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TOWARDS A UNIVERSAL FRAMEWORK FOR INSURANCE ANTI-DISCRIMINATION LAWS

RONEN AVRAHAM, KYLE D. LOGUE &
DANIEL SCHWARCZ[†]

Discrimination in insurance is principally regulated at the state level. Surprisingly, there is a great deal of variation across coverage lines and policyholder characteristics in how and the extent to which risk classification by insurers is limited. Some statutes expressly permit insurers to consider certain characteristics, while other characteristics are forbidden or limited in various ways. What explains this variation across coverage lines and policyholder characteristics? Drawing on a unique, hand-collected data-set consisting of the laws regulating insurer risk classification in fifty-one U.S. jurisdictions, this Article argues that much of the variation in state-level regulation of risk classification can in fact be explained by focusing exclusively on three factors: (i) the predictive capacity of the characteristic in question; (ii) the extent of the adverse selection problem created if the characteristic is restricted; and (iii) the extent to which discrimination on the basis of the characteristic is considered illicit. The Article concludes by suggesting that this implicit conceptual framework, which is embedded in the pattern of general and specific insurance anti-discrimination laws that have been enacted by states across the country, sheds new light on the nearly-universal state prohibition against “unfair discrimination” by insurers.

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I. INTRODUCTION

During the last fifty years state and federal laws have prohibited numerous types of discrimination. In the case of insurance, however, discrimination on the basis of traits such as race, national origin, gender, and sexual orientation is not always prohibited.¹ Sometimes such discrimination is even expressly permitted by state law, which, at least outside of the health insurance domain, is the predominant source of law on insurance discrimination.² With fifty states (plus the District of Columbia) all regulating insurance companies, insurance anti-discrimination law varies widely. In a previous article, we empirically demonstrated the specific contours of this variation, which exists not simply across states, but also across lines of insurance and policyholder characteristics.³ In this Article, we attempt to explain why this cross-line and cross-characteristic variation occurs.

This inquiry is motivated by the seemingly puzzling contours of state insurance anti-discrimination laws. For instance, why is state regulation of discrimination in the automobile and property lines of insurance more robust than in the cases of health, life, or disability insurance? Why are insurance companies allowed to use gender in health insurance underwriting and rating, but not in automobile insurance? Why do states (and the federal government) prohibit insurers' use of genetic information in health insurance, but hardly regulate the use of such information for other lines of insurance?

At a high level of abstraction, the answer to these and other puzzles is simply that laws regulating insurance discrimination represent different tradeoffs between the "efficiency" costs of regulation and the "fairness" benefits.⁴ We have little quarrel with this framing of the issue. But it is too

¹ See Ronen Avraham, Kyle Logue & Daniel Schwarcz, *Understanding Insurance Anti-Discrimination Laws*, 87 S. CAL. L. REV. 195 (2014).

² Jonathan R. Macey & Geoffrey P. Miller, *The McCarran-Ferguson Act of 1945: Reconceiving the Federal Role in Insurance Regulation*, 68 N.Y.U. L. REV. 13, 20–26 (1993).

³ See Avraham, Logue & Schwarcz, *supra* note 1.

⁴ See, e.g., Kenneth S. Abraham, *Efficiency and Fairness in Insurance Risk Classification*, 71 VA. L. REV. 403 (1985) (discussing the conflict between "efficiency-promoting features of insurance classification" and risk-distributional fairness and examining the different methods of resolving this conflict); Michael Hoy & Michael Ruse, *Regulating Genetic Information in Insurance Markets*, 8 RISK MGMT. & INS. REV. 211, 211–12 (2005) ("Economists can contribute to th[e]

generic to helpfully explain or predict state law, as numerous types of efficiency and fairness arguments can be offered in any particular case. As we showed in our earlier article, these factors pull in different directions and make it hard to predict when and how a state will regulate particular forms of discrimination in a given line of insurance.⁵

In this Article we narrow our discussion and focus on two efficiency considerations and one fairness consideration to understand state insurance anti-discrimination laws. The first efficiency consideration involves the capacity of a potential trait to predict policyholder losses. Irrespective of applicable law, insurers are not likely to discriminate among policyholders unless doing so helps them to better predict potentially insured losses. The second efficiency consideration is adverse selection: prohibiting risk classification forces insurers to charge the same premiums to individuals who pose different predicted risks.⁶ This can produce adverse selection, as policyholders who know they cannot be charged more for insurance, even if they possess a risky trait, may be more likely to buy coverage because they will not pay its full price.⁷ Finally, the fairness benefit on which we focus is that insurance anti-discrimination laws can prohibit carriers from relying on characteristics that are socially suspect, thus preventing insurers from exacerbating or trading on inequalities that exist outside of the insurance system (loosely characterized here as preventing insurers from illicitly discriminating).

We argue that these three factors, standing alone, can predict much of the cross-line and cross-characteristic variation in state insurance anti-discrimination law. This is very surprising. One would expect that much of the variation in state anti-discrimination laws depends on state specific circumstances like the preferences of the constituents regarding questions of discrimination, the ideology of the legislature, the strength of the insurance lobby, and a host of other socio-economic factors that are unique

debate [about regulating genetic information in insurance markets] . . . by casting the problem as a classic efficiency-equity trade-off . . .”).

⁵ See Avraham, Logue, & Schwarcz, *supra* note 1.

⁶ See Ronen Avraham, *The Economics of Insurance Law-A Primer*, 19 CONN. INS. L.J. 29, 44 (2012).

⁷ See Michael Hoy, *Risk Classification and Social Welfare*, 31 GENEVA PAPERS ON RISK & INS. 245, 245 (2006). To be sure, insurers will classify risks even without the threat of adverse selection, because competition from other carriers will otherwise skim away the good risks. This does not represent a social cost, however, unless it causes at least some policyholders to purchase less insurance than they would like to purchase at actuarially fair rates.

to each state. As we show below, one can abstract from all these factors and still have a pretty good understanding of what explains insurance anti-discrimination laws in the U.S. In particular, we advance the following simple three-prong model to understand how state legislatures strike a balance between the efficiency and fairness considerations involved in insurance discrimination:

- a) *The predictive property*—State legislatures will be more likely to consider regulating (either by prohibiting or permitting) risk classification based on a characteristic (like age) if that characteristic has predictive value for policyholder risk.⁸
- b) *The adverse selection property*—State legislatures will tend to allow risk classification to the extent that limiting such discrimination might plausibly trigger substantial adverse selection.
- c) *The illicit discrimination property*—State legislatures will be more inclined to prohibit risk classification based on a characteristic (like age) to the extent that doing so would help combat (or appear to combat) illicit discrimination.

These properties must be balanced against each other to determine the outcome of state laws.

Although this Article is principally empirical and descriptive, it has important normative implications as well. In particular, the Article helps define the nearly-universal state prohibition against “unfair discrimination” by insurers.⁹ Existing applications of this concept are haphazard and inconsistent. Some courts and commentators assume unfair discrimination only occurs when insurers discriminate in ways that cannot be justified by

⁸ State legislatures therefore tend to not regulate risk classifications when insurers have no economic incentives to discriminate because the characteristics convey no relevant information for that line of insurance. An example is sexual orientation in automobile insurance.

⁹ See generally Eric Mills Holmes, *Solving the Insurance/Genetic Fair/Unfair Discrimination Dilemma in Light of the Human Genome Project*, 85 KY. L.J. 503, 563 (1996). According to our data, thirteen states have general statutes forbidding “unfair discrimination” or “unfairly discriminatory” rates by insurers in all lines of insurance. Those states are: Arizona, Indiana, Louisiana, Maryland, North Carolina, Oregon, Pennsylvania, South Carolina, Texas, Utah, Vermont, Washington, and Wisconsin. And every state except Iowa, Utah, Vermont, Washington, and Wisconsin has a statute prohibiting “unfair discrimination” by insurers or “unfairly discriminatory” rates or both in connection with life insurance in particular.

actuarial data.¹⁰ But others insist that this understanding is too narrow, and could be used to justify pricing and underwriting practices that are *prima facie* unfair, such as charging more for life insurance to African-Americans.¹¹

By exposing an implicit conceptual framework that explains insurance anti-discrimination laws across varying jurisdictions, this Article provides new support for the latter, more robust, understanding of the prohibition against unfair discrimination. Because “unfair discrimination” is a statutory term that implicitly invokes broadly shared social understandings, its meaning should be substantially informed by consistent and widely endorsed applications of this concept in insurance law and regulation. Our model reveals that such a framework is embedded in the pattern of general and specific insurance anti-discrimination laws that have been enacted by states across the country.¹²

Building on this framework, a state insurance regulator might, for instance, determine that discrimination on the basis of sexual orientation in health insurance should be prohibited as “unfair discrimination.”¹³ As we suggest below, such a prohibition would likely not generate meaningful adverse selection, because the expected cost differentials between individuals with different sexual orientations are relatively small.¹⁴ And,

¹⁰ See, e.g., *State Dept. of Ins. v. Ins. Serv. Office*, 434 So.2d 908, 912–13 (Fla. Dist. Ct. App. 1983); Robert H. Jerry, II, *The Antitrust Implications of Collaborative Standard Setting By Insurers Regarding The Use of Genetic Information In Life Insurance Underwriting*, 9 CONN. INS. L.J. 397, 429–30 (2003).

¹¹ See, e.g., *Hartford Accident & Indem. Co. v. Ins. Comm’r*, 482 A.2d 542 (Pa. 1984); Leah Wortham, *Insurance Classification: Too Important to be Left to the Actuaries*, 19 U. MICH. J.L. REFORM 349, 385 (1986).

¹² To be sure, we do not argue that courts and regulators should use our model only because it reflects legislatures’ understanding of what unfair discrimination is. We believe that the norms embedded in the model have force in and of themselves, which justify using them when interpreting “unfair discrimination.” At the same time, we believe that the fact that these norms also reflect the preferences of states’ legislatures supports our normative claims.

¹³ Indeed, one state, Colorado, has already done exactly this. See Dep’t of Regulatory Agencies: Div. of Ins., Bulletin No. B-4.49, *Insurance Unfair Practices Act Prohibitions on Discrimination Based Upon Sexual Orientation*, available at <http://www.one-colorado.org/wp-content/uploads/2013/03/B-4.49.pdf> (hereinafter Colo. Div. of Ins. Bulletin).

¹⁴ See *infra* Part V.

depending on the individual state, such discrimination might well violate newly emerging norms of illicit discrimination.¹⁵

Because this Article focuses on cross-line and cross-policyholder variations, it omits another important set of explanatory variables: differences among states. Part of what explains the overall variation in the data almost certainly includes differences in the populations, economies, and political and regulatory cultures in the various states and how those factors have changed over time. For example, differences in the levels of strictness with regard to insurance anti-discrimination laws could be caused by, or at least correlated with, differences across states in the views of citizens regarding anti-discrimination laws generally. Another cross-state explanatory variable might be the strength of the insurance industry in each state, since insurers' interests in controlling adverse selection may be better represented in states where insurance companies are especially politically powerful. Or perhaps the Red State/Blue State divide might provide some explanatory power. Such questions will require detailed information regarding the history of each state's insurance anti-discrimination laws. In this Article, we focus only on cross-line and cross-characteristic variations.

The Article proceeds as follows. Part II provides an overview of the adverse selection, illicit discrimination, and predictive properties, considering how each factor might be concretely applied to particular combinations of coverage lines and policyholder characteristics. Part III describes briefly the empirical approach that provides the backbone and evidence for this Article. Part IV then reviews various cross-line and cross-characteristic variations in state insurance laws that are difficult to explain. It then applies the model detailed above and in Part II to explain much of this variation. Finally, Part V concludes by exploring the potential normative implications of our empirical findings.

II. A GENERAL MODEL FOR INSURANCE ANTI-DISCRIMINATION LAWS

A. INSURERS' USAGE OF POLICYHOLDERS' CHARACTERISTICS

Laws forbidding the use of a characteristic in underwriting or rating may be hard to justify if insurers are not actually discriminating

¹⁵ Norms on discrimination on the basis of sexual orientation have, of course, been changing rapidly in recent years. *See, e.g.*, *U.S. v. Windsor*, 133 S. Ct. 2675 (2013).

among policyholders on the basis of that characteristic.¹⁶ To some extent, though, this depends on why insurers are not using the relevant characteristic.

First, if insurers do not use a rating characteristic because it has no apparent predictive value, then the case for legally restricting the use of this characteristic is extremely weak. Insurers are unlikely to ever use a characteristic in underwriting or rating if that characteristic has no predictive power. Consequently, the only social benefit such a law might provide is to articulate a moral commitment to a principle. But such a law could produce potentially meaningful social costs in the form of the public cost of legislating and the private cost of policing compliance.¹⁷

Second, the case for regulation may be slightly stronger when the reason that carriers do not use a policyholder characteristic is because the cost of determining and verifying the characteristic outweighs the benefits of a more refined classification scheme.¹⁸ A plausible case can be made for laws restricting insurers' usage of such characteristics: even though insurers are not currently employing the troubling characteristic in their rating or underwriting, this may change as the composition of the population or cost of collecting accurate policyholder information changes. Legal prohibitions on risk classification can therefore be justified as a mechanism for preventing potentially problematic insurer behavior in the future.

¹⁶ Evidence suggests that states often do pass coverage mandates that have no practical effect because all known insurance plans are consistent with those mandates. See Amy Monahan, *Fairness Versus Welfare in Health Insurance Content Regulation*, 2012 U. ILL. L. REV. 139, 193 (2012).

¹⁷ It is a common critique of expressivist theories generally that they provide a compelling argument for action only when they happen to coincide with some other type of argument, such as an efficiency or distributive fairness-type argument. See generally, e.g., Matthew D. Adler, *Expressive Theories of Law: A Skeptical Overview*, 148 U. PA. L. REV. 1363 (2000). Compliance costs may exist even if insurers are not using the underlying risk characteristic because the carrier must expend funds confirming that this is not the case.

¹⁸ See generally Amy Finkelstein & James Porterba, *Testing for Asymmetric Information Using Unused Observables in Insurance Markets Evidence From the U.K. Annuity Market* (Nat'l Bureau of Econ. Research, Working Paper No. 12112, 2006) (noting that insurers often do not use policyholder characteristics in underwriting or rating even though these characteristics have predictive value, and offering various potential explanations for this phenomenon).

Finally, the case for regulation is relatively strong if insurers are refraining from using problematic policyholder characteristics because they fear the potential reputational or regulatory consequences of doing so.¹⁹ There is good evidence that this occurs. For instance, both auto and life insurers often do not take into account policyholder occupation, even though this characteristic has been shown to predict claims and is relatively easy for insurers to determine.²⁰ Similarly, long-term care insurers do not generally take into account gender, even though this has a substantial impact on claims experiences.²¹ Evidence that smaller and newer firms have been more willing than established firms to introduce rating innovations suggests that this behavior is partially explained by the fear of public or regulatory backlash; newer and smaller firms are likely to be less deterred by the prospect of reputational or market backlash as a result of risk classification innovation.²² In these cases, laws explicitly limiting insurers' ability to employ the suspect characteristics have the benefit of reducing regulatory uncertainty. Of course, a coherent argument can be made that regulation in these settings is neither necessary nor wise: when norms and reputation are sufficient to constrain private behavior, it may be best for law to avoid intervention because of the risk that it may "crowd out" those norms.²³

B. ADVERSE SELECTION

Adverse selection is a familiar potential efficiency cost of legal restrictions on insurers' risk-classification practices. Indeed, some commentators label adverse selection resulting from legal restrictions on

¹⁹ See *id.* at 23–24. Finkelstein and Porterba note a fourth potential explanation: that the predictive content of characteristics such as place of residence may be limited by the extent to which such characteristics are subject to change in response to characteristic-based pricing differentials. As they note, however, this is unlikely to be a substantial factor in most cases because the difficulty of changing the underlying characteristic will generally be larger than the potential insurance benefits of doing so. *Id.* at 15–18.

²⁰ E.g., Finkelstein & Porterba, *supra* note 18.

²¹ Jeffrey Brown & Amy Finkelstein, *The Private Market for Long-Term Care Insurance In The United States: A Review of the Evidence*, 76 J. RISK & INS. 5, 13 (2009).

²² E.g., Finkelstein & Porterba, *supra* note 18, at 24.

²³ Uri Gneezy & Aldo Rustichini, *A Fine Is a Price*, 29 J. LEGAL STUD. 1, 3 (2000); Larry E. Ribstein, *Law v. Trust*, 81 B.U. L. REV. 553, 568–71 (2001).

insurers' risk classification practices as "regulatory adverse selection."²⁴ Such regulatory adverse selection stems from the fact that legal restrictions on insurers' risk classification practices force insurers to charge the same premiums to high-risk policyholders who possess the trait and low-risk policyholders who do not. This, in turn, can cause high-risk policyholders who cannot be charged more for insurance even though they possess a risky trait to be more likely to buy coverage because they will not pay its full price.²⁵ If this occurs, then insurers may respond by charging low-risk individuals premiums that are too high for their risk. Responding to this sort of inaccuracy in pricing, low-risk individuals may exit the risk pool and opt not to purchase insurance coverage at all, or to purchase reduced amounts of insurance. The resulting risk pool will then be comprised of predominantly higher risk (and more expensive) insureds.²⁶

Increasingly substantial empirical research demonstrates that this threat is more contingent on the characteristics of particular insurance markets than has traditionally been assumed.²⁷ Some insurance markets are quite susceptible to adverse selection, while others are resistant to adverse selection even if regulations substantially limit the capacity of insurers to

²⁴ E.g., Hoy & Ruse, *supra* note 4, at 245; see also Keith J. Crocker & Arthur Snow, *The Theory of Risk Classification*, in THE HANDBOOK OF INSURANCE 245–74 (Georges Dionne ed., 2000).

²⁵ To be sure, insurers will classify risks even without the threat of adverse selection, because competition from other carriers will otherwise skim away the good risks. This does not represent a social cost, however, unless it causes at least some policyholders to purchase less insurance than they would like to purchase at actuarially fair rates.

²⁶ The best example of this type of adverse selection death spiral involves Harvard University's offer to employees of a generous PPO plan and a less generous HMO plan. Riskier employees adversely selected into the more generous plan, resulting in a classic death spiral. See David M. Cutler & Richard J. Zeckhauser, *Adverse Selection in Health Insurance*, in FRONTIERS IN HEALTH POLICY RESEARCH 1–14 (Alan M. Garber ed., 1998).

²⁷ Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1224 (2004) (showing that such death spirals are quite rare and that, in many cases, adverse selection is itself uncommon). In a recent update and extension of this Article, Siegelman and Cohen find more mixed evidence of adverse selection in insurance markets, concluding that the phenomenon varies substantially across different lines of insurance and even within particular insurance lines. Alma Cohen & Peter Siegelman, *Testing for Adverse Selection in Insurance Markets*, 77 J. RISK & INS. 39, 77 (2010).

classify risks.²⁸ Unfortunately, the empirical literature does not provide precise guidelines about when insurance markets are more or less vulnerable to adverse selection.²⁹ Moreover, virtually none of this literature examines the susceptibility of specific insurance markets to regulatory adverse selection. Instead, virtually all of this literature examines the susceptibility of particular insurance markets to adverse selection given constant levels of regulation.

Despite these limitations in the empirical literature, at least eight factors seem likely to be relevant to determining if a particular risk-classification restriction creates a real danger of adverse selection in a particular line of coverage. First, rules limiting insurers' ability to classify risks are less likely to generate adverse selection when the percentage of high-risk individuals is small relative to the population of potential insureds.³⁰ In such cases, compelling insurers not to discriminate against high-risk individuals will result in only a small increase in actuarially-fair pooled premiums, as the characteristics of all policyholders will, on the aggregate, be quite similar to the characteristics of the low-risk policyholders. As such, low-risk individuals will be unlikely to opt out of the insurance pool because the value they derive from complete coverage is larger than this minimally increased cost. Nor will rival firms attempt to appeal to low-risk individuals by offering incomplete insurance coverage because they can anticipate that such efforts will ultimately prove unprofitable.³¹ Notably, the effect of regulation may be even smaller than

²⁸ See generally Seth J. Chandler, *Visualizing Adverse Selection: An Economic Approach to the Law of Insurance Underwriting*, 8 CONN. INS. L.J. 435 (2002) (using computer modeling to show the extent to which adverse selection depends on numerous factors in the underlying insurance market).

