themselves have, accordingly, established governance systems. Funding mechanisms are in place that are geared towards analysing risk of loss, and replenishing the finances of enterprises in the event of actual loss. We also have established building and support industries that carry out post-loss redevelopment. These are systems that the developing world does not have to the same extent.

But the liability of established systems is their entrenched state. Unless a system is designed to effectively manage evolution it will be unable to keep up with the dynamism of free markets, and regulatory systems will spend their time trying to catch-up. The result of entrenchment is the incentive to maintain the status quo – innovation is harder work than maintenance, it is uncertain and it requires expensive investment of funds that could otherwise be used to enrich executives and shareholders. This is a heavy temptation that generally is not overcome except when necessity dictates action. The necessity that dictates action comes from the consuming public in the marketplace, or from the voting public pressuring government to make legislative choices that force change. For that reason, enterprises that have the means will always seek to influence the mind-set of the consuming and voting public in what ways they can, and will in addition establish relationships with government not only to prevent the enactment of laws that they see as threatening to their short-term financial interests.[198]

The development of international environment law remains in a state of adolescence, confused by the awkwardness of its growth, lacking any grace in the coordination of its many limbs. Much has to be done in this area to provide a reliable structure according to which global industry

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[198] *See The Century of Self* (BBC TV 2002) (an award-winning documentary film by filmmaker Adam Curtis focused on how Edward Bernays, a pioneer in the field of public relations and propaganda, employed the psychological understanding of his uncle, Sigmund Freud, to influence the way corporations and governments analyse markets and populations; and, further, on how that knowledge has been used to influence consumers and voting populations).

can feel confident investing in next-generation infrastructure. Until the environmental regulatory context has matured, insurers will be impeded in effectively analysing risks related to climate change.

Considering the enormity of the losses that will accrue on the basis of climate change forces already set in motion, the insurance regulatory world needs to work together to harmonize law, to continue the push to match supervision to the cross-border enterprises in question so as to prevent the development of systemic risks, and to increase the efficiency of the global spreading of risk. Without environmental-policy change, the risks we face will be unaffordable. The insurance industry, and its regulators, should be pushing hard for as much certainty as can possibly be found – only by standing on relatively firm ground will the industry be able to digest the challenges that will come.

Considering the extent of the deep pockets involved, the increasing social awareness of climate issues, the increasing value of money for the majority of people in light of the general and continuing economic slump, and the evolution of ingenious methodologies for overcoming legal hurdles, it is actually not unlikely at all that in the coming future we will see a shift towards accountability for those companies that have contributed the most to climate change. To add grist to the mill, consider that "OECD countries in particular are implementing measures to internalise environmental costs. Pollution costs are rising through: Regulations are being strengthened by governments worldwide to protect human health and the environment[; i]ncreasing levels of fines and penalties for breaching environmental legislation[; l]awsuits[; s]tricter environmental impact assessment requirements to obtain planning permission for developments and [for securing] a license to operate[; r]ising corporate taxation[; and market based instruments that enable cost-effective abatement…."[199]

While optimistic in the sense that it highlights incremental changes where far larger shifts are needed, the above quote is right to highlight these changes – they suggest the way of things to come. The upshot of these developments is that the ability to fund a massive overhaul of our economic and social systems is far more possible than it would at first seem.[200] This cannot happen fast enough, but it will take intelligent and concerted efforts from all stakeholders, from government officials, and from industry, to make sure that it happens through a sufficiently considered structure as may lay an efficient foundation for a future economy.

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[199] PRINCIPLES FOR RESPONSIBLE INV. & UN ENV'T PROGRAM FIN. INITIATIVE, *supra* note 162, at 34.

[200] "The removal of environmentally damaging subsidies, such as over US $300 billion in fossil fuel subsidies in G20 countries, and the surge in environment-related subsidies, tax breaks and other financial incentives, will change competitive dynamics" *Id.*

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