²⁹ See Cohen & Siegelman, *supra* note 27, at 4026.

³⁰ See Hoy, *supra* note 7, at 249–69; see also Chandler, *supra* note 28, at 498 (making similar point by noting that homogeneity of risks in the underlying pool decreases the prospect of adverse selection, whereas heterogeneity increases this risk).

³¹ This result is predicted by the Wilson Foresight model. In the classic Rothschild-Stiglitz model, there is actually no equilibrium when the number of high-risk individuals is sufficiently low, because firms in that model do not exhibit foresight about future risks. They consequently attempt to generate a separating equilibrium in a manner that ultimately proves unprofitable. Anticipating this result, carriers in the Wilson Foresight model do not attempt to disrupt the pooling equilibrium. See Charles Wilson, *A Model of Insurance Markets with Incomplete Information*, 16 J. ECON. THEORY 167 (1977).

this analysis suggests, as, even in the absence of regulation, insurers may not be inclined to discriminate against a small number of high-risk individuals because the costs of doing so may outweigh the benefits.³²

Second, adverse selection is less likely to result from restrictions on risk classification when the expected costs of policyholders possessing that forbidden characteristic are only slightly higher than the expected costs of other policyholders.³³ For instance, if men are only 1% more likely to be in car accidents than women, then legal restrictions on the capacity of auto insurers to discriminate on the basis of gender will be unlikely to generate substantial adverse selection. The explanation for this effect is the same as above: the impact of such laws on the premiums charged to “low-risks” will be limited. Consequently, relatively few low-risks will drop coverage and the impact of those that do will be minimal.³⁴

Third, risk-classification regulation is not likely to produce adverse selection when the purchase of minimum insurance policies is legally mandated.³⁵ In these settings, low-risk individuals are legally compelled to remain within the insurance pool and cross-subsidize high-risk individuals. Prominent examples of laws requiring individuals to purchase insurance include automobile liability insurance and health insurance under the Affordable Care Act.³⁶ An important caveat here is that adverse selection

³² See *infra* Part IV.B.7.

³³ See generally Hoy & Ruse, *supra* note 4 (arguing that a ban on the use of genetic testing for the purpose of generating rates would result in minimal adverse selection costs).

³⁴ When the use of the characteristic has only minimal effects, of course, insurers are less likely to use the characteristic in the first place, which means that the benefits of risk-classification restrictions are likely to be low.

³⁵ Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371, 380 (2003).

³⁶ The “individual mandate” in the Affordable Care Act, requires most individuals to purchase “minimum essential coverage” or to pay a fine. 42 U.S.C. § 18091 (2012) (originally enacted as Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1501(a), 124 Stat. 119, 907 (2010)); 26 U.S.C. § 5000A (2012). However, using an individual mandate or similar tool to combat adverse selection poses several complications. Such a system must be designed to police the minimum coverage floor effectively so that carriers cannot “classify by design” by offering stripped-down coverage to low-risk policyholders. It also must preclude carriers from classifying by design in other ways, such as by offering additional coverage that affirmatively appeals only to low-risk individuals. *E.g.*, Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform By Dumping Sick Employees*, 97 VA. L. REV. 125, 158–62 (2011).

can occur even when minimum coverage is mandated, because high-risk policyholders may choose to purchase more insurance coverage than is legally required.³⁷ Thus, larger and more comprehensive insurance mandates will tend to reduce the risk of adverse selection more than minimal insurance mandates.

Fourth, adverse selection is unlikely to result from legal restrictions imposed on insurers' risk-classification practices when policyholder demand for insurance is relatively inelastic. In such cases, policyholders will tend not to drop out of the insurance market notwithstanding increases in the price of coverage caused by risk-classification regulation. Inelastic demand is a general phenomenon that can be attributable to a variety of factors. For instance, it is more likely in settings where minimal levels of insurance are *practically* required, as in the case of homeowners insurance, which lenders generally require as a condition of a mortgage.³⁸ Alternatively, demand may be more inelastic when the cost of insurance can be largely passed on to others. Thus, doctor demand for medical malpractice insurance may be inelastic if premium costs are principally borne by patients and their health insurers.³⁹ And, of course, inelastic demand may simply reflect the fact that individuals are very risk averse.⁴⁰

(describing specific strategies by which employers complying with the ACA may still be able to “dump” high-risk employees on to insurance exchanges but continue to cover low-risk employees). Finally, it must limit the capacity of carriers to design their marketing and sales strategies to target presumptively low-risk individuals. *Id.*

³⁷ See generally Pierre-Andre Chiappori et al., *Asymmetric Information in Insurance: General Testable Implications*, 37 RAND J. ECON. 783 (2006) (describing positive correlation property of adverse selection, wherein high-risk policyholders choose to purchase more insurance than low-risk policyholders).

³⁸ Daniel Schwarcz, *Reevaluating Standardized Insurance Policies*, 78 U. CHI. L. REV. 1263, 1320 (2011).

³⁹ See generally William J. Casazza, *Rosenblum, Inc. v. Adler: CPAs Liable at Common Law to Certain Reasonably Foreseeable Third Parties Who Detrimentally Rely on Negligently Audited Financial Statements*, 70 CORNELL L. REV. 335, 351–52 (1985) (citing RICHARD POSNER, *ECONOMIC ANALYSIS OF LAW* 235 n.4 (2d ed. 1977) (noting that, where demand for CPA malpractice insurance is inelastic, the increased cost of the insurance can be passed on to clients)).

⁴⁰ See Chandler, *supra* note 28; see also Mark V. Pauly et al., *Price Elasticity of Demand for Term Life Insurance and Adverse Selection* 30–31 (Nat'l Bureau of Econ. Research, Working Paper No. 9925, 2003) (concluding that elasticity of demand in term life insurance is generally low, and hence that such insurance is generally resistant to adverse selection). One special case of inelastic demand, and

Fifth, risk-classification restrictions are less likely to generate adverse selection when high-risk policyholders *cannot* over-insure.⁴¹ In some settings, most notably life insurance, insurance coverage is non-exclusive, meaning that individuals can own multiple different policies and the benefits owed under one policy are not impacted by the existence of other policies.⁴² In these cases, standard requirements that individuals insure only up to their economically insurable interest may not effectively restrict the capacity of policyholders to enjoy a windfall in the event of a loss.⁴³ For this reason, life insurance policyholders can effectively multiply the impact of their high-risk status on the pool, resulting in low-risk individuals being forced to shoulder a larger burden as a result of risk-classification restrictions.⁴⁴

thus decreased adverse selection risk, may occur in settings where individuals face substantial “classification risk.” This reflects the prospect that a policyholder’s future premiums will increase or that coverage will become unavailable as a result of insurers’ classification efforts. See, e.g., Pierre-André Chiappori, *Econometric Models of Insurance under Asymmetric Information*, in HANDBOOK OF INSURANCE 365, 365–94 (Georges Dionne ed., 2000).

⁴¹ See Hoy & Ruse, *supra* note 4, at 222; see Michael Hoy & Mattias Polborn, *The Value of Genetic Information in the Life Insurance Market*, 78 J. PUB. ECON. 235, 235–52 (2000) (“The fundamental difference between life insurance and other insurance policies is, from an institutional point of view, that individuals can buy life insurance from as many companies as they want and therefore price–quantity contracts are not a feasible means against adverse selection; insurance companies can only quote a uniform price for all life insurance contracts. A second important difference between life insurance and other insurance is that there is no natural choice for the size of loss.”).

⁴² In most insurance contexts, policies contain coordination of benefits or “other insurance” provisions, which prevent a policyholder from recovering under multiple policies in a way that would improve the policyholder’s financial condition as a result of the loss.

⁴³ At least when policyholders do not face any financial constraints on purchasing excess coverage. See Chandler, *supra* note 28, at 454–55 (noting that some insurance is sufficiently expensive that even if policyholders were legally entitled to over-insure, many would be unable to do so because of liquidity constraints).

⁴⁴ Life insurers do have ways of limiting over-insurance of this sort. In their applications, they usually ask whether the applicant already has life insurance coverage and, if so, how much and with what insurer. Presumably the insurer considering the application takes into account the problem of over-insuring, and its

Sixth, the risk of adverse selection is smaller when a secondary market for insurance policies does not exist, a factor whose importance has seemingly escaped attention in the risk-classification literature. In life insurance and annuity markets, policyholders can, and frequently do, sell their policies to investors via the life settlement market.⁴⁵ These secondary markets may increase the risk of adverse selection by allowing high-risk individuals not merely to purchase a policy with an *expected* net benefit – the fifth advantage mentioned above – but instead to purchase a policy with an immediate *guaranteed* profit. An individual with a genetic predisposition need merely purchase life insurance coverage and then sell this coverage to a third-party investor, who will pay some portion of the expected recovery to the policyholder in return for becoming the policy owner. While individuals have an incentive to hide their genetic defects from insurers, they have the opposite incentive when selling policies to third-party investors: the sooner the policyholder is to die, the more investors will be willing to pay for the policy.⁴⁶ Not only do secondary markets increase the prospect of adverse selection by transforming expected values into assured values, they also allow high-risk individuals to benefit *personally* from their life insurance products. Without such markets, high-risk individuals could only benefit their heirs by purchasing additional insurance, which might limit the adverse selection risk.⁴⁷

Seventh, product design can substantially impact the risk of adverse selection. In some cases, product design can counteract the risk of regulatory adverse selection. One setting where this is possible is when

implications for adverse selection and moral hazard when deciding whether to issue a policy to such an applicant.

⁴⁵ See generally Robert Bloink, *Catalysts for Clarification: Modern Twists on the Insurable Interest Requirement for Life Insurance*, 17 CONN. INS. L.J. 55, 77–81 (2010).

⁴⁶ Risk classification rules that would prevent investors from asking about individuals' genetic makeup cannot prevent such transactions because these rules would not stop high-risk policyholders from volunteering information about their genetic predispositions.

⁴⁷ One potentially interesting twist here is that by over-insuring and selling a policy to investors, an individual could potentially buy better medical care that may eventually save his or her life. J.J. McNabb, *Viatical Settlements: Myths and Misconceptions*, GREATER WORCESTER COMMUNITY FOUND., <http://www.pgdc.com/pgdc/viatical-settlements-myths-and-misconceptions> (last updated May 18, 2011). This possibility may tend to work against the risk of adverse selection.

policyholders typically learn whether they are high-risk at some point after they have the opportunity to purchase coverage, as may occur with health status or genetic predispositions (as opposed to race or gender). In these cases, policyholders who discover they are low risk can drop coverage, leaving behind a disproportionately high-risk pool. Insurers can counteract this threat through effective policy design, such as by requiring policyholders to pre-pay for future coverage, so that they forfeit these payments if they leave the insurance pool once they discover they are low risk.⁴⁸ In other cases, though, product design can increase the risk of regulatory adverse selection. Particularly in life and health insurance markets, for instance, insurers cannot cancel an insured's policy once the statutorily prescribed incontestability period has run, except for extraordinary reasons—such as proof of outright fraud. The same is not true of other types of insurance.⁴⁹ This fact raises the value to life and health insurance applicants of engaging in adverse selection.

Eighth, regulatory restrictions on risk classification are more likely to produce adverse selection to the extent that policyholders both know about their own classification status and appreciate its link to risk.⁵⁰ Where these conditions are not met, regulatory restrictions on insurer risk classification will not create information asymmetries between policyholders and insurers, and thus cannot generate adverse selection.⁵¹ For instance, regulatory prohibitions on the use of genetic composition will not tend to create adverse selection if policyholders are not themselves aware of their own genetic composition or fail to appreciate the connection between their genetic makeup and their risk levels.

To be sure, these eight factors are neither exhaustive nor likely to be relevant in every case. However, they provide an important set of considerations in gauging the risk that restrictions on insurers' risk classification practices might generate regulatory adverse selection.

⁴⁸ This is the strategy that level-premium life and disability insurance policies take, as they effectively require pre-payment of premiums in the early stages of life before many policyholders learn their risk status based on health developments. See Baker, *supra* note 35, at 379–83.

⁴⁹ An insurer that sells individually underwritten auto or non-auto liability and property policies can cancel policies or decline to renew when the policy comes up for renewal. See ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW 696 (2d ed. 1996).

⁵⁰ See Cohen & Siegelman, *supra* note 27, at 39.

⁵¹ See *id.* at 40.

C. FAIRNESS AND ILLICIT DISCRIMINATION

Any type of discrimination can be considered illicit to the extent that it trades on individual characteristics that are socially suspect. Policyholder characteristics can be deemed socially suspect for two related reasons.⁵² First, insurers' use of certain risk characteristics may reinforce or perpetuate broader social inequalities by making insurance less available or more expensive to historically disadvantaged groups.⁵³ For instance, insurers who charged more to immigrant drivers would thereby perpetuate preexisting inequalities. Second, risk-classification schemes may be socially suspect because they cause some sort of expressive harm, even though they do not penalize with higher rates members of groups who are traditionally disadvantaged. As an example, we might object to an insurer who announced that it was willing to sell annuities at better rates to African-Americans because they tend to have a shorter life span. Unlike the first example, this objection might persist even though the traditionally disadvantaged group is made better off as a result of the insurer classification scheme. Here the problem is not that a traditionally disadvantaged group is economically harmed. Instead, the concern is that the insurance classification scheme perpetuates inappropriate stereotyping.⁵⁴

⁵² Abraham frames this category more broadly, stating that a classification can be suspect for at least four reasons: (i) it is used improperly in other fields, (ii) it is not supported by sufficient data, (iii) it systematically works to the disadvantage of a particular group, or (iv) it perpetuates unfair disadvantages outside of the insurance system. In general, though, none of the first three explanations seem problematic unless they are coupled with the fourth. It is not, for instance, troubling that classification schemes systematically work to the disadvantage of individuals with bad driving records. Similarly, Abraham himself argues elsewhere in his article that mere inaccuracy is not, in itself, a basis for a fairness objection. See Abraham, *supra* note 4, at 442.

⁵³ Although often framed in terms of fairness, this argument can also be understood in economic terms as an externality argument: insurers impose harms on society at large by relying on certain suspect classifications.

⁵⁴ See Elizabeth S. Anderson & Richard H. Pildes, *Expressive Theories of Law: A General Restatement*, 148 U. PA. L. REV. 1503, 1504 (2000) ("[E]xpressive theories tell actors—whether individuals, associations, or the State—to act in ways that express appropriate attitudes toward various substantive values.").

In many cases, of course, both types of argument can be deployed to label a classification scheme illicit or socially suspect. At times, though, classification schemes may be socially suspect based only on one of these two considerations. For instance, automobile insurance rating schemes have recently been criticized because they may result in lower-income individuals paying higher rates.⁵⁵ This objection is principally based on the first type of argument: insurers' rating schemes are perpetuating income inequality by requiring lower income individuals to pay more for coverage. Indeed, it is hard to articulate an expressive harm from insurers' underwriting efforts because insurers generally do not explicitly rely on policyholder income in rating policies; instead, other classification measures may simply have the impact of disproportionately harming low-income policyholders. By contrast, objections to the use of gender in life insurance (but not annuities) may tend to rely exclusively on the second type of argument, because gender-based premiums economically benefit women, whose expected life span is longer than men. Objections to such practices must therefore emphasize the expressive harm associated with reaffirming the relevance of gender-based social patterns and practices.

III. VARIATION IN STATE INSURANCE ANTI-DISCRIMINATION LAWS

A. THE EMPIRICAL APPROACH: CODING STATE ANTI-DISCRIMINATION LAWS⁵⁶

To understand state law governing insurance discrimination, we investigated how each state (as well as Washington, D.C.) regulates insurers' use of nine policyholder characteristics – race, religion, ethnicity, gender, age, genetic testing, credit score, sexual orientation, and zip code – across the five largest lines of insurance – life, health, disability, auto, and property/casualty. This produced 2,295 sets of rules (9 traits times 5 lines of insurance times 51 jurisdictions), derived from state statutory,

⁵⁵ Stephen Brobeck & J. Robert Hunter, *Lower-Income Households and the Auto Insurance Marketplace: Challenges and Opportunities*, CONSUMER FED'N OF AM. (Jan. 30, 2012), <http://www.consumerfed.org/news/450>.

⁵⁶ This Article includes only a brief discussion of the empirical approach. For more details on how data was selected and coded, see Avraham, Logue & Schwarcz, *supra* note 1.

administrative, and judicial materials.⁵⁷ For each state/characteristic/line combination, we then converted the applicable rules to one of six possible codes. These codes range along a continuum, from those that are least restrictive of insurers' underwriting decisions to those that are most restrictive. The entire continuum is reproduced below:⁵⁸

Expressly Permit (-1)—The state has a statute expressly or impliedly permitting insurers to take the characteristic into account.

No Law on Point (0)—The state laws are silent with respect to the particular characteristic.

General Restriction (1)—The state has a statute that generally prohibits "unfair discrimination," either across all lines of insurance or in some lines of insurance, but that statute does not provide any explanation as to what constitutes unfair discrimination and does not identify any particular trait for limitation.

Characteristic-Specific Weak Limitation (2)—The state has a statute that limits but does not prohibit the use of a particular characteristic in either issuance, renewal, or cancellation.

Characteristic-Specific Strong Limitation (3)—The state has a statute that prohibits the use of a particular characteristic when the policy is either issued, renewed, or cancelled, or, the state has a statute that limits, but does not completely prohibit, the use of a particular characteristic in rate-setting.

Characteristic-Specific Prohibition (4)—The state has a statute that expressly prohibits insurers from taking into account a specific characteristic in setting rates.

1. An Overview of Variation in the Intensity of Risk Classification Regulation

The data developed above reveal substantial variations in state insurance antidiscrimination laws across the nine characteristics that we

⁵⁷ Judicial decisions and administrative rulings rarely impacted the coding derived from state statutes. Surprisingly, out of the 2,295 trait/line combinations (9 traits times 5 lines of insurance times 51 jurisdictions), only sixteen total trait/line combinations were changed on this basis.

⁵⁸ We acknowledge that this continuum from permissive to stringent restrictions is neither perfectly continuous nor perfectly scaled, but it is the best that can be done given the nature of the data. It allows us to "see" the data in a way that makes it more accessible.

investigated. This is easily seen in Chart 1, which compares the average level of restrictiveness for each characteristic, for all lines of insurance and all states combined.⁵⁹ Overall, Chart 1 demonstrates that race, national origin, and religion are the most heavily regulated of the characteristics. Each of these averages more than a weak limitation (a 2 in our coding scheme). The next most regulated characteristic is gender, followed by sexual orientation. Age is the least restricted, averaging less than a 1 in our coding scheme, which means that, on average, state insurance anti-discrimination laws tend to prohibit unfair discrimination generically, but do not specify when or how age-based discrimination might be impermissible.

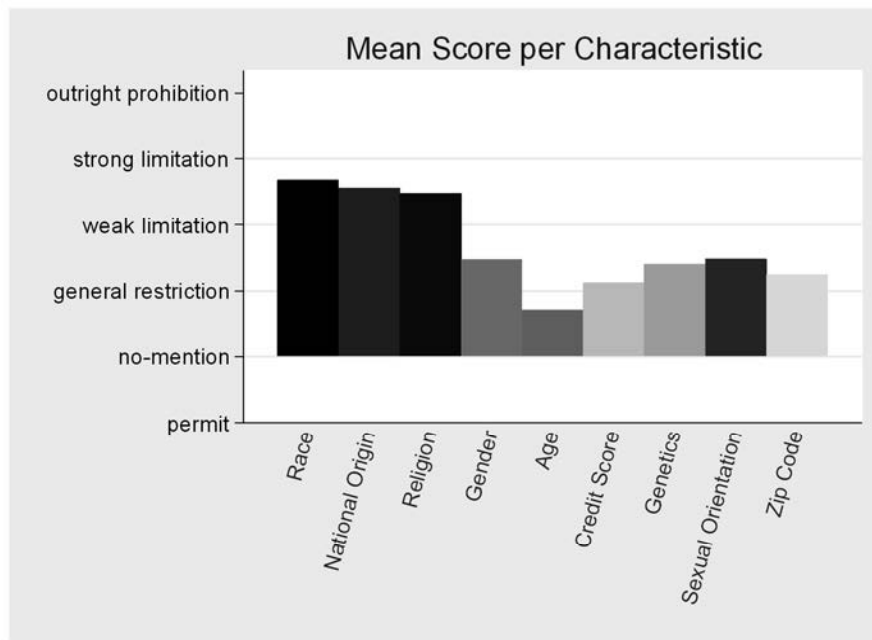


Chart 1

State insurance anti-discrimination laws vary not only across regulated characteristics, but also across insurance coverage lines. Chart 2 illustrates this cross-line variation in the intensity of risk-classification

⁵⁹ For example, in Chart 1 the bar for “race” shows the average treatment for race across all fifty-one states and all five insurance lines. This is a total of 255 (51 x 5) laws that are, on average, slightly less than a strong limitation (a “3” on our coding scale).

regulation. It reports the average level of restrictiveness for each line of insurance, this time averaging together scores for all policyholder characteristics and all states. This value varies between just more than a “General Restriction” (or numerical score of 1) for disability insurance to just more than a Characteristic-Specific “Weak Limitation” (or numerical score of 2) for auto and property/casualty. Thus, our data suggest that state laws regulating risk-classification practices are most restrictive in the auto and property/casualty insurance lines and least restrictive for disability and life insurance lines.⁶⁰ State anti-discrimination laws for health insurance fall in between these extremes.

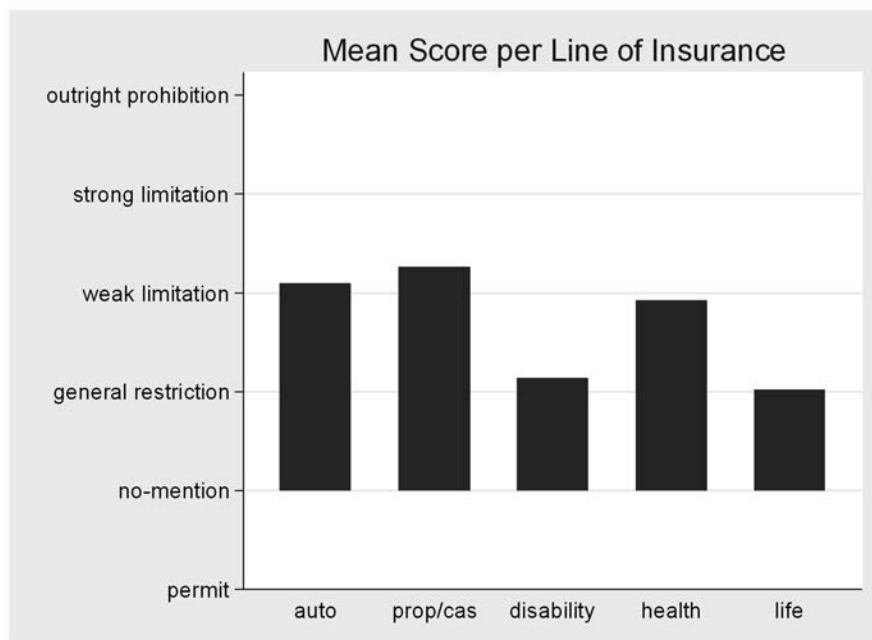


Chart 2

⁶⁰ One possible explanation for the restrictiveness of each line of insurance is that states with general restriction statutes for a specific line of insurance may not have felt a need to pass stricter laws. However, as seen in Avraham, Logue & Schwarcz, *supra* note 1, this was not a relevant factor in explaining cross-line variations.

Chart 3, below, reports the restrictiveness of state risk-classification regulations by characteristic as well as by coverage line. It contains the same information as in Chart 2, but with the blue bar “removed” to expose the average scores across states for each line/characteristic combination.

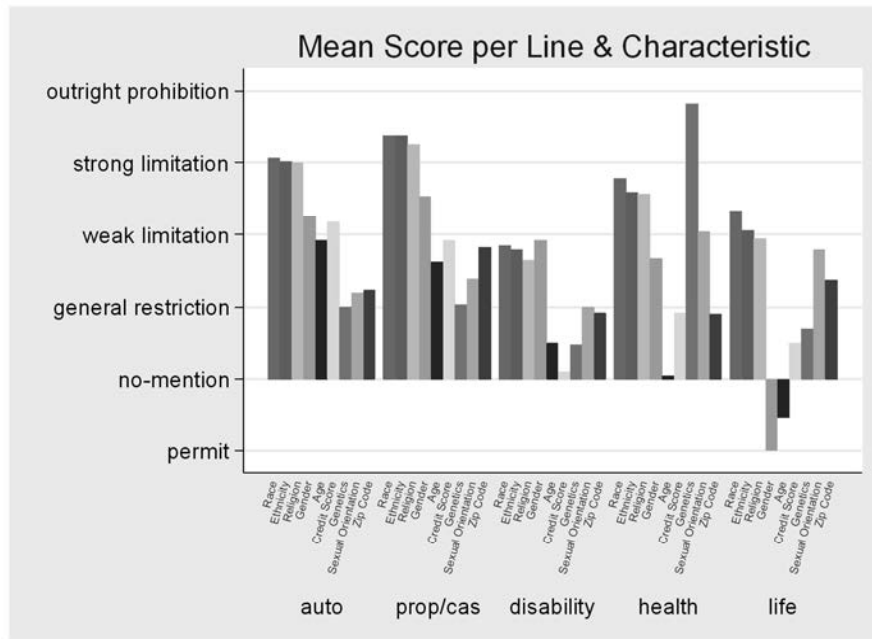


Chart 3

Chart 3 suggests that the similarities in risk-classification restrictions in auto and property/casualty insurance extend beyond the similar aggregate measures reported in Chart 2. Both lines of insurance seem to have a very similar pattern of risk classification restrictions across different characteristics, as reflected in the similar patterns of data reported in the auto and property/casualty insurance entries in Chart 3. A similar point can be made for health and life insurance, with the exception of genetics, age, and gender, which vary significantly in their treatment across these two lines of coverage. Disability insurance seems to stand out as unique in its pattern of risk-classification restrictions.

Chart 3 also shows that the comparatively heavy regulation of race, national origin, and religion noted in Chart 1 exists across all lines of insurance. These characteristics (the top three bars) are almost always the

most intensely restricted characteristics in every coverage line, with sometimes a full one-point difference between them and the next most restricted characteristic, namely gender.⁶¹

In addition to adding some nuance to the data reported in Charts 1 and 2, Chart 3 also reveals interesting disparities in how individual policyholder characteristics are treated across different lines of coverage. Consider policyholder genetics, for instance. Chart 3 shows that forty-eight of the fifty-one jurisdictions completely prohibit the use of genetics for health insurance, giving genetics the highest overall restrictiveness score of any characteristic for a single line of insurance, even though in the other four lines the mean score for genetics is low.⁶² This near-consensus among states regarding the use of genetic information in health insurance is reflected in the 2008 passage of the federal Genetic Information Non-Discrimination Act, which forbids the use of genetic information in health insurance.⁶³

Genetics is not the only policyholder characteristic that is regulated differently across different lines of insurance. Chart 3 also shows that gender is highly restricted in auto, property/casualty, and disability insurance, but only weakly restricted in health and is permitted by all states in life.⁶⁴ Somewhat similarly, Chart 3 shows that credit score is more intensely restricted in automobile and property/casualty insurance than in disability, health, and life insurance. Finally, age is also regulated quite different across different lines of insurance. In health and life insurance, age tends towards the “permitted” score, whereas age is regulated much

⁶¹ The only exceptions are restrictions on genetic traits in health insurance underwriting and restrictions on gender in disability insurance. The “big three” phenomenon can also be seen when looking at the number of jurisdictions that completely prohibit the use of a characteristic across all five lines of insurance. Race (nine states), ethnicity (nine states), and religion (seven states), along with sexual orientation (five states) and gender (one state), are the only characteristics that were banned in all five lines of insurance by a state. For further information, see Avraham, Logue, & Schwarcz, *supra* note 1.

⁶² New York is the only state that allows (with heavy restrictions) insurers to use genetic testing in health insurance. See N.Y. INS. LAW § 2615 (McKinney 2000).

⁶³ Genetic Information Non-Discrimination Act of 2008, Pub. L. No. 110-233 § 102(b)(1)(B), 122 Stat. 881, 893 (2008). Under the Act genetic testing is defined to include family history of disease.

⁶⁴ As noted later, federal health care reform prohibited this practice in health insurance starting in 2014.

more strongly (averaging a weak restriction) in property/casualty and auto insurance.⁶⁵ These disparities in how individual policyholder characteristics are treated across different lines of coverage are explored more extensively below, where we attempt to explain them using our model.

In summary, there are wide variations in state regulation of insurers' risk-classification practices. Across policyholder characteristics, the most restricted characteristics are race, ethnicity, and religion (the "big three"), and the most restrictive combination (outside of the big three) is genetics in health insurance. Across insurance lines, automobile insurance and property/casualty insurance are similarly regulated, and constitute the most restrictive lines of insurance. Health and life insurance are also similarly regulated with respect to permissible risk-classification, with health being more restrictive. Finally, various individual policyholder characteristics, including genetics, gender, credit score, and age, are regulated very differently across different lines of coverage.

IV. EXPLAINING VARIATION OF CHARACTERISTIC/LINE COMBINATIONS

This Part attempts to explain the variations described in Part II by reference to the three factors described in Part I. As described at the outset, our basic model suggests that state legislatures strike a balance between the efficiency and fairness considerations involved in insurance discrimination as follows:

a) *The predictive property*—State legislatures will be more likely to consider regulating (either by prohibiting or permitting) risk-classification based on a characteristic (such as age) if that characteristic has predictive value for policyholder risk.⁶⁶

b) *The illicit discrimination property*—State legislatures will be more inclined to *prohibit* risk-classification based on a characteristic (such as age) to the extent that doing so would help combat (or appear to combat) illicit discrimination.

⁶⁵ See *supra* Chart 3. Chart 3 reveals that on average sexual orientation and zip code are treated very similarly in all lines of insurance. They almost always fall around the score of "general restriction."

⁶⁶ State legislatures therefore tend to not regulate risk classifications when insurers have no economic incentives to do it because the characteristics convey no relevant information for that line of insurance. An example for that is sexual orientation in automobile insurance.

c) *The adverse selection property*—State legislatures will tend to *allow* risk classification to the extent that limiting such discrimination might plausibly trigger substantial adverse selection.

These properties must be balanced against each other to determine the outcome of state laws.

Section A of this Part begins with the easiest task: explaining the broad patterns of cross-characteristics variation in the intensity of state insurance anti-discrimination law described above. Section B then attempts to explain the patterns of cross-line variation. Finally, Section C uses our proposed model to explain cross-line variations in states' treatment of individual policyholder characteristics, including gender, age, and genetics.

A. EXPLAINING CROSS-CHARACTERISTIC VARIATIONS

The cross-characteristic variation described in Chart 1 can largely be explained by the illicit discrimination prong of our model. First, the fact that race, national origin, and religion are the three most restricted characteristics is broadly consistent with social judgments that discrimination on the basis of these characteristics is socially suspect, as reflected in both federal anti-discrimination laws and Supreme Court precedent. Thus, federal antidiscrimination laws, like Title VII⁶⁷ and Title VIII,⁶⁸ prohibit discrimination because of an individual's "race, color, religion . . . or national origin." Similarly, discrimination on the basis of race, national origin, and religion has long been subject to strict scrutiny under the Supreme Court's Equal Protection jurisprudence.⁶⁹

Correspondingly, gender – the next most heavily regulated characteristic in state insurance regulation – is subject to similar, though slightly less robust, federal anti-discrimination protections than the big three. Both Title VII and Title VIII prohibit discrimination on the basis of gender to the same extent that they prohibit discrimination on the basis of

⁶⁷ 42 U.S.C. § 2000e-2 (2012) (banning employment discrimination).

⁶⁸ 42 U.S.C. § 3604 (2012) (banning discrimination in the sale or rental of housing).

⁶⁹ Protection from religious discrimination has also been a part of the Constitution since our country's founding. U.S. CONST. amend. I; *Miller v. Johnson*, 515 U.S. 900, 904 (1995); *Church of Lukumi Babalu Aye, Inc. v. Hialeah*, 508 U.S. 520, 533 (1993); ERWIN CHEMERINSKY, *CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES* 711 (4th ed. 2011).

race, national origin, and religion. But gender only receives an intermediate level of scrutiny under the Supreme Court's Equal Protection jurisprudence.⁷⁰

The fact that sexual orientation is the next most restricted characteristic after gender is also broadly consistent with emerging norms about socially suspect characteristics. To be sure, discrimination on the basis of sexual orientation has not been recognized for protection by federal laws in the same way that race, religion, national origin, and gender have been. And while the Court has implied a willingness to protect gays and lesbians from discrimination, so far it has done so only using rational basis review.⁷¹ Moreover, gay rights have been enjoying greatly enhanced protections at the state level in recent years, with numerous states passing new laws in support of gay marriage⁷² and prohibiting discrimination on the basis of sexual orientation in areas like employment.⁷³

Age is the least regulated characteristic in state insurance law, which is a little harder to understand based solely on the illicit discrimination prong of our model. On one hand, discrimination on the basis of age is only subject to rational basis review under Equal Protection analysis,⁷⁴ and it is not protected under Title VII or Title VIII. On the other hand, though, the Age Discrimination in Employment Act provides basically the same protections for age as Title VII does for race, color, religion, sex, and national origin.⁷⁵

⁷⁰ *United States v. Virginia*, 518 U.S. 515, 531 (1996) (“[p]arties who seek to defend gender-based government action must demonstrate an ‘exceedingly persuasive justification’ for that action.”).

⁷¹ *Id.* at 575.

⁷² Jon Cohen, *Gay Marriage Support Hits New High in Post-ABC Poll*, WASH. POST. (Mar. 18, 2013), <http://www.washingtonpost.com/blogs/the-fix/wp/2013/03/18/gay-marriage-support-hits-new-high-in-post-abc-poll> (showing 58% of Americans support gay marriage).

⁷³ *See Gay and Lesbian Rights Poll*, GALLUP (May 11, 2014), <http://www.gallup.com/poll/1651/gay-lesbian-rights.aspx> (showing 89% of Americans agree that homosexual men and women should have equal job opportunities); *see also Poll Results: Gay Rights*, YUGOV (October 31, 2013, 12:32 PM), <https://today.yougov.com/news/2013/10/31/poll-results-gay-rights/> (showing 69% of Americans believe it is already illegal under federal law to fire someone for being homosexual).

⁷⁴ CHEMERINSKY, *supra* note 69, at 802.

⁷⁵ *See* 29 U.S.C. § 623 (2012).

B. EXPLAINING CROSS-LINE VARIATIONS

The broad patterns of cross-line variation in state insurance anti-discrimination law can largely be explained by our model, particularly the third prong – the adverse selection property. Recall that the auto and property/casualty insurance lines are the most heavily restricted by state anti-discrimination laws. This is consistent with our conjecture that these coverage lines are relatively less susceptible to adverse selection than other lines of coverage, giving the state more leeway to prohibit discrimination without triggering adverse selection.

There is good reason to believe that auto and property/casualty insurance lines are relatively resistant to adverse selection because minimum coverage levels are generally legally or practically mandated in these lines. Automobile drivers, of course, are legally required to carry a minimum amount of liability insurance in virtually every state. They are also frequently required to purchase UIM coverage. When individuals finance the purchase of a car, which is quite common, they are also commonly required to maintain comprehensive and/or collision coverage. Similarly, individuals who finance the purchase of a home, which is almost all homeowners, are required by their lenders to maintain minimum levels of homeowners insurance. Recall from Part II that when coverage is mandated, either *de jure* or *de facto*, the risk of adverse selection is smaller. Although this may be less true for liability coverage limits, which tend to be relatively low-value, financiers of automobiles and homes generally require the purchase of relatively comprehensive insurance.

Just as the adverse selection property of our model can explain the relative strength of state anti-discrimination laws in auto and homeowners insurance, it can also explain the relative weakness of these laws in the context of life and disability insurance. This is because there is good reason to believe that life and disability insurance are comparatively quite susceptible to regulatory adverse selection. This point is particularly compelling with respect to life insurance for three reasons.⁷⁶ First, life

⁷⁶ We acknowledge here that the empirical literature on adverse selection in insurance markets does not demonstrate that adverse selection is more common in life insurance markets than in other insurance markets. See, e.g., John Cawley & Tomas Philipson, *An Empirical Examination of Information Barriers to Trade in Insurance*, 89 AMER. ECON. REV. 827 (1999); Cohen & Siegelman, *supra* note 27. This, however, is of only limited relevance given that this literature does not focus on the risk of regulatory adverse selection. Given the extensive benefits that

insurance may be especially susceptible to adverse selection from asymmetric information because individuals can relatively easily over-insure their own lives by purchasing policies from several insurers.⁷⁷ Second, there exists a robust secondary market for life insurance policies, allowing high-risk individuals to immediately profit with certainty from the purchase and the immediate sale of these policies when regulatory rules preclude accurate underwriting. Third, insurers cannot cancel an insured's life insurance policy merely because the individual's risk has changed. The renewability of a life insurance policy is generally guaranteed for a fixed period of time or until the insured dies or decides to drop their coverage. Thus, every high-risk insured who makes it into the pool will remain in the pool for a relatively long time.

Adverse selection may also be a problem in the context of disability insurance, though this is less clear than in the case of life insurance. The peculiar risk of adverse selection in disability insurance stems from the fact that, relative to other lines of coverage, disability insurance claims occur infrequently, but often involve large payouts.⁷⁸ This means that a small number of high-risk individuals within a disability

policyholders could enjoy in the life insurance context by taking advantage of information asymmetries regarding their risk levels, life insurers go to great lengths to limit information asymmetries by engaging in very careful underwriting processes. This is presumably an important reason why adverse selection is so rarely a substantial problem in life insurance markets. Our point is that, to the extent that life insurers were legally restricted from engaging in risk classification activities, this would be likely to result in substantial adverse selection because of the monetary gains that could thereby be enjoyed by high-risk policyholders.

⁷⁷ See Hoy & Polborn, *supra* note 41, at 236 (2000) (“The fundamental difference between life insurance and other insurance policies is, from an institutional point of view, that individuals can buy life insurance from as many companies as they want and therefore price-quantity contracts are not a feasible means against adverse selection; insurance companies can only quote a uniform price for all life insurance contracts. A second important difference between life insurance and other insurance is that there is no natural choice for the size of loss.”). On the other hand, when life insurers issue new policies, they require applicants to list all other life insurance policies in force on the person whose life is being insured. If the amount of combined coverage exceeds a given threshold, the life insurer is unlikely to issue the new policy, or will at least insist on a high premium, on adverse selection grounds.

⁷⁸ *The Use of Genetic Information in Disability Income and Long-Term Care Insurance*, ISSUE BRIEF (Am. Acad. of Actuaries), Spring 2002, at 2, available at http://www.actuary.org/pdf/health/genetic_25apr02.pdf.

insurance pool can substantially skew the prices that low-risk individuals pay.⁷⁹

Finally, the risk of regulatory adverse selection also seems to provide a plausible explanation for the fact that relative strictness of state anti-discrimination laws in health insurance fall in between property/casualty and auto insurance, on one end, and life and disability insurance, on the other. This is because adverse selection concerns with respect to the type of discrimination we investigate – which does not include health-based discrimination – are quite nuanced in the health insurance context. On one hand, none of the special factors applicable to life insurance apply to health insurance markets: over-insurance is not possible, there are no secondary markets for policies, at least until recently insurers could drop high risk insureds, and substantial payouts are made on a comparatively large number of policyholders. Additionally, depending on state law, health insurance carriers (until very recently) could combat adverse selection through product design, for example by asking for applicants' medical history.⁸⁰ Health insurance carriers also enjoy a unique ability to sell coverage on a group basis because the tax code confers substantial tax benefits on employer-sponsored coverage.⁸¹ Employer-

⁷⁹ This corresponds to the first adverse selection argument that there are a small number of high-risk individuals.

⁸⁰ See Jacob Glazer & Thomas G. McGuire, *Optimal Risk Adjustment in Markets with Adverse Selection: An Application to Managed Care*, 90 AM. ECON. REV. 1055, 1055, 1057 (2000). The extent to which life and disability insurance underwriters also use product design to combat adverse selection is unclear. To the extent that they do not request information about one's family history of genetic disease, the rationale for this is also unclear. What we do know is that requesting a family history of diseases is the norm with individually underwritten health insurance policies.

⁸¹ Specifically, federal tax laws allow the full value of employer-provided health insurance to be excluded from employees' income for purposes of calculating their income tax liability. 26 U.S.C. § 106(a) (2012). While life and disability insurance are also frequently sold on a group basis, there is less bias towards group markets in these contexts, principally because of the absence of comparable tax subsidies. Approximately 50% of life insurance policies are sold through employers, and approximately 50% are sold through the individual market, though policies sold in the individual market tend to be larger. See *The Life Insurance Coverage Gap: Strategies for Financial Professionals to Close the Gap*, PRUDENTIAL FINANCIAL 1 (2013), http://research.prudential.com/documents/rp/RP_The_Life_Insurance_Coverage_Gap.pdf (citing LIMRA, PERSON-LEVEL TRENDS IN U.S. LIFE INSURANCE OWNERSHIP (2011)). A substantial majority of

sponsored coverage combats the risk of adverse selection without any underwriting because employees are relatively heterogeneous with respect to most health-related factors, and definitely with respect to their genetic predisposition to illness.⁸²

The adverse selection prong of our model cannot fully explain the treatment of health insurance, as regulatory adverse selection caused by at least some of the anti-discrimination rules we isolate is a very real risk in health insurance for two reasons. First, and most importantly, the expected costs of high-risk policyholders in the context of some anti-discrimination rules – particularly age and gender – can be substantially larger than the expected costs of low-risk individuals.⁸³ Second, there are a potentially large number of people who constitute high-risk individuals in this context.⁸⁴ All of this is consistent with the fact that the Affordable Care Act (“ACA”) limits discrimination on the basis of age and prohibits discrimination on the basis of gender. The ACA also contains the individual mandate and substantial tax subsidies, both of which were specifically designed to limit the risk of adverse selection.

The middling level of state anti-discrimination law in health insurance becomes more understandable, though, when the illicit discrimination prong is added back in to the analysis. Concerns about illicit discrimination are stronger in health insurance than in any other line of coverage, as many view adequate health insurance to be a “right,” whereas few make similar arguments for other forms of coverage.⁸⁵ As

private health insurance is sold through employers. See David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL’Y L. & ETHICS 23, 26 (2001).

⁸² See Hyman & Hall, *supra* note 81, at 32–33.

⁸³ See *supra* Part II.A (discussing factor two).

⁸⁴ See *supra* Part II.A (discussing factor one).

⁸⁵ See William Nowlan, *A Rational View of Insurance and Genetic Discrimination* 297 SCIENCE 195, 195 (2002) (“[A] clear distinction exists between economic and ethical considerations involved in underwriting health insurance and those that apply to life insurance. Life insurance in this country is not a societal right, although everyone is potentially eligible for limited survivorship benefits through social security.”). But see Susan M. Wolf & Jeffrey P. Kahn, *Genetic Testing and the Future of Disability Insurance: Ethics, Law & Policy*, 35 J.L. MED. & ETHICS 6, 8, 13 (2007) (noting that the difference in the laws may be attributable to the difference in “social importance” that people place on health insurance over life and disability insurance, but arguing that genetic information should be banned from disability insurance as well).

such, even if adverse selection concerns were as substantial in health insurance as they are in life and disability, thus tending to lead to less state anti-discrimination regulation, the illicit discrimination prong would tend to push in the opposite direction, promoting stronger anti-discrimination laws. The result would be a middling level of protection, precisely what we observe.

C. EXPLAINING PARTICULAR CROSS-LINE/CROSS-CHARACTERISTIC COMBINATIONS

Our model does a relatively good job of explaining the broad trends in cross-characteristic variation and cross line variation that we observe. In this section, we show that the model also provides relatively good explanations for many of the more specific patterns of state antidiscrimination law, wherein variation exists in the treatment of individual policyholder characteristics across different lines of coverage.

1. Cross-Line Treatment of Genetics

As noted in Part III, and more specifically illustrated in Chart 4 below, there is tremendous variation in the treatment of genetics across policy lines. This variation, moreover, does not follow the more general trends in cross-line variation: most notably, health insurance is much more strongly regulated than the other lines. In fact, the use of genetic information in health insurance underwriting is the most restrictive trait in our study. By contrast, Chart 4 shows that there is very little regulation of genetics in the other lines of insurance.⁸⁶ In fact, many states go so far as to explicitly permit the use of genetic information in other lines of insurance (a “-1” in our coding scheme). This can be seen in life insurance, and to a greater degree in disability insurance, which are regulated similarly with respect to genetics.⁸⁷ The Genetic Information Nondiscrimination Act

⁸⁶ New York is the only state to permit the use of genetic testing in health insurance, making it an outlier. New York is not even consistent, also permitting genetic discrimination in life and disability insurance, but restricting the use of genetics in auto and property/casualty.

⁸⁷ The main visual difference between life and disability insurance in Chart 4 is that while there are several states which do not mention anything about the usage of genetic test in disability insurance (score 0), there are no such states in life

(“GINA”) mirrors this result at the federal level, prohibiting health insurers (and employers) from using individuals’ genetic information, but leaving other forms of insurance unregulated with respect to genetic discrimination.

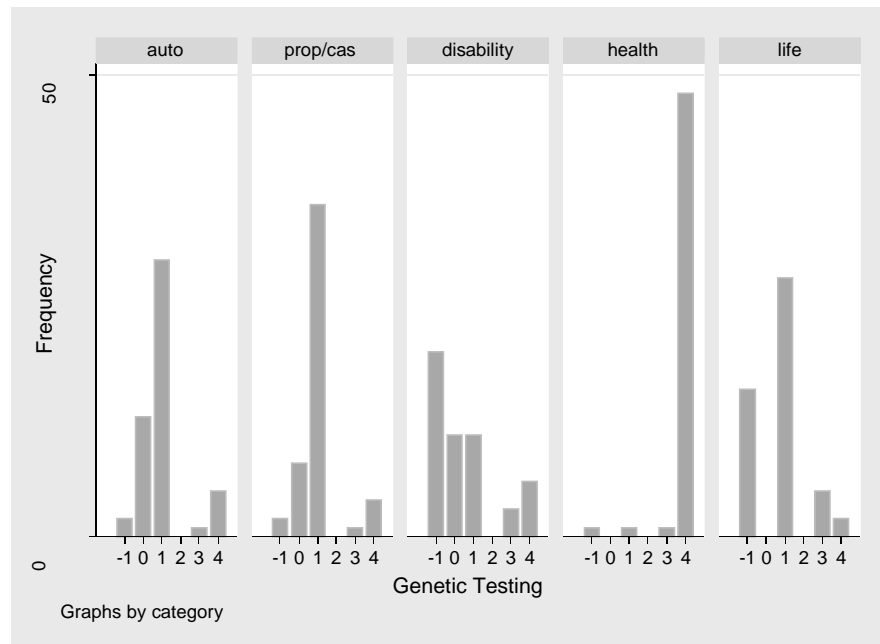


Chart 4: Distribution of States’ Scores for Genetic Testing, by Insurance Line

Our model does a relatively good job of explaining these patterns.⁸⁸ First, consider the treatment of genetic information in automobile and property/casualty insurance, which is usually restricted only under states’ general restriction laws (coded as a 1). Observe next that many states do not even mention genetic information in their laws, and that only two states expressly permit discrimination based on genetic information. These

insurance, and more states have the score of 1 (general restriction). That is not a major difference.

⁸⁸ For other attempts to explain these patterns, see generally Hoy & Polborn, *supra* note 41 (discussing the use of genetic testing in life insurance) and Wolf & Kahn, *supra* note 85 (discussing the use of genetic testing in disability insurance).

trends are consistent with prong one of our model, reflecting the fact that genetic testing does not (at least yet) seem to provide information that is predictive of expected losses with respect to auto and property/casualty insurance. As the first prong of our model predicts, legislatures are unlikely to act when insurance companies are not using, and are not likely to use, a specific characteristic in their underwriting decisions.

The observed patterns in life and health insurance are also consistent with our model. In these domains, where genetics is indeed quite predictive of risk, the illicit discrimination prong of our model becomes central. Genetic discrimination in the context of health, life, and disability insurance immediately evokes Nazi Germany and its obsession with promoting the reproduction of more “genetically desired” people and eliminating “genetically defective” individuals. Under this worldview, Nazis first forced those with Huntington’s disease to be sterilized and later murdered them in extermination facilities.⁸⁹ The United States also has a history of forced sterilization based on supposed genetic defects.⁹⁰ This history has led to broad social protections for those with genetic conditions, and suggests that in the health, life, and disability insurance domain, insurers’ use of genetics would raise strong concerns about illicit discrimination on the basis of socially suspect categories.⁹¹

At the same time, the adverse selection prong of our model is also relevant to assessing prohibitions on insurers’ use of genetic information. This fact largely explains why genetic discrimination is treated so differently in health insurance, on the one hand, and life and disability insurance, on the other hand. As was explained in the previous section on

⁸⁹ Thomas Lemke, “A Slap in the Face”. *An Exploratory Study of Genetic Discrimination in Germany*, 5 GENOMICS, SOC’Y & POL’Y 22, 29 (2009).

⁹⁰ Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, § 2(2), 122 Stat. 881, 882 (2008).

⁹¹ Standing on their own, illicit discrimination arguments are not persuasive in explaining the differential treatment of genetic discrimination in health, on the one hand, and life and disability on the other. One might argue that genetic risk should be prohibited as a factor for obtaining health insurance based upon the view that adequate health insurance is a “right.” While this argument may contribute to the differences in treatment of genetic information across insurance lines, the fact that gender and age *are* allowed to be taken into account in health insurance (as we show below), suggests that the economic impact of adverse selection is a more powerful explanation. In fact, the Genetic Information Nondiscrimination Act specifically clarifies that “[t]he term ‘genetic information’ shall not include information about the sex or age of any individual.” *Id.* at § 101(d)(6)(C).

the intensity of regulation, life and disability insurance markets are generally more susceptible to adverse selection than health insurance markets (at least with respect to the policyholder characteristics we studied). As such, while the illicit discrimination prong overwhelms the adverse selection prong in health insurance, it is unable to do so in life and disability insurance, where the efficiency argument for allowing the use of genetic information is stronger.

This argument is enhanced by the fact that adverse selection concerns about genetic information in the health insurance context are relatively muted for health insurance policies purchased in individual markets. Such policies are often only in force for a short time. Yet genetic predisposition to illness represents a long-term, and typically a probabilistic, threat. For these reasons health insurers often focus on the short-term risks of their policyholders and may not have an incentive to attempt to identify such long-term risks.⁹²

2. Cross-Line Treatment of Gender

The most striking result shown in Chart 5 is that every jurisdiction in the country expressly permits insurers to take gender into account in life insurance. Interestingly, this has not always been the case. Until the mid 1980s the picture was quite similar to that of health insurance. In particular, twenty-one jurisdictions permitted using gender compared with nineteen jurisdictions which strongly limited it and two states, Montana and North Carolina, which prohibited it. The remaining nine jurisdictions restricted its use. Every jurisdiction had some opinion on how gender should be treated, as there were not any “no-law-on-point” entries. In 1983 the Supreme Court delivered the famous decision of *Arizona Governing Committee for Tax Deferred Annuity & Deferred Compensation Plans v. Norris*.⁹³ In *Norris* the Court ruled that employers cannot use gender-based retirement tables as this was impermissible in the employment context under Title VII of the Civil Rights Act of 1964.⁹⁴ Because states became concerned that similar principles will be applied to privately provided life insurance, eventually every jurisdiction made clear that life insurers are

⁹² See Nowlan, *supra* note 85, at 195.

⁹³ 463 U.S. 1073 (1983).

⁹⁴ *Id.* at 1074.

permitted under state law to use gender-blended or gender-based mortality tables, at their discretion.⁹⁵

Besides life insurance state laws vary dramatically across coverage lines in the extent to which they allow insurers to take into account gender in classifying policyholders.⁹⁶ This is most vividly demonstrated in the domain of health insurance. As Chart 5 reveals, eighteen jurisdictions expressly permit the use of gender in health insurance, while twenty-eight jurisdictions strongly limit or expressly prohibit its use. Gender is such a prominent issue for health insurance that every jurisdiction has addressed it in one way or another – either with a general or a specific statute; in other words, there are no entries in the “no-law-on-point” column of Chart 5. Interestingly, the Affordable Care Act prohibits insurers from charging higher rates due to gender in the individual and small group insurance markets.⁹⁷

⁹⁵ See Avraham, Logue & Schwarcz, *supra* note 1, at 244 n. 140.

⁹⁶ Recently, the Court of Justice of the European Union banned insurers’ use of gender in all forms of insurance. *See* Case C-236/09, Association Belge des Consommateurs Test-Achats ASBL, Yann van Vugt, Charles Basselier v. Conseil des Ministres, 2011 E.C.R. I-800, I-817 (invalidating Article 5(2) of Council Directive 2004/113/EC of 13 December 2004 as inconsistent with the Directive’s purpose of combatting gender discrimination in insurance).

⁹⁷ *Key Features of the Affordable Care Act By Year*, U.S. DEPARTMENT OF HEALTH & HUM. SERVICES <http://www.hhs.gov/healthcare/facts/timeline/timeline-text.html> (last visited Nov. 17, 2014). Irrespective of whether this approach is “correct,” Chart 5 suggests that the Affordable Care Act can be defended on the basis that it establishes a national policy on the issue. Even though states generally have autonomy to make their own decisions about various issues, the federal government has long played a central role in regulating discrimination on the basis of gender. *See, e.g.*, 42 U.S.C. § 2000e-2(a) (2012) (prohibiting employers from discriminating on the basis of sex).

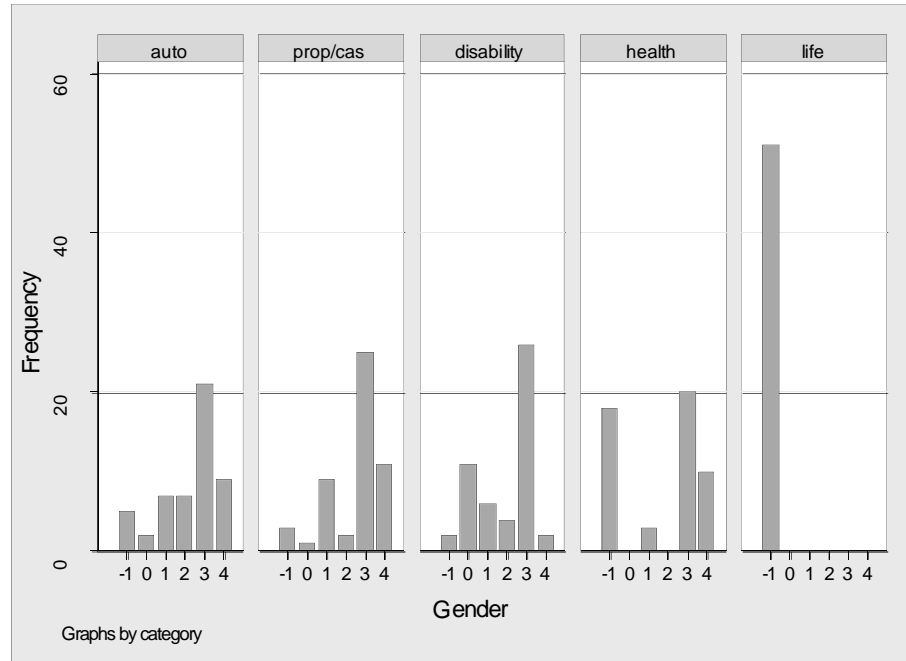


Chart 5: Distribution of States' Scores for Gender, by Insurance Line

The use of gender is both less polarized and more restricted in the other three lines of insurance. For the property/casualty line, most states are on the restrictive side of the chart, with twenty-five strongly limiting its use.⁹⁸ Not surprisingly, state laws display a similar pattern with respect to auto insurance.⁹⁹ Disability insurance is also restrictive with only Washington expressly permitting the use of gender and twenty-six strongly limiting it.

The cross-line variation in the treatment of gender substantially matches the more general cross-line variation described in Chart 2. Both overall and with gender specifically, auto and property/casualty insurance received the most restrictive scores. Similarly, life insurance received the lowest score overall with a clean -1 for all states. The only lines for which

⁹⁸ Only Maryland expressly permits the use of gender and Kansas has no law on point.

⁹⁹ Only four states (California, Delaware, Louisiana, and Maryland) permit gender's use and twenty-two strongly limit it.

gender differed from the average of all nine characteristics were health and disability. As seen in Chart 2, health insurance on average is treated more restrictively than disability insurance, but with gender the opposite is true – states are more restrictive with disability insurance and less restrictive with health insurance.

All of this suggests that the broad explanations for cross-line variation discussed above – which focus predominantly on adverse selection – can also explain the more specific pattern of cross-line variation found with respect to gender. Indeed, when looking at gender and life insurance, the differences between men and women in mortality risks are more important than is often assumed. Although the average difference in life expectancy between men and women is only several years, the difference in one's chance of dying in a given year varies greatly by gender.¹⁰⁰ Indeed, following *Norris* it was the fear of adverse selection that pushed all fifty-one jurisdictions to either issue a regulation or pass a statute (or both) in order to make clear that, if the Court were to expand its *Norris* holding to privately provided life insurance, then life insurers would have the discretion whether to use gender-blended or gender-based mortality tables.

Similarly, substantial differences exist in the expected healthcare costs of men and women due to the costs of child bearing, meaning that adverse selection also a substantial risk when gender-based classification is prohibited with respect to health insurance.¹⁰¹ While troubling on fairness grounds, this makes sense because it prevents an individual from waiting until she intends to become pregnant before enrolling in an insurance plan. If insurers cannot discriminate on the basis of gender they may have to charge higher prices to men relative to their (assigned) risk, causing them to drop out of the risk pool.¹⁰² This explanation is consistent with the

¹⁰⁰ But see Mary W. Gray & Sana F. Shtasel, *Insurers Are Surviving Without Sex*, 71 A.B.A. J. 89, 91 (1985).

¹⁰¹ One way that insurance companies prevent adverse selection in the individual market is by not including coverage for maternity costs. See NAT'L WOMEN'S LAW CTR., STILL NOWHERE TO TURN: INSURANCE COMPANIES TREAT WOMEN LIKE A PRE-EXISTING CONDITION 3 (2009), available at <http://www.nwlc.org/sites/default/files/pdfs/stillnowheretoturn.pdf> (finding that 87% of health plans in the individual market available to a 30-year-old woman do not provide maternity coverage).

¹⁰² Interestingly, this might have the opposite effect for women with no plans to become pregnant. Such women would face an even greater discrepancy between

ACA's ban on gender-based underwriting, as the risk of adverse selection is largely counteracted by the incorporation of the individual mandate in the statute.¹⁰³ By contrast, adverse selection is not a substantial risk when state laws prohibit insurers from using gender in auto or property/casualty insurance. In addition to coverage mandates and lender requirements (which are explained above), this is because gender does not appear to correlate strongly with risk in property/casualty insurance, a fact that both limits the practical effect of the law as well as the risk of adverse selection. In the automobile insurance context, where gender may arguably play a role, the expected differences in risk between men and women, once other policyholder characteristics are taken into account, may be relatively small.

To the extent that the cross line variation for gender does not match the broader patterns of cross-line variation described above, they are nonetheless consistent with our model. In particular, the fact that health insurance is more strongly regulated than disability insurance likely stems from the first prong of our model: gender has a clear predictive value in life and health insurance, and therefore it is clear why no state has left gender unregulated in these lines of insurance. In contrast, it is not clear that gender has a predictive value in disability insurance (at least after controlling for whether the insured is working and, if so, what industry he or she is working in), which may explain why ten states have left it unregulated. Prong one in the specific context of gender thus alters the usual ordering of health and disability insurance.

Our model is also consistent with the fact that gender is permitted in life insurance. Illicit discrimination arguments against gender-based discrimination in the life insurance context are comparatively less compelling than in other lines. First, while gender-based discrimination increases women's premiums for annuities, it decreases women's premiums for life insurance products, so the net actual effect is likely to be small and may even be null.¹⁰⁴ Second, the ultimate beneficiaries of life insurance products are frequently the spouse or children of the person insured, therefore, even if discrimination was prohibited and one gender was forced to pay systematically higher premiums than the other gender, it is not clear that the incidence of such a premium differential would be

their true risks and their premiums if insurers charged only women for the expected costs of child birth than if they spread this risk among women and men.

¹⁰³ See *supra* Part II.

¹⁰⁴ Most states treat traditional life insurance and annuities similarly in their risk classification regulations.

borne systematically by one gender or the other. Both of these points mean that discrimination does not systematically harm or help women, and thus that any fairness-based argument trading on the notion that gender is a socially suspect classification category is substantially weakened.

3. Cross-Line Treatment of Age

States' regulation of age-based classifications also varies substantially across insurance lines, as reflected in Chart 6. On one hand, state laws are strongly permissive with respect to insurer use of age in life and health insurance.¹⁰⁵ In life insurance thirty-nine jurisdictions permit its use and none specifically limit or prohibit it. In health insurance, thirty-six jurisdictions – more than two-thirds – permit the use of age by insurance companies, while only eleven strongly limit its use.¹⁰⁶ The ACA limits differentials in premiums based on age to no more than a ratio of three to one.¹⁰⁷ On the other hand, age is more restricted in auto and property/casualty lines of insurance. Most states are on the restrictive side of the chart in these lines, with twenty-five having only general unfair discrimination rules applying to age.¹⁰⁸ Finally, most jurisdictions do not mention age in their disability insurance laws, or only provide a general

¹⁰⁵ Chart 3 showed that age is the only characteristic that, on average, leans towards being expressly permitted for any line of coverage. This is true for both health insurance and life insurance.

¹⁰⁶ Notably, eleven jurisdictions strongly limit the use of age in health insurance (California, Idaho, Illinois, Florida, Maine, Massachusetts, Michigan, Minnesota, Pennsylvania, and Vermont).

¹⁰⁷ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2701(a)(1)(A)(iii), 124 Stat. 119, 155 (2010).

¹⁰⁸ In auto insurance, only Delaware, Louisiana, and Michigan permit the use of age, five others have no-law-on-point, and the rest are roughly equally distributed between the four restrictive categories. Even in jurisdictions that expressly prohibit the use of age, younger drivers may pay higher automobile insurance premiums if insurers are allowed to rate based on the number of years of driving experience while others that have a specific restriction may permit the use of age under certain circumstances, like if there is a proven correlation between accident rate and the characteristic. *Compare* CAL. INS. CODE § 1861.02(a)(3) (West 2008) (allowing use of the number of years of driving experience), *with* N.Y. INS. LAW § 2331 (McKinney 2000) (forbidding the state approval of auto insurance plans that consider age, gender, or marital status, “unless such filing is supported by and reflective of actuarially sound statistical data.”).

restriction.¹⁰⁹ Overall, disability insurance is another non-restrictive line of insurance with the unique fact that most states (twenty-six) do not mention anything at all.

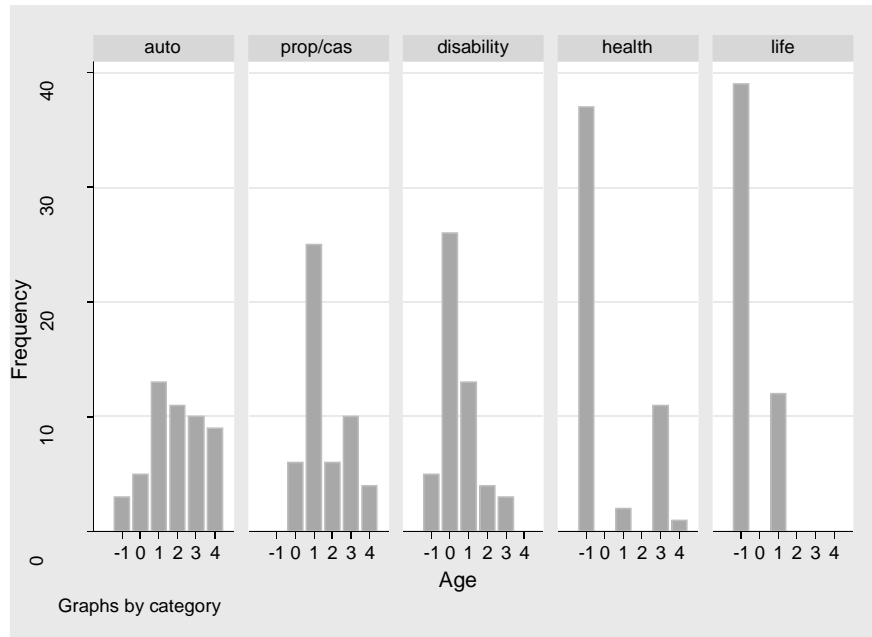


Chart 6: Distribution of States' Scores for Age, by Insurance Line

Because the patterns of cross-line variation with respect to age match the broader patterns of cross line variation, our model can explain these findings in the same way that it explains the broader cross-line variation described in Part B. But prong three of our model also helps to explain the more specific fact that state regulation of age is particularly permissive in the context of health and life insurance. Regulatory restrictions on the use of age in the context of health and life insurance would raise particularly large adverse selection concerns. This is because the magnitude of the correlation between age and death/illness is very large and very well understood by policyholders. Indeed, the connections between age, on the one hand, and the risks of illness and death, on the

¹⁰⁹ No state prohibits the use of age in disability insurance and only three states strongly limit it (Michigan, Pennsylvania, and Texas).

other, are so intuitive that many deaths and illnesses (such as dehydration) are simply attributed to “old age.”¹¹⁰

Admittedly, our model does have trouble explaining one element of the cross-line regulation of age: the lack of state law specifically regulating the use of age in disability insurance. Prong one could explain this finding if age had no predictive value in disability insurance. But this seems unlikely, although the nature of the connection between age and disability is certainly less clear than it is in the context of health, life, and auto insurance.

4. Cross-Line Treatment of Credit Score

The cross-line treatment of credit score discrimination matches the larger trends seen across all characteristics: it is most heavily regulated in auto and property/casualty and less heavily regulated in life, health and disability. Aside from demonstrating this fact, Chart 7 also shows that insurers’ use of credit score is specifically addressed by almost every state in property/casualty and auto insurance.¹¹¹ By contrast, many state laws generally do not specifically address the use of credit score in health, life, and disability insurance, where the majority of the laws are coded as either a “0” or a “1.” Where this is not the case, states explicitly permit the use of credit score, and few explicitly restrict it.

¹¹⁰ Spencer Kimball, *Reverse Sex Discrimination: Manhart*, 1979 AM. B. FOUND. RES. J. 83, 108 (1979) (“Age discrimination is so basic in life insurance and annuities that any serious challenge to it seems unlikely.”); *see also* Lea Brilmayer et al., *Sex Discrimination in Employer-Sponsored Insurance Plans: A Legal and Demographic Analysis*, 47 U. CHI. L. REV. 505 (1980).

¹¹¹ In auto insurance, the only jurisdiction that does not mention credit score is the Washington, D.C.

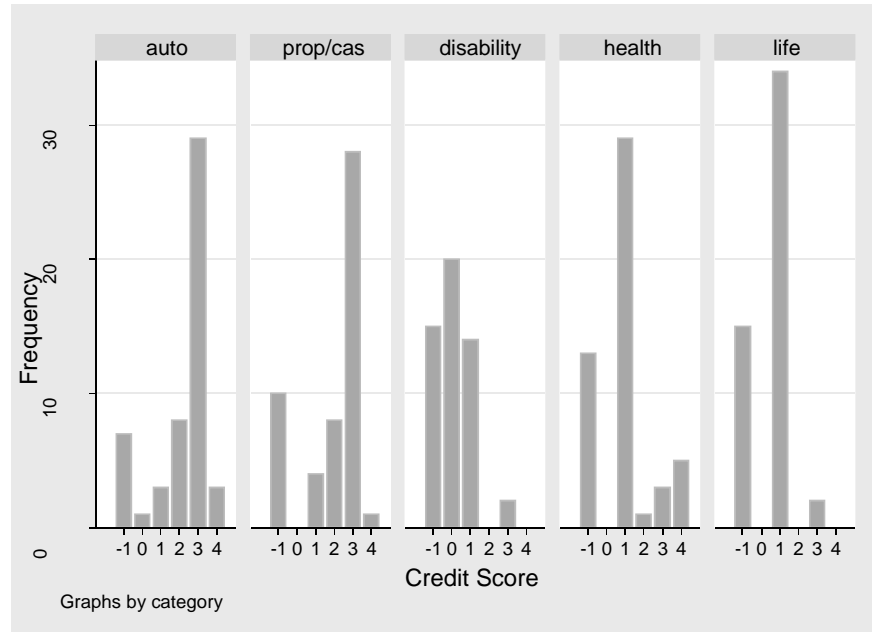


Chart 7: Distribution of States' Scores for Credit Score, by Insurance Line

Once again, these findings are broadly consistent with both general trends and our explanations for these general trends. But our model also provides some more nuanced explanation for these findings. In particular, the fact that credit score is so rarely mentioned in state laws governing health, life, and disability, but specifically addressed in auto and property/casualty, is quite consistent with prong one of our model, the predictive property. Put quite simply, credit score has repeatedly been shown to predict losses in property/casualty and auto insurance.¹¹²

¹¹² See FED. TRADE COMM'N, CREDIT BASED INSURANCE SCORES: IMPACTS ON CONSUMERS OF AUTOMOBILE INSURANCE (2007), *available at* http://www.ftc.gov/os/2007/07/P044804FACTA_Report_Credit-Based_Insurance_Scores.pdf (discussing widespread use of credit scores in auto and homeowners). The reason why, however, is not well understood. According to the National Association of Independent Insurers, at least, “people who manage their personal finances responsibly tend to manage other important aspects of their life with that same level of responsibility and that would include being responsible behind the wheel of their car or being responsible in maintaining their home.” ERIC SIEGAL, PREDICTIVE ANALYTICS: THE POWER TO PREDICT WHO WILL CLICK, BUY, LIE, OR

However, we are unaware of any research suggesting that credit score is a useful predictor of risk in other lines of insurance. Indeed, insurers in these three lines of insurance have not historically used credit information in their underwriting practices.¹¹³ Thus, there was never a need to restrict the usage of credit score in these lines.¹¹⁴

Our model also explains why the regulation of credit score in property casualty and automobile insurance tends to hover around a strong limitation (“3”) rather than a prohibition (“4”) in our data. Our second prong, the illicit discrimination property, suggests that there is a rationale for strong regulation in this domain. The core justification for regulating credit score is that it is not causally linked to risk and instead serves as a proxy for socially suspect characteristics like race and income. At the same time, adverse selection, our third prong, at least mildly pushes against the outright prohibition of credit score. The result is a strong limitation with some states explicitly prohibiting this practice.

5. Cross-Line Treatment of Race, Religion, and Ethnicity

Chart 3 above showed that race, ethnicity, and religion (the “big three”) are the most intensely restricted characteristics in every line of insurance, with sometimes a full one-point difference between them and the

DIE 83 (1st ed. 2013) (quoting David Hanson of the National Association of Independent Insurers).

¹¹³ See NAIC, CREDIT REPORTS AND INSURANCE UNDERWRITING (1997) (“As reported by the American Council of Life Insurance (ACLI) and the Health Insurance Association of America (HIAA), life and health insurers do not use credit reports of the type that are used to establish a person's eligibility for credit . . .”); Christopher Cruise, *How Credit Score Affects Insurance Rates*, BANKRATE (Sept. 23, 2003), <http://www.bankrate.com/brm/news/insurance/credit-scores1.asp> (“So far, spokesmen at the trade associations for health and life underwriters say they don't know of any of their members use credit scoring in underwriting and pricing policies . . .”).

¹¹⁴ There is some anecdotal evidence that life, disability, and health insurers may be experimenting with using credit score to rate policyholders. If so, then this suggests that states should be cautious in restricting limitations on insurance discrimination to lines in which carriers presently use the characteristic at issue. Doing so can produce unjustified discrepancies in legal restrictions if insurers' underwriting or rating patterns change.

next most restricted characteristic, namely gender.¹¹⁵ Surprisingly, though, states do not uniformly prohibit insurers from using race, religion, and ethnicity, a fact we explore at length in related work.¹¹⁶ For present purposes, the key issue is the variation in states' regulation of the "big three," which resembles the broader cross-line trends: property/casualty insurance is the most restrictive line of insurance, then auto, health, life and lastly disability insurance.

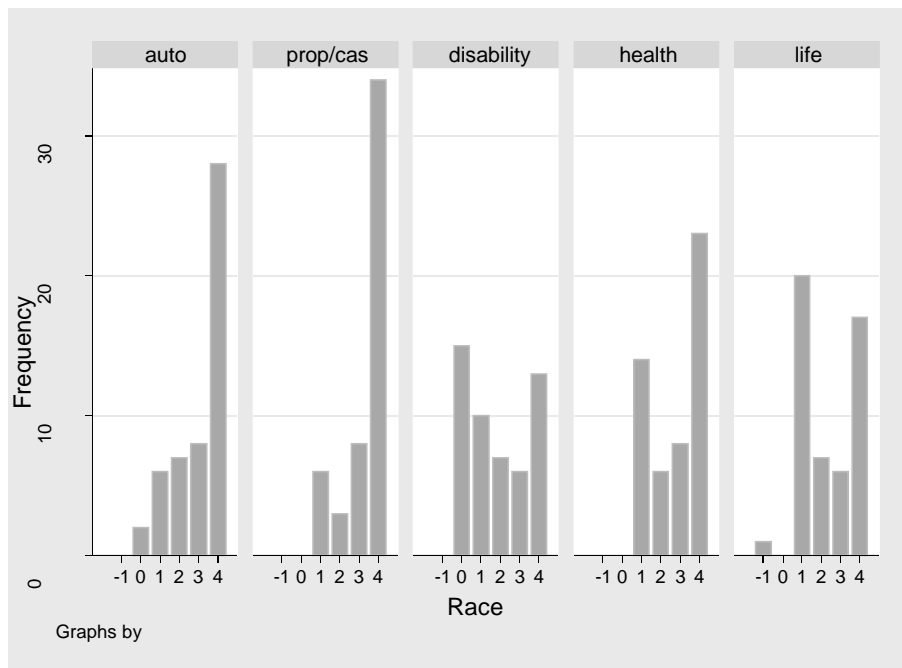


Chart 8: Distribution of States' Scores for Race, by Insurance Line

¹¹⁵ Interestingly, the prohibition on using religious affiliation is stricter on average than the prohibition on using race or ethnicity. *See supra* Chart 3.

¹¹⁶ *See* Avraham, Logue & Schwarcz, *supra* note 1.

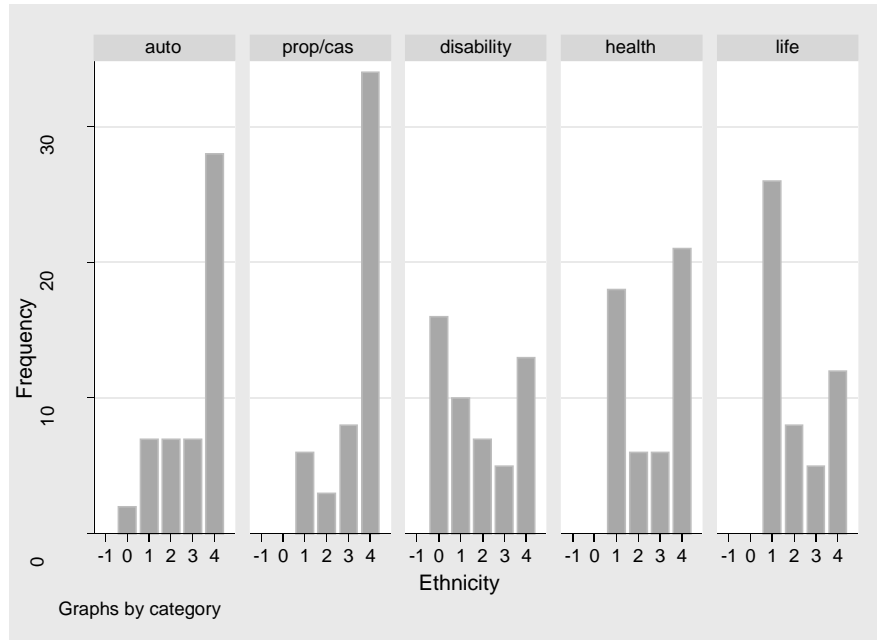


Chart 9: Distribution of States' Scores for Ethnicity, by Insurance Line

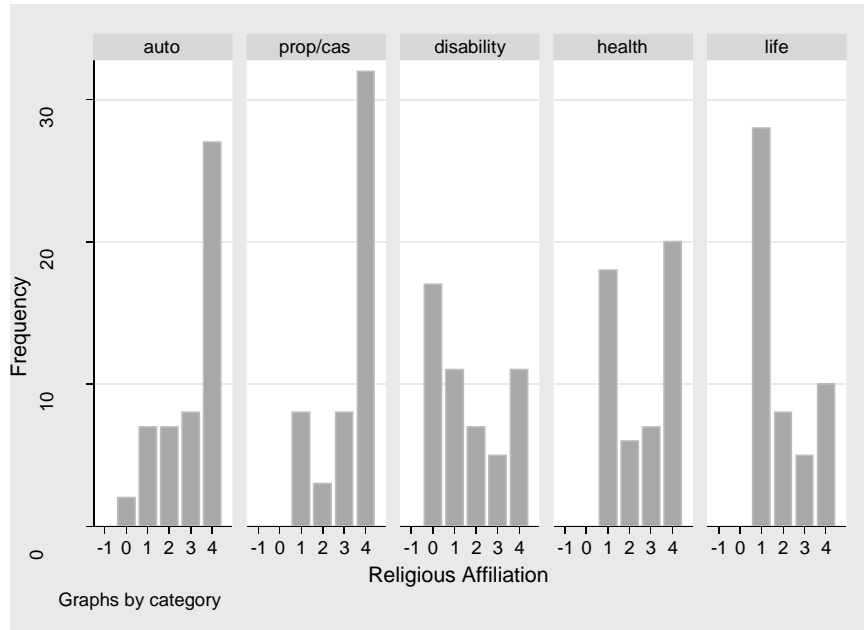


Chart 10: Distribution of States' Scores for Religion, by Insurance Line

At least with respect to the big three, however, we think that the best explanation for this pattern is not the adverse selection property, which was the principal explanation we offered for cross-line variation that was no trait specific. Instead, it is likely that the patterns found in each of the charts above are better explained by prong one of our model: the predictive property. There is substantial historical precedent for homeowner and automobile insurers using race, or proxies for race, ethnicity, and religion in their underwriting.¹¹⁷ By contrast, there is much less historical precedent for race, ethnicity, or religion ever been used in health, life, or disability insurance, and it is not immediately clear that these factors would offer much predictive value to insurers even if they were to use them.¹¹⁸

¹¹⁷ See, e.g., J. Gabriel McGlamery, Note, *Raced Based Underwriting and the Death of Burial Insurance*, 15 CONN. INS. L. J. 531, 538–39 (2009).

¹¹⁸ The one exception was industrial life insurance, which amounts to a form of burial insurance. For years this insurance was classified according to race, which apparently was never considered illegal, but the practice died out some thirty years ago. *Id.* at 531, 538–39.

If at all, the question is why not *every* state in the country *prohibits* the use of race, ethnicity, and religion. In other words, why do some states just limit the use of race? In our previous article we offered a number of theories. Perhaps state regulators and their constituents are under the impression that federal law already bans the use of these characteristics. Or, maybe state legislatures that have not adopted bans for the big three are of the view that insurers have stopped using race, ethnicity, and religion already and thus that a law prohibiting their use would simply be unnecessary.

We are still left with a puzzle though: why do state insurance anti-discrimination laws impose stiffer restrictions on the use by insurers of the “big three” in auto and property/casualty insurance than they do for health, life, and disability. As in the case of credit score above, we believe that adverse selection does not provide an adequate answer. Even if these characteristics have predictive value for health, life, or disability insurance, unlike the case of credit score, none of these lines actually permits taking these characteristics into account. We therefore believe that the best explanation is that these characteristics clearly fall under the general restrictions rules (coded as 1), which explains the low average score.

6. Cross-Line Treatment of Zip Code

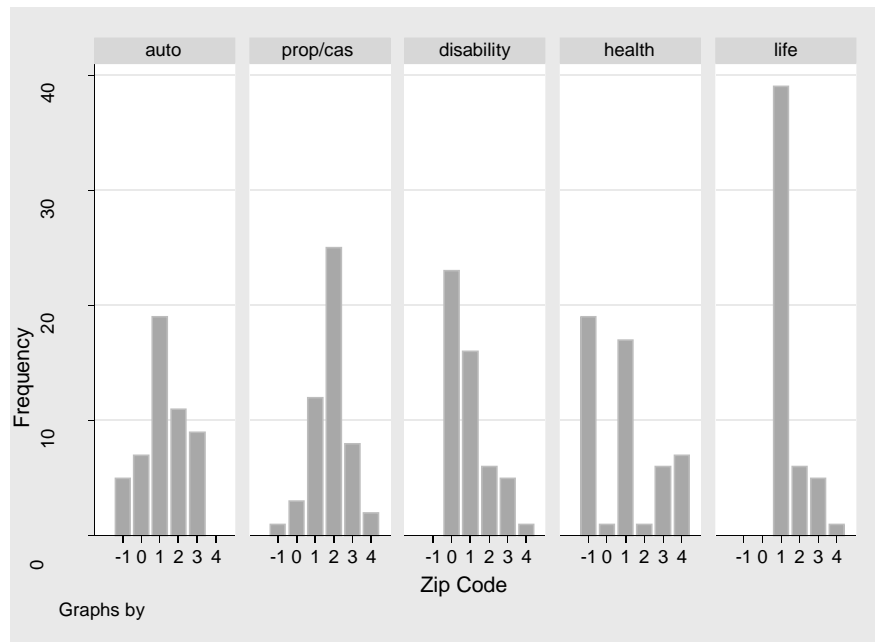


Chart 11: Distribution of States' Scores for Zip Code, by Insurance Line

States' regulation of discrimination on the basis of policyholder zip code varies along the same lines that generic antidiscrimination rules vary across lines: it is regulated most restrictively in property/casualty insurance and least restrictively in health and disability insurance. Chart 11 demonstrates this fact, while revealing that state laws specifically mentioning zip code are much more common in auto, property/casualty, and health insurance than they are in life and disability insurance. Chart 11 also shows that almost twenty states explicitly permit health insurers to classify policyholders' risks based on their zip code, compared with only five states which permit it in automobile insurance, and only one in property/casualty insurance.

Once again, these results are consistent with our model. First, the fact that state law specifically mentions zip code much more frequently in health, property/casualty, and auto than in disability and life insurance is consistent with prong one of our model. Zip code has clear predictive value in the lines where states tend to regulate it. Thus, zip code is quite

relevant to health insurance risk, as there is substantial geographical variation in the general cost level of medical services in different geographic area.¹¹⁹ Zip code also has predictive value for property/casualty insurance because it can provide information about the risk of fire, the likelihood of theft, the cost of rebuilding, and numerous other factors that are constitutive of a homeowner's risk.¹²⁰ Similarly, zip code can help predict auto policyholders' risk because it provides information about traffic patterns, density, and risk of loss.¹²¹ Indeed, the vast majority of states do not leave zip code unregulated in auto insurance. Therefore the first prong of our model is helpful in explaining the variation in zip code regulations. By contrast, it is unclear whether zip code has any capacity to predict risk for disability and life insurance (at least once other underwriting factors are used).¹²²

As for the disparate treatment of zip code for health insurance, on the one hand, and automobile and property/casualty insurance on the other, this too is consistent with our model. The relatively strong restrictions on using zip code in automobile and homeowners insurance stems from the fact that commentators and consumer groups have argued that zip codes are, or in the past have been, used by insurers as proxies in the home and auto insurance context for socially suspect characteristics, such as race. Although the same concern might apply in the health insurance domain, adverse selection pushes in the opposite direction given the large geographical variation in the costs of health care. The magnitude of that variation makes adverse selection a much larger threat in health insurance than in home or auto insurance.¹²³

¹¹⁹ *Understanding of the Efficiency and Effectiveness of the Health Care System*, DARTMOUTH ATLAS OF HEALTH CARE, <http://www.dartmouthatlas.org/> (last visited Nov. 21, 2014).

¹²⁰ The ISO (Insurance Services Office) evaluates public fire protection capabilities. See *ISO's Public Protection Classification (PCC) Program*, ISO MITIGATION ONLINE, <http://www.isomitigation.com/ppc/0000/ppc0001.html> (last visited Nov. 21, 2014).

¹²¹ David Lazarus, *ZIP Code Still a Factor in Auto Insurance*, L.A. TIMES (Apr. 6, 2008), <http://www.latimes.com/business/custom/yourmoney/la-fi-lazarus6apr06,0,693725.column?page=2>.

¹²² We note that mortality and disability rates should also depend on crime rates and accident rates, both of which depend on zip code.

¹²³ See *supra* Part II (discussing adverse selection).

7. Cross-Line Treatment of Sexual Orientation

As Chart 12 shows, the most restrictive line with respect to sexual orientation is health, followed by life insurance. By contrast, sexual orientation is less regulated in auto, property/casualty, and disability insurance, with many states having a no-law score with respect to sexual orientation.

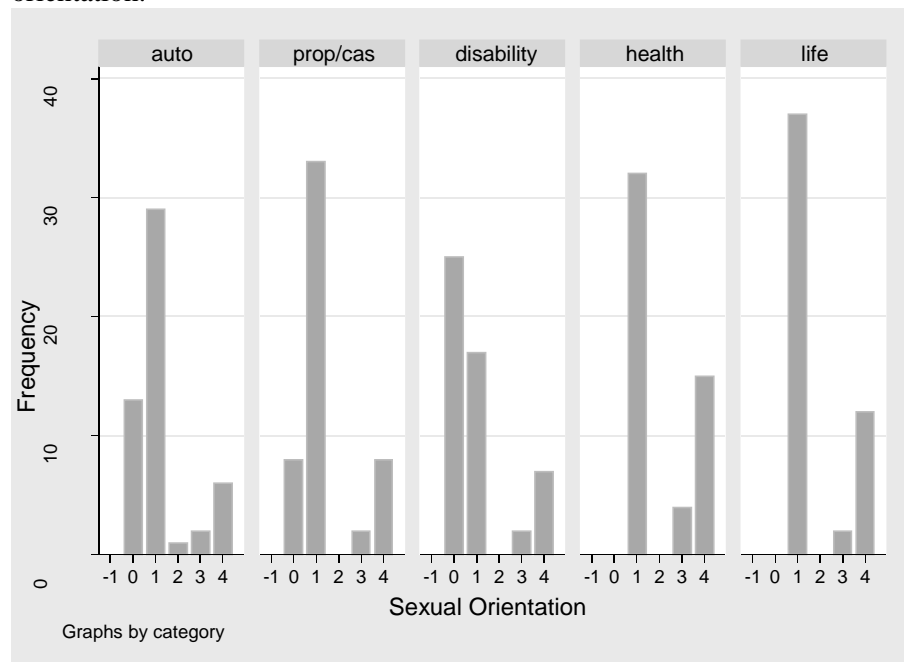


Chart 12: Distribution of States' Scores for Sexual Orientation, by Insurance Line

Once again, these results are largely consistent with our model. First, it is quite clear that sexual orientation has currently no predictive power with respect to auto, prop/casualty, and disability. This explains why a number of states in these lines of insurance have no law on point (our first prong). By contrast, at several points in recent history sexual orientation was perceived to have predictive power with respect to healthcare costs and an increased mortality rate via its perceived association (whether empirically proven or not) with AIDS. This explains why all states in health and life insurance chose to regulate it. Second, sexual orientation has over the past decades become recognized as

deserving protection against discrimination, as discussed above.¹²⁴ Thus, there is a strong fairness based argument that sexual orientation should not be used in the lines where it does have perceived predictive power: life and health insurance. Third, the number of individuals who actually are gay and have AIDS is quite small relative to the aggregate pool of policyholders. As a result, prohibiting discrimination on this basis is unlikely to cause any substantial amounts of adverse selection costs.

V. CONCLUSION AND NORMATIVE IMPLICATIONS

Insurance regulations governing permissible forms of discrimination vary among states, characteristics, and lines of coverage. This Article demonstrates that a tremendous amount of this variation can be explained by a simple three-pronged model that emphasizes the predictive value of a characteristic in a particular line, the extent to which that characteristic is socially illicit, and the risk that limiting discrimination on the basis of that characteristic will result in adverse selection.

Although this Article is primarily descriptive and empirical, it also may have important normative implications by helping to give meaning to a central, but largely under-developed and rarely employed, principle in insurance law. That principle – that insurers cannot engage in “unfair discrimination” – was a primary element of the modern origins of insurance regulation.¹²⁵ Yet specific applications of this prohibition, either by regulators or through the judicial system, have been sporadic and haphazard. This is ironic, in light of this Article’s finding that state laws regulating discrimination in insurance reflect a relatively limited and consistent set of principles that can easily be extended to a wide range of different forms of discrimination.

The existence of a consistent set of insurance anti-discrimination principles can, and should, empower courts and regulators to supplement specific statutory prohibitions with “unfair discrimination” in insurance where the implicit model suggests this would be appropriate. To understand why, it is important to appreciate that each of the elements of the general model we uncover can evolve quickly over time. For instance, insurers’ methods for discriminating among policyholders are subject to constant innovation, which is driven by the profits that private insurers can derive from “skimming” good risks from their competitors. Obesity, for

¹²⁴ See *supra* Part IV.A (charting discrimination based on sexual orientation).

¹²⁵ Leah Wortham, *supra* note 11, at 385.

example, might become a new subject of insurance discrimination. Similarly, whether or not prohibitions against particular forms of discrimination will generate meaningful adverse selection depends on changing market dynamics, such as elasticity of demand and risk differentials among policyholders in a particular state. Finally, state norms regarding what constitutes illicit discrimination are themselves constantly evolving, though this type of change (standing alone) may well be at a pace that legislative, rather than regulatory or judicial, responses would be appropriate.

Given the potential for swift changes in each of the relevant elements of the basic components of the implicit model that seems to define the contours of state anti-discrimination law, state legislation will often be too slow to identify emerging forms of unfair discrimination. It is likely for this very reason that legislators enact both specific and more general laws governing anti-discrimination in insurance. At varying points in time, states prohibit specific forms of insurance discrimination, based on current insurer practices, insurance market realities, and social norms. Prohibitions against insurance discrimination on the basis of race or ethnicity are obvious examples. At the same time, states enact, or maintain, broad prohibitions against “unfair discrimination,” which empower regulators and courts to be more responsive to changing insurer practices, market conditions, and social norms. Such statutes reflect, in other words, state legislature’s farsighted understanding that the relevant conditions for identifying “unfair discrimination” in insurance are constantly changing.

This division of labor among the branches of government provides the conceptual connection between the principles (the three-prong model) that underlie state insurance anti-discrimination law and the framework that should guide commissioners and courts alike in applying prohibitions against “unfair discrimination.” By interpreting prohibitions against “unfair discrimination” according to the three-prong model this Article describes, courts and regulators apply broad social understandings underlying insurance anti-discrimination norms to ever-changing practices, markets and norms.

Consider one example of how this might work in practice. Recently, the Colorado Division of Insurance released a bulletin informing health insurers that discrimination against policyholders on the basis of sexual orientation violated state laws against unfair discrimination.¹²⁶ This

¹²⁶ See Colo. Div. of Ins. Bulletin, *supra* note 13.

type of action is perfectly consistent with the larger model we uncover in this Article. First, the Department's action was triggered by information suggesting that certain health insurers were discriminating among policyholders on the basis of sexual orientation suggesting that in the eyes of these health insurers sexual orientation is a predictor of costs. Second, prohibiting such discrimination would be extremely unlikely to generate adverse selection, as differentials in health care usage among people with different sexual orientations are unlikely to be particularly large. Third, emerging norms in Colorado and elsewhere increasingly consider discrimination against individuals on the basis of sexual orientation to be illicit. Taken together, these factors suggest that Colorado's application of its prohibition against unfair discrimination to the specific case of discrimination against gay people in health insurance reflects broad social understandings of "unfair discrimination" in insurance.

Ultimately, then, our model provides a consistent and workable framework for breathing life into the largely dormant prohibition against unfair discrimination. Not only that, but it suggests the need for doing precisely that, as the very features that help define unfair discrimination as a descriptive matter are capable of changing swiftly, thus necessitating a more nimble form of regulation than that which can be provided by the slow and difficult process of passing state legislation pertaining to specific forms of insurance discrimination. Finally, the model is itself grounded in implicitly shared understandings among the states regarding what types of discrimination are permissible in the insurance domain.

REINSURANCE AS GOVERNANCE: GOVERNMENTAL RISK MANAGEMENT POOLS AS A CASE STUDY IN THE GOVERNANCE ROLE PLAYED BY REINSURANCE INSTITUTIONS

MARCOS ANTONIO MENDOZA¹

Scholars have eloquently detailed the “Insurance as Governance” concept, the potential capacity for reinsurer regulatory influence on insurers, and the many aspects under which these theories may arise. This Article takes the next step in analyzing the complex reinsurer-insurer relationship through empirical research into how carriers are actually influenced by reinsurers, and what effect this has on the parties.

As a case study in the governance role played by reinsurance institutions, this Article organizes survey interview responses of senior officials in the governmental entity self-insured risk management pool sector into four distinct discussion areas: (i) how reinsurers influence pools in general and in the key areas of underwriting, claims, and finance/solvency; (ii) the duty of utmost good faith and its effect; (iii) the level to which pools afford accommodation to reinsurers; and (iv) whether reinsurer influence varies based on pool circumstances, or external factors. While analysis of the data collected showed varying degrees of regulation or governance by reinsurers, the Article concludes that not only does a form of reinsurance influence or ‘governance’ clearly exist in the largely unregulated world of self-insured pools, whether characterized as direct, indirect, or regulatory in nature, but also that the governance effect is an open and recognized influence that is accepted by the pools.

¹ B.A., Baker Univ., 1986; J.D., Washburn Univ. Sch. of L., 1989; LL.M. (Insurance Law, with Honors), Univ. of Conn. Sch. of L., 2014. I would like to thank my family, loved ones and friends for their encouragement in the completion of this paper. I especially want to thank my father, Manuel, a lawyer, and my mother, Margot, for the sacrifices they made and the love they showed, and my sisters—Lisa, a lawyer, and Noëlle, an insurance claim adjuster—for their support of my endeavors, all these many years. I also want to thank sincerely Professors Thomas O. Farrish and Patricia A. McCoy for being so kind with their time and insight; without their assistance, this paper would have not materialized. Above all, to my wife, Celina. The author can be contacted at Marcos.Mendoza@tasb.org.

I. INTRODUCTION

This Article will discuss, as part of the ‘insurance as governance’² debate, to what degree reinsurers can ‘govern’ or ‘regulate’ insurers. Professor Aviva Abramovsky first addressed the impact of reinsurers on insurers in *Reinsurance: the Silent Regulator?*,³ indicating that reinsurers had a potential contractual influence on the insurance industry, therefore reinsurers must be part of the regulatory discussion.⁴ While Professor Abramovsky outlined the potential impact of reinsurers on insurers quite well, it is important to hear from industry officials themselves to confirm the existence of any contractual influence rising to the point of a governance or regulatory role.⁵ Since there are many complex issues in the reinsurer-insurer relationship, this Article’s focus will be to answer how the carriers are actually influenced by reinsurers, and what effect this has on the parties.

Evidence gathered for this Article from senior officials in the governmental entity risk management pooling industry, carriers that are largely unregulated by insurance departments in most states, indicated varying degrees of regulation or governance by their reinsurers. However, this governance operates in the foreground, with the open acknowledgment of both pool and reinsurer, much like a homeowner and their neighborhood association. Overall, it is beneficial for both the reinsurer and the insurer.

This Article will examine:

- In Part II, Background—the history of self-funded pooling and typical legal construction; an overview of reinsurance operative concepts;⁶ the basic theories of insurance and reinsurance as governance; and the overview of this original research;

² ‘Governance’ is defined as “controlling, directing, or regulating influence; control, sway, mastery.” THE COMPACT EDITION OF THE ENGLISH OXFORD DICTIONARY 1181 (18th ed. 1979). ‘Regulating influence’ and ‘sway’ will be the focus of this Article.

³ Aviva Abramovsky, *Reinsurance: The Silent Regulator?*, 15 CONN. INS. L.J. 345 (2009).

⁴ *Id.* at 405.

⁵ The second part of Prof. Abramovsky’s premise, that reinsurers must be discussed as part of the insurance regulatory process because of their regulatory-type influence, is outside the scope of this Article.

⁶ Abramovsky, *supra* note 3, at 350–75, has a more detailed overview of the reinsurance process.

- In Part III, Research Survey Methodology—a brief review of how the survey was conducted and the participants chosen;
- In Part IV, Survey Results—the distinct influences of reinsurance on pools, the effect of utmost good faith, the accommodation of pools, and factors affecting reinsurer influence; and
- In Part V, Conclusion—how reinsurers create the governance effect.

II. BACKGROUND

To frame the discussion accurately, Part II first outlines the history of governmental entity pools, including the Texas model as an example. Second, it provides an overview of reinsurance concepts. Finally, Part II discusses the basic theories of insurance and reinsurance as governance.

A. BRIEF HISTORY OF GOVERNMENTAL ENTITY POOLS AND THE TEXAS MODEL

Governmental entity pools, which are self-funded cooperatives, operate as ‘insurance’ carriers for most governmental entities today, and are largely not subject to states’ regulation.⁷ Although they are not considered insurance, these pools extend nearly identical coverage through similar underwriting and claim activities, as well as provide other risk management services. Though pools are a small segment in the insuring market in terms of capital, their history shows that pools have a growing impact in that market.

The relatively short history of pooling in the United States gives a perspective of how pooling became a viable risk management alternative for governmental entities. Pooling has been defined as “. . . a risk financing mechanism whereby a group of public entities contribute to a shared fund that in turn pays claims for and provides service to the participating entity.”⁸

⁷ Even in states where pools are generally unregulated by their insurance department, like Texas, certain lines of coverage may be individually regulated by statute; e.g., for political subdivision pools regarding workers’ compensation, TEX. LAB. CODE ANN. §§ 504.001 *et. seq.* (West 2006).

⁸ Harold Pumford, Address at the 2012 AGRiP Spring Conference (Mar. 5, 2012). A related PowerPoint presentation is available from AGRiP, *available at* <http://www.agrip.org>.

The Governmental Accounting Standards Board #10 describes it as:

A cooperative group of governmental entities joining together to finance an exposure, liability, or risk. Risk may include property and liability, workers' compensation, or employee health care. A pool may be a stand-alone entity or included as part of a larger governmental entity that acts as the pool's sponsor.⁹

In other words, when two or more independent public entities wish to share risk, they may do so by forming a pool, rather than independently going to the market to obtain coverage.

Pools are both risk-finance and risk-transfer mechanisms. The member entities of the pools transfer their exposures (minus a deductible) to the pool, sharing with other entities in the pool the transfer of related risks.¹⁰ The services (underwriters, claim operations, loss prevention/risk management, reinsurance purchasing) are provided by the pool, or by third parties retained by the pool.¹¹ Pools do not issue an insurance policy, but a similarly functioning document called a 'plan document' or 'coverage agreement' that is a contract for coverage between the member entity and the pool. Under the agreement, the pool will indemnify the member based on the terms and conditions of the coverage agreement in exchange for a 'contribution,' rather than a 'premium.'¹² These coverage agreements operate essentially like insurance policies, with coverage terms, exclusions, exceptions to exclusions, coverage territories, and coverage periods.¹³ These agreements typically have coverage for general liability, professional liability, auto liability, property, and workers compensation, utilizing both claims-made and occurrence-based agreements.¹⁴

⁹ Gov'tal Acct. Stds. Bd., *Statement No. 10 of the Governmental Accounting Standards Board*, in GOVERNMENTAL ACCOUNTING STANDARDS SERIES 49 (Nov. 1989).

¹⁰ Jason E. Doucette, Note, *Wading Into the Pool: Interlocal Cooperation in Municipal Insurance and the State Regulation of Public Entity Risk Sharing Pools—a Survey*, 8 CONN. INS. L.J. 533, 537 (2002) (hereinafter Doucette).

¹¹ *Id.*

¹² *Id.*

¹³ *Id.* at 537–38.

¹⁴ General liability, auto liability, property, and workers compensation coverages are typically occurrence based, while professional liability is typically

Pools have many advantages over insurers for their members. They tend to protect their members from cyclic insurance rates,¹⁵ offer loss prevention services, offer savings (as they are non-profit organizations and do not lose funds through broker fees), and have focus and expertise in governmental entities not often found in insurers.¹⁶ However, pools' typical disadvantage for their members is that they are generally unregulated. Therefore, their only duties are those outlined in the coverage agreements with their members, and they are not generally subject to prompt payment acts, bad faith claims, or penalties.¹⁷

Self-insured governmental pooling has its roots in the United States in 1974 after the Texas legislature allowed entities to form pools to self-insure.¹⁸ During this period, public entity officials in all states had concerns

claims-made based. Occurrence based relies on the date of the occurrence for determining coverage, while claims-made depends on the date the claim is made and reported to the carrier.

¹⁵ George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1529–39 (1987), has an excellent discussion of market cycles and their causes.

¹⁶ Yuhua Qiao, *The New Generation of Public Risk Pools: What Is New?*, 1–2 (on file with author).

¹⁷ It is the author's experience that this tends to be mitigated because pools have limited markets and therefore inherently attempt to service members promptly to maintain their member base. Most operational charters limit the potential membership, so even though a pool has a potential market of 1000 or more members, it is still quite a finite number compared to markets for insurers. Even if entities sign an interlocal agreement it usually does not obligate them to be *in* the pool—it just gives them the option to be in the pool if they pay their annual contribution, so high levels of service are inherently necessary to keep members. See, e.g., App. D. The member potentially may go in and out of the pool in various lines of coverage. *Infra* App. D, ¶¶ 2, 3, and 4. However, most pools are organized so the governing boards are comprised of members' representatives. Doucette, *supra* note 10, at 538. This board representation gives pool members direct input as to policy.

¹⁸ The author has found no evidence of a pool's formation prior to January 4, 1974, when the Texas Association of School Boards, Inc., legally formed the TASB Workers' Compensation Self-Insurance Fund, although several pools claim senior status. The formation documents are on file with TASB, Inc. The TASB WCSIF merged into the TASB Risk Management Fund in 1997. *History and Mission*, TASB RISK MGMT. FUND, <https://www.tasbrmf.org/About/History-and-Mission.aspx> (last visited Dec. 27, 2014). While California may claim precursor legislation since 1949 regarding the ability of municipalities to act jointly, risk

that the insurance industry was charging excessive premiums when compared to the exposures,¹⁹ and that coverage and services developed for the private sector did not adequately address public needs.²⁰ The core reason for the actions taken by the insurance industry was the view that, due to the loss of many governmental immunities throughout this time period, insurers had to increase premiums for governmental entities and limit coverage for ordinary governmental activities, such as providing parks and swimming pools. This led to a choice for governments: pay the higher premiums for insurance, potentially limiting services and raising taxes, or forgo insurance to self-insure, risking bankruptcy from large judgments.²¹ Self-insuring was especially difficult for smaller local governments, since the government's local tax base was the source of income. Lacking a sufficiently broad tax base, a small government was in the difficult position of being unable to afford coverage, as well as lacking the ability to pay any large judgments, should it go uninsured.²²

Pools began their operations by capitalization through member deposits or bond issues; some were not capitalized at all.²³ Coverage was the initial and primary concern for the governmental entities, but these pools also developed loss prevention programs for their members. Public agencies traditionally viewed insurance buying as little more than fulfilling a requirement of a government code, and it was rare for a carrier to offer loss prevention services for a public risk.²⁴

Risk pool professionals formed industry associations to assist in the development of this new industry. The Public Risk Management Association's (PRIMA)²⁵ section on pooling formed in 1978, and

pooling itself was not authorized in California until 1975. Doucette, *supra* note 10, at 547. Texas prevails, as usual.

¹⁹ See generally James R. Hackney, Jr., Note, *A Proposal for Funding Municipal Tort Liability*, 98 YALE L.J. 389 (1988).

²⁰ See generally Karen Nixon, *Public Entity Pooling—Built to Last* (2011), <http://www.cajpa.org/documents/Public-Entity-Pooling-Built-to-Last.pdf>.

²¹ See Hackney, *supra* note 19, at 389.

²² Doucette, *supra* note 10, at 534–35 (citing Louis P. Vitullo & Scott J. Peters, *Intergovernmental Cooperation and the Municipal Insurance Crisis*, 30 DEPAUL L. REV. 325, 334) (1981)).

²³ Nixon, *supra* note 20, at 1.

²⁴ *Id.* at 2.

²⁵ The Association's mission is to promote effective risk management in the public interest as an essential component of public administration. See *Strategic*

eventually spun off to become the Association of Governmental Risk Pools (AGRiP) in 1998.²⁶ State insurance regulators, however, were slow to react, and most chose not to assert any regulatory authority over what was largely viewed as self-insurance. While the National Association of Insurance Commissioners²⁷ eventually began an effort in 1991 to determine if model regulations were needed for pools, this effort was eventually abandoned.²⁸

While the complete history of pooling—its rise during the 1980s and 1990s, and the insurance industry’s coincident struggles during the same period—is outside the scope of this Article,²⁹ pools continued to grow and take market share because insurers were unwilling or unable to fill the needs of increasingly exposed governmental entities. During this period of tort excesses, subsequent tort reform and market instability, insurers lost a great deal of the commercial market insureds, including governmental entities, to alternative forms of risk transfer.³⁰ Policyholders formed captive

Plan, PUBLIC RISK MGMT. ASS’N, <http://www.primacentral.org/content.cfm?sectionid=9> (last visited Dec. 27, 2014).

²⁶ Nixon, *supra* note 20, at 2. AGRiP is a national organization and independent trade organization representing public entity pools. AGRiP’s vision statement and organizational mission is: “As the recognized authority on and resource for information on intergovernmental pools, AGRiP is the leading national association for pool management. As a result of our efforts, the pooling community is united to achieve excellence in pool governance, management and services.” *What Is AGRiP?*, ASS’N OF GOV’TAL RISK POOLS, <http://www.agrip.org/whatisagrip> (last visited Dec. 27, 2014).

²⁷ The National Association of Insurance Commissioners is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. *See generally* NAT’L ASS’N OF INS. COMM’RS, <http://www.naic.org/> (last visited Dec. 27, 2014). While the NAIC sets standards for states to follow voluntarily, it has no inherent regulatory authority. However, it does have a great deal of influence in the insurance industry.

²⁸ Doucette, *supra* note 10, at 543 (citing the Nat’l Ass’n of Ins. Comm’rs, 1992 Summer National Meeting, Executive Committee 10, *70–71, Lexis 1992-2 NAIC Proc. 10).

²⁹ *But see* Doucette, *supra* note 10, at 543; *see also* Priest, *supra* note 15; *see generally* Nancy Blodgett, *Premium Hikes Stun Municipalities*, 72-JUL A.B.A. J. 48 (1986); Kenneth Abraham, *The Rise and Fall of Commercial Liability Insurance*, 87 VA. L. REV. 85 (2001). These papers give a fascinating look at the various causes of the insurance crisis, and show how legislatures, regulators, and the judiciary played respective roles during this time.

³⁰ Abraham, *supra* note 29, at 99–102.

insurers, risk retention groups and pools to provide themselves coverage.³¹ These vehicles allowed them to deal directly with the reinsurance market through the closely controlled pools, allowing governmental entities risk diversification services without the need (or cost) of conventional commercial general liability policies as an intermediary.³² The governmental entity business lost by the commercial market during these years never returned, as the entities learned during this insurance crisis they did not need to rely on the insurance market.³³ Furthermore, because of the skyrocketing premiums,³⁴ governmental entities came to distrust insurers; as a result, the alternative market of pooling increased its percentage of the market in the ensuing years.³⁵

There are approximately 91,000 distinct governmental entities currently operating in the United States, including counties, cities, school districts, townships and special districts.³⁶ Approximately 500 pools are now in existence providing coverage, in some form, for approximately 75,000 of those 91,000 governmental entities.³⁷ Pools have differing administrative operations—39% of pools have their own employees, 35% are staffed by third party administrators of varying sizes and 26% are administered by association employees.³⁸ Pool staffs are small compared with those of insurers: of pools with their own employees, 37% have a staff of five or less, 26% have more than 20 employees, 21% have 11-20 employees, and 16% have 6-10 employees.³⁹ Annual contributions (premiums) by members to their U.S. pools are estimated to be 13 to 17 billion dollars.⁴⁰ The pooling industry, while small compared to the main line insurers, is a substantial sector of the insurance market.⁴¹

³¹ *Id.* at 101–02 (citing Priest, *supra* note 15).

³² *Id.* at 102.

³³ *Id.*

³⁴ *Id.* at 99.

³⁵ *Id.* at 102.

³⁶ Pumford, *supra* note 8 (citing 2007 U.S. Census statistics stating that the special districts include health and hospital districts, airport authorities, port authorities, and utility districts).

³⁷ *Id.*

³⁸ Nixon, *supra* note 20, at 3 (using 2009 AGRiP data).

³⁹ *Id.*

⁴⁰ Pumford, *supra* note 8.

⁴¹ For a more negative view of pooling versus insurance companies or pools, such as the Missouri Public Entity Risk Management Fund, which operate more

Since laws vary throughout the United States and a survey of the states' pooling laws is beyond the scope and focus of this Article, Texas statute and case law will be used to assist in the initial understanding of the legal organization and operation of pools. Most states are similar to Texas in that they have little or no regulation of pools since they are not considered insurance carriers by statute or case law.⁴² For the purposes of this discussion, their organization is not as relevant as is the cause and effect of reinsurance. But, for those unfamiliar with pooling, here are the basic legal constructs.

Local governments⁴³ that join in a common purpose⁴⁴ under the Texas Interlocal Cooperation Act⁴⁵ may self-insure against claims.⁴⁶ In

like insurers, see generally Thomas W. Rynard, *The Local Government as Insured or Insurer: Some New Risk Management Alternatives*, 20 URB. L. REV. 103 (1988).

⁴² E.g., *City of S. El Monte v. So. Cal. Joint Powers Ins. Auth.*, 45 Cal. Rptr. 2d 729, 732 (Cal. Ct. App. 1995). CAL. GOV'T CODE § 990.8(c) (West 2010) states "[t]he pooling of self-insured claims or losses among entities as authorized in subdivision (a) of Section 990.4 shall not be considered insurance nor be subject to regulation under the Insurance Code." See also OHIO REV. CODE ANN. § 2744.081(E)(2) (West 2006) ("A joint self-insurance pool is not an insurance company. Its operation does not constitute doing an insurance business and is not subject to the insurance laws of this state"); COLO. REV. STAT. ANN. § 24-10-115.5(2) (West 2008) ("Any self-insurance pool authorized by subsection (1) of this section shall not be construed to be an insurance company nor otherwise subject to the provisions of the laws of this state regulating insurance or insurance companies . . ."); OR. REV. STAT. ANN. §§ 731.036(4), (5) (West 2003) ("[T]he Insurance Code does not apply to any of the following to the extent of subject matter of the exemption . . . (4) Public bodies . . . that either individually or jointly establish a self-insurance fund for tort liability . . . [or] (5) Public bodies . . . that either individually or jointly establish a self-insurance fund for property damage . . ."); FLA. STAT. ANN. § 624.4622 (West Supp. 2007) (which does not subject pools to the Florida Insurance Code, other than some reporting and initial capitalization requirements).

⁴³ TEX. GOV'T CODE ANN. § 791.003(4) (West 2012) (defining "local government").

⁴⁴ TEX. GOV'T CODE ANN. § 791.001 (West 2012) ("The purpose of this chapter is to increase the efficiency and effectiveness of local governments by authorizing them to contract, to the greatest possible extent, with one another and with agencies of the state.").

⁴⁵ TEX. GOV'T CODE ANN. §§ 791.001–.033 (West 2012).

⁴⁶ *Tex. Ass'n of Sch. Bds. Risk Mgmt. Fund v. Benavides Indep. Sch. Dist.*, 221 S.W.3d 732, 733 (Tex. App. 2007).

accordance with the Interlocal Cooperation Act, Texas law permits any governmental unit⁴⁷ to establish a self-insurance fund to protect the governmental unit, its officers, employees, and agents from any insurable risk or hazard.⁴⁸ The issuance of available money for a self-insurance fund is deemed a public purpose of the governmental unit and such funds are not subject to the Texas Insurance Code and other laws of Texas relating to the provision or regulation of insurance.⁴⁹

Self-insurance funds themselves are not subject to the Texas Insurance Code pursuant to Texas case law. In *Hill v. Texas Council Risk Management Fund*,⁵⁰ the Court of Appeals held that self-insurance funds established by governmental units⁵¹ are exempt from the Texas Insurance Code.⁵² The plaintiff in this case brought suit against her employer's self-insurance fund, the Texas Council Risk Management Fund, alleging that uninsured motorist and underinsured motorist insurance should be presumed to exist in her policy because it was not rejected by her in writing as required by the Texas Insurance Code.⁵³ The Texas Council Risk Management Fund argued that pursuant to Texas Civil Statute Article 715c,⁵⁴ because the self-insurance fund was created by money available to the governmental unit, the fund was not subject to the Texas Insurance Code or any other laws relating to the provision and regulation of insurance.⁵⁵ The court agreed.

The Texas Supreme Court solidified the position of pools in *Ben Bolt-Palito Blanco Consolidated Independent School District v. Texas Political Subdivisions Property/Casualty Joint Self-Insurance Fund*,⁵⁶ in which the Texas Supreme Court decided the self-insurance fund was its own distinct governmental entity, which entitled the pool to assert

⁴⁷ TEX. GOV'T CODE ANN. § 2259.001(1) (West 2008) (defining a "governmental unit" as a "state agency or institution, local government, or an entity acting on behalf of a state agency or institution or local government.").

⁴⁸ TEX. GOV'T CODE ANN. § 2259.031(a) (West 2008).

⁴⁹ TEX. GOV'T CODE ANN. §§ 2259.032, .037 (West 2008).

⁵⁰ 20 S.W.3d 209 (Tex. App. 2000).

⁵¹ The provision cited by the *Hill* court has since been repealed but is incorporated in TEX. GOV'T CODE ANN. ch. 2259 (West 2008).

⁵² *Hill*, 20 S.W.3d at 213.

⁵³ Cited in *Hill* as TEX. INS. CODE ANN. § 5.06-1. The statute has since been repealed, but is incorporated in TEX. INS. CODE ANN. § 1952.101 (West 2009).

⁵⁴ *Supra* note 51.

⁵⁵ *Hill*, 20 S.W.3d at 212–13.

⁵⁶ 212 S.W.3d 320 (Tex. 2006).

immunity in its own right and enjoy the same immunities as the political subdivisions that comprised the pool.⁵⁷ However, even pools waive this immunity when entering into written contractual agreements, such as contracts for coverage with their own members.⁵⁸

Essentially, the legal process works as follows: two or more governmental entities decide to share risk, sign an interlocal agreement stating so, form the pool, fund the pool, and hire personnel to handle the administration of the pool.

B. OVERVIEW OF REINSURANCE CONCEPTS

Generally, reinsurance operates identically with pools as it does with insurers. Pools, like insurance carriers, obtain reinsurance for those exposures that are too great to retain. Reinsurance may be defined as a contractual arrangement under which one insurer, known as the primary insurer, transfers to another insurer, known as the reinsurer, some or all of the losses insured by the primary insurer under insurance contracts it has issued or will issue in the future.⁵⁹ The primary insurer is sometimes referred to as the ceding insurer, ceding entity, cedent, or reinsured. For consistency, the term cedent (or pool) and reinsurer will be used when referring to reinsurance situations.

In most cases, the reinsurer does not assume all of the liability of the cedent pool. The reinsurance agreement usually requires the cedent to keep a portion of the liability. This is known as the cedent's retention, and may be expressed as a dollar amount, a percentage of the original amount of insurance, or a combination of the two. There is usually an upper limit to the reinsurer's limit of liability.⁶⁰

The primary functions of reinsurance are: stabilization of the cedent's long-term loss experience; giving the cedent large line capacity; cedent financing; cedent catastrophe protection; underwriting assistance; and, allowing the cedent to retire from a territory or class of business.⁶¹

Discussing the primary functions of reinsurance in order:

⁵⁷ *Id.* at 325–26.

⁵⁸ *See id.*; *see also* TEX. LOC. GOV'T CODE ANN. § 271.152 (West 2005).

⁵⁹ 2 BERNARD L. WEBB ET AL., INSURANCE OPERATIONS 1 (2d ed. 1997).

⁶⁰ *Id.* at 1–2.

⁶¹ *Id.* at 2. Retirement from a territory or class of business is generally not relevant to pooling and will not be discussed here.

Stabilization of loss experience—A pool must have a consistent positive underwriting experience in order to increase its capital and surplus to support growth and stability of the pool. Because losses can fluctuate, sometimes widely, a major function of reinsurance is to lessen the impact of large losses through controlled spending of reinsurance premiums.⁶²

Large line capacity—There are two kinds of capacity in the property and casualty world—large line capacity and premium capacity. Large line refers to a cedent's ability to provide a high limit of insurance on a single loss exposure. A cedent may write a large line by keeping its retention within a reasonable relationship to its capital and surplus and reinsuring the balance. A competitive market environment creates the need for reinsurance;⁶³ without reinsurance, a carrier could not market to larger exposures, ceding the available market to larger carriers.

Financing—The second kind of capacity is premium capacity, which refers to the aggregate premium volume a pool can write. The common measure of capacity is expressed in terms of contribution-to-surplus ratio. This is because there is a limit to the amount of contributions a pool can write. The limit for any pool is a function of the carrier's surplus.⁶⁴ A pool is likely to be considered overextended if its net written contributions, after deduction of contributions on reinsurance ceded, exceeds its surplus by a ratio of more than three to one.⁶⁵

Catastrophe Protection—Property and casualty insurers (and to a lesser extent, workers' compensation insurers), are subject to catastrophic losses that may result in millions of dollars of claims to a single pool. The purpose of reinsurance is generally related to the purpose of stabilizing loss experience, as catastrophes are major causes of the instability.⁶⁶

Underwriting Assistance—Reinsurers deal with a wide variety and a large number of carriers. As a result, they accumulate a great deal of information regarding the experience of various cedents in certain markets.

⁶² *Id.* at 2–3.

⁶³ *Id.* at 4.

⁶⁴ Surplus is defined as the amount by which assets exceed liabilities. Int'l Risk Mgmt. Inst., Inc., *Surplus*, IRMI RISK MGMT. & INS. EDUC. & INFO., <http://www.irmi.com/online/insurance-glossary/terms/s/surplus.aspx>. (last visited Dec. 27, 2014).

⁶⁵ WEBB ET AL., *supra* note 59, at 4.

⁶⁶ *Id.* at 7.

This experience can be helpful to pools, particularly to smaller pools or carriers planning on entering new and unfamiliar markets.⁶⁷

As can be seen above, reinsurers have far-ranging functions and benefits in the marketplace.

As to the types of reinsurance, there are two basic forms: treaty reinsurance and facultative reinsurance.⁶⁸ Facultative reinsurance is purchased for a specific risk insured by a cedent, such as a particular piece of machinery.⁶⁹ Treaty reinsurance, the most commonly used reinsurance in pooling, is an agreement that binds the cedent to cede a specific portion of the risk of an entire class of business, such as all property coverage written by the cedents, to a reinsurer. Through one contract, the treaty reinsurer is required to cover a cedent on an entire book of business, even on business yet unwritten by the cedent.⁷⁰

There are two main duties in the reinsurance relationship with cedents that are relevant to our discussion. The first is a common law duty of “utmost good faith”⁷¹ between the parties.⁷² This is defined as the “most abundant good faith; absolute and perfect candor or openness and honesty; the absence of any concealment or deception, however slight.”⁷³ This common law duty of utmost good faith was viewed as necessary for the very foundation of reinsurance:

Historically, the reinsurance market has relied on a practice of the exercise of utmost good faith to decrease monitoring costs and *ex ante* contracting costs. Reinsurance works only if the sums of the reinsurance premiums are less than the original insurance premium. Otherwise, the ceding insurers will not reinsure. For the reinsurance premium to be less,

⁶⁷ *Id.* at 7–8.

⁶⁸ There are many sub-types of reinsurance: facultative obligatory and automatic facultative, among others. *Id.* at 10–11.

⁶⁹ BARRY R. OSTRAGER & MARY KAY VYSKOCIL, MODERN REINSURANCE LAW AND PRACTICE 2-5 to 2-7 (2d ed. 2000).

⁷⁰ *Id.* at 2-4 to 2-5; *see also* WEBB ET AL., *supra* note 59, at 10.

⁷¹ In Latin, *uberrima fides*.

⁷² OSTRAGER & VYSKOCIL, *supra* note 69, at 3-4 to 3-6.

⁷³ *Id.* at 3-4 (citing BLACK’S LAW DICTIONARY 1520 (6th ed. 1990)).

reinsurers cannot duplicate the costly but necessary efforts of the primary insurer in evaluating risks and handling claims . . . [t]hey are protected, however, by a large area of common interest with ceding insurers and by the tradition of utmost good faith, particularly in the sharing of information.⁷⁴

Because of the nature of reinsurance, the cedent's duty to the reinsurer to disclose information is very broad. The duty of utmost good faith also extends to all of a cedent's business activities, including underwriting and claims handling.⁷⁵ However, case law makes it very clear this duty of utmost good faith is a reciprocal one, owed by both cedents and their reinsurers.⁷⁶ Reinsurers must appropriately investigate and pay cedent's claims.

The second main duty in this reinsurance relationship is the "follow the fortunes" doctrine. Similar in concept to utmost good faith, this doctrine requires the reinsurer to follow the cedent's underwriting fortunes. In other words, if the pool suffers an underwriting loss due to a large claim, the reinsurer has the duty to suffer a loss by the agreement terms as well, restricting the reinsurer from questioning the validity of cedents' good faith claim payments. Under this doctrine, reinsurers must indemnify cedents for reasonable settlements and judgments.⁷⁷ The reinsurer is required to indemnify the cedent for reasonable payments made within the terms of the original agreement with their insured (or member,

⁷⁴ *Id.* at 3-5 (citing *Unigard Sec. Ins. Co. v. N. River Ins. Co.*, 4 F.3d 1049, 1054 (2d Cir. 1993)).

⁷⁵ *Id.* at 3-19 (citing *Am. Marine Ins. Grp. v. Neptunia Ins. Co.*, 775 F. Supp. 703, 708 (S.D.N.Y. 1991), *aff'd*, 961 F.2d 372 (2d Cir. 1992) (discussing that a ceding insurer satisfies its duty when it acts "honestly and . . . [with] all proper and businesslike steps")).

⁷⁶ *Id.* at 3-6 (citing *Compagnie de Reassurance d'Ile de France v. New Eng. Reinsurance Corp.*, 57 F.3d 56, 88 (1st Cir.), *cert. denied*, 516 U.S. 1009 (1995); *United Fire & Cas. Co. v. Arkwright Mut. Ins. Co.*, 53 F. Supp. 2d 632, 642 (S.D.N.Y. 1999) ("The duty of utmost good faith is a mutual one; it is an obligation of the reinsurer as well as the cedent.")).

⁷⁷ *Id.* at 9-3 (citing *Sumitomo Marine & Fire Ins. Co. v. Cologne Reinsurance Co.*, 552 N.E. 2d 139, 140 (1990)).

for pools), even if the claim is technically not covered by it.⁷⁸ One purpose of the follow the fortunes doctrine is to allow reinsurers to avoid the unnecessary expense, delay and risk that would result from duplicative claims handling, and instead rely on the cedent's honesty and competence in adjusting claims.⁷⁹ The doctrine also promotes settlements since, without the doctrine, cedents would have to litigate every coverage dispute with its insured or member, or obtain consent from reinsurers to settle on every file. Additionally, reinsurers seeking to deny coverage would then use defenses that the cedents might raise against their insureds or members in coverage disputes. The same coverage dispute would be re-litigated repeatedly upward along the risk transfer chain.⁸⁰

The doctrines of utmost good faith and follow the fortunes are distinguished from other reinsurance topics because, since the mid-1990's, these doctrines appear to be the aspects of the reinsurance framework that received the most scrutiny. As profit margins of the era diminished, and catastrophic claims grew, the acceptance of the historical 'gentleman's agreement' regarding reinsurance seemed to be in peril.⁸¹ The push by both cedent and reinsurer was towards arms-length and sophisticated transactions, instead of relying on treaty certificates of only a few pages,

⁷⁸ *Id.* at 9-5 (citing *Christiana Gen. Ins. Corp. v. Great Am. Ins. Co.*, 979 F. 2d 268, 280 (2d Cir. 1992)).

⁷⁹ *Id.* at 9-11 (citing *Ins. Co. of the State of PA v. Grand Union Ins. Co.*, [1989] 1 Lloyd's Rep. 208, 210 (C.A.)).

⁸⁰ *Id.* at 9-12 (citing *N. River Ins. Co. v. CIGNA Reinsurance Co.*, 52 F. 3d 1194, 1204 (3d Cir. 1995)). Reinsurers sometimes have their own reinsurers, known as retrocessionaires. *Retrocessionaire*, INT'L RISK MGMT. INST., RISK & INSURANCE, <http://www.irmi.com/online/insurance-glossary/terms/r/retrocessionaire.aspx> (last visited Dec. 27, 2014). Such retrocessionaires would add to the coverage litigation complexity were it not for the 'follow the fortunes' doctrine.

⁸¹ See generally Steven W. Thomas, *Utmost Good Faith in Reinsurance: A Tradition in Need of Adjustment*, 41 DUKE L.J. 1548 (1992). Thomas emphasized environmental claims, which are not usually involved with governmental entities, but also felt large catastrophic claims were a culprit in this distancing of the cedent-reinsurer relationship. It is the author's experience that governmental pools have large exposures as well, usually in the form of property with weather related exposures, such as hail or tornadoes.

and a degree of faith. The trust factor was diminishing and courts were playing a part in dismantling the doctrines,⁸² thus bringing us to the present.

C. INSURANCE AND REINSURANCE AS GOVERNANCE

Analysis of the governance role of insurance starts with the basic argument raised by *Insurance as Governance*,⁸³ in which the authors explored their theory that the insurance industry has a great societal impact, largely invisible and freely accepted, that functions as a form of government beyond the state. The authors examine, first, how the insurance industry is one of the most pervasive and powerful institutions in society, and, second, despite acting in the background, how insurance governs our lives.

Insurance as Governance analyzes how society consumes insurance products, becomes part of the product, and how insurers then govern through the maintenance of risk pools of insureds that are large enough to ensure losses are reasonably predictable, thus subject to governance. It points to the economic, social, legal, cultural and political dimensions of insurance as governance, and to the significance of insurance for political sociology. The authors describe insurance as “moral technology,” defining how people should act, and finds that insurance as governance focuses on a form of private regulation of moral risks, all of which are subject to classification and segmentation by insurers.

While a fascinating work regarding insurers as a governance force in society, *Insurance as Governance* did not examine the insurer of insurers, the reinsurers, and how reinsurers’ influence in the marketplace might take the form of governance over insurers, and thus society. While the authors described the reinsurer relationship as one of suspicion, and the reinsurance process as being fraught with moral risk judgments and implications,⁸⁴ they did not address the relationship aspect further as to the governance potential of reinsurance.

However, Professor Aviva Abramovsky’s article, *Reinsurance: the Silent Regulator?*, opened the discussion as to the potential for reinsurer

⁸² OSTRAGER & VYSKOCIL, *supra* note 69, at 3-24 (citing Franklin D. Marsteller, *Uberrima Fides: Reinsurers Take Aim at Lack of Good Faith*, 8 L. DIG. 24 (1988)).

⁸³ See generally RICHARD V. ERICSON ET AL., *INSURANCE AS GOVERNANCE* (2003).

⁸⁴ *Id.* at 114-25, 365.

governance. She posited that *insurers themselves* might be silently regulated, apart from state regulation, by the influence of reinsurers whose product is necessary to those insurers. Her conclusion was that reinsurance, through private contract, had the capacity to certainly influence, if not directly regulate, insurer behavior. This influence, Professor Abramovsky felt, took forms such as affecting insurer underwriting and claim handling, as well as the potential for reinsurers to support rather than prohibit unfair insurer practices through the moral hazard of reinsuring tortious activity.⁸⁵ Because of this ability, she opined, reinsurance influence capacity should be a part of regulatory discussions of the insurance industry as a whole.⁸⁶ While Professor Abramovsky demonstrated in detail the *potential capacity* for reinsurer regulatory influence and many aspects under which it might arise, her research did not delve into what was *actually happening* on the ground with carriers and their staff. Were insurers actually influenced by the reinsurer relationship, and if so, to what extent? What did their experience reflect? Field research would be necessary for a fuller understanding of this reinsurer influence concept.

Based on research conducted for this Article, a clear conclusion can be reached that pools, while not regulated *per se* by reinsurers, are substantively influenced in their operations by reinsurers' specific requests, whether pre- or post-engagement. These reinsurers' requests, with consent by the pools, create a form of governance *voluntarily accepted* by the pools. Through varying parameters set forth by reinsurers, pools can individually decide to what degree they wish to have their operations governed. Because of the necessity of reinsurance for some pools, they agree to more oversight; because of the financial strength of other pools, they are able to insist on less governance, or none at all through complete self-insurance. Some pools feel the influence greatly in both underwriting and claims, some in one area or the other, and some only indirectly or generally. Nevertheless, while reinsurance governance varies from pool to pool, and is voluntarily accepted, this research shows that it exists.

This research also indicates, because of these close relationships, that governmental risk pools are a corner of the market where the reinsurance concept of "utmost good faith" still appears to thrive. At least in pooling, utmost good faith is a vital part of the reinsurer-cedent process,

⁸⁵ Abramovsky, *supra* note 3, at 385–401.

⁸⁶ *Id.* at 405.

and is only growing more necessary for the profitability of the reinsurers, and the operating efficiency of many pools.

Additionally, pools are accommodating to reinsurer's input, although the accommodation levels vary; and several factors affect the level of reinsurer influence, most notably the financial solvency of the pool. Both of these results tie back into the utmost good faith and the voluntary acceptance of the reinsurers' form of governance mentioned above.

No doubt, some readers may disagree with this interpretation of the evidence, and some survey participants may differ regarding the characterization of their comments. This may arise from the general vision, for good or ill, of 'governance' or 'regulation' as linked with state power, often in a negative fashion.⁸⁷ Additionally, while this research cannot be directly extrapolated to main-line insurers or even give a complete and comprehensive view of the pooling world, it constitutes a waypoint for future research and discussion.

III. RESEARCH SURVEY METHODOLOGY

Because of the author's current professional position,⁸⁸ the focus of the research was on one small corner of the insurance and risk management world, the governmental entity self-insured risk management pools, as a case study. Limiting the discussion to this segment of the market allowed an examination of a more pure reinsurer-cedent environment. Rather than research with insurers that already felt the effects of state regulators, there was an opportunity to interview carriers that had little or no state regulation. While interviewing insurers would be broader research, it

⁸⁷ *Id.* at 346 ("Yet such a restrictive vision of regulation is simplistic and ignores the capacity of private institutions to regulate the activities of large swaths of social actors.").

⁸⁸ The author is currently Assistant Director, Legal and Regulatory Affairs, for the Texas Association of School Boards, Inc., the third party administrator for the TASB Risk Management Fund, an administrative agency of cooperating local governments. The Fund, based in Austin, Texas, is a self-insured governmental entity risk management pool providing coverage for approximately 1100 school districts, junior colleges, and related educational entities throughout Texas. The Fund is the result of separate funds merging in 1997 to put all lines of coverage under one entity. TASB, Inc., the administrator to the Fund, currently has 450 employees, of which 176 are solely assigned to the administration of the Fund. The Fund has total assets of \$333,764,377 and a members' equity of \$227,923,874 (as of August 31, 2013). Documents on file with TASB, Inc.

would be more difficult to disentangle the state regulator influence from the initial discussion.

For this research, four pooling industry sources provided suggestions for potential survey participants. These sources eventually became interviewees themselves.⁸⁹ The author knew three of the interviewees professionally prior to the survey. Because of the necessity for introductions to the rest of the survey group, the survey was not conducted in a purely random manner.⁹⁰ While this ‘referral’ method increased the response rate to nearly 100%, the survey lacked a randomness factor and perhaps the size needed for a more scientific survey. However, this referral survey method may have led to greater candor and willingness for detailed responses, even more so for one interviewee whom had recently retired.⁹¹

Thirteen senior officials with pools from across the country responded to the survey. Their responses were unique to their own pool or experiences; some pools only have one or two lines of coverage, some join with other pools for certain lines of coverage, and some offer all lines of coverage for their members. The pools are distributed geographically across the United States: two pools located in the Midwest, three in the South, three in the East, and five in the West. Additionally, two senior officials, one current and one former, with the Association of Governmental Risk Pools (AGRiP), also responded, as well as a reinsurer underwriter. The two AGRiP officials, having interacted with leaders of over 200 member pools across the country, were probably in the best position to see broad trends, as was the reinsurer underwriter.⁹² However, the pooling officials were in the best current position for opining on direct reinsurer effects.

⁸⁹ This is both fortunate, because of their immense experience, and unfortunate, as they cannot be publicly thanked due to the ethical format rules of publishing survey research. However, they know who they are. The author wishes to thank them all for their guidance through the world of pooling.

⁹⁰ Had the survey been completely random, rather than by referral, the response rate would have likely been greatly reduced. Only one person did not respond. Industry officials, on the author’s behalf, contacted several other potential participants, with no response. This number is unknown, but estimated to be less than ten.

⁹¹ Additionally, one other participant was an active official during the survey and retired prior to the completion of this paper.

⁹² No other reinsurer representative was willing to participate.

The survey interview was in a written format via email; although one was a telephone interview with follow up confirming emails as to content.⁹³ The interview was semi-structured in nature, in that interviews began with the same general questions to all pooling official participants, but follow-up questions were individualized based on the types and forms of responses.⁹⁴ The survey questions were altered for the AGRiP officials and the reinsurer underwriter because of their more industry-wide view.⁹⁵ Three appendices of the initial research survey questions are attached. The responses were free form, which resulted in additional contact with most of the survey participants for the purpose of follow-up questions or clarifications. Because of this, the survey results acquired a “snowball” effect, gathering information down the winter path, injecting some degree of randomness along the way. Many interviewees took their own course as to the responses, and did not stay with the original question format. The responses tended to be conversational in nature; while making it more difficult to place in context for this Article, the result was beneficial to this research.

IV. SURVEY RESULTS

Having explored the history and legal constructs of pooling, reviewed the purpose of reinsurance, examined the concept of insurance

⁹³ The telephone interview was simply a preference by the participant; he later approved his quotes via email. The initial questions were identical.

⁹⁴ In retrospect, with the conclusion in hand, there may have been more effective initial and follow up questions (*e.g.*, *infra* note 164). Hindsight is a wonderful teacher.

⁹⁵ All of the individuals responding gave the author permission to quote them verbatim, although some minor corrections for any typographical errors and for clarity in the context of this Article were made. The author sincerely thanks all of the respondents for making this Article possible through their extremely generous contributions of time, as well as their patience, with the author’s inquiries. Their assistance was invaluable. The original e-mails are on file with the author. Because some respondents had no opinion on a particular matter, or lacked experience in a particular area, not every respondent answered every question. The survey participants also demonstrated a willingness of several of the participants to share specific underwriting information, which may seem unusual in this proprietary age. However, this is because the pools themselves are public entities using public funds, and as such, their records are open; *e.g.*, the Texas Public Information Act, TEX. GOV. CODE ANN. §§ 552.001 *et seq.* (West 2012).

and reinsurance as governance, and outlined the survey mechanics, we arrive at the focus of this paper: to what extent does reinsurance have a governance effect on insurers?

Four distinct discussion areas arose in the survey interviews:⁹⁶

- How reinsurers influence pools—underwriting, claims, finance/solvency, and generally;
- The duty of utmost good faith and its effect;
- To what level pools afford accommodation to reinsurers; and
- Whether reinsurer influence varies based on pool circumstances, or external factors.

Because of the overlapping nature of some of the answers, many of the responses could apply to several subject matter units and it was often difficult to extricate the comments into singular areas. Therefore, some comments, based on the correlative relationship subject matter, may easily apply to several topics. At some point, interviewees' opinions had to find a home, although some may disagree as to their placement. So, we begin.

A. HOW REINSURERS INFLUENCE POOLS

The initial question to the pooling senior officials was straightforward—do you think pools are influenced by reinsurers, and if so, how? The term 'regulated' was not mentioned to the pooling senior officials due to the concern that the term would be interpreted too restrictively and compared directly to state regulation, which pooling officials tend to view as their kryptonite.⁹⁷ For initial inquiries directed to

⁹⁶ The four areas materialized through the form of the question, or in the manner in which the interviewees responded.

⁹⁷ It has been the author's experience that this general attitude has little to do with specific concerns about regulatory oversight, or apprehension regarding irradiated fragments from exploded planets. It has to do more with the greater ability to be competitive in the marketplace and serve their members more efficiently and with flexibility. As discussed in the pooling background section, pools are extremely transparent in their operations due to their public nature, much more so than private insurers. Because their executive boards are filled with representatives of their own members, it is felt they will 'do the right thing' on their members' behalf without burdensome, and expensive, regulatory oversight.

the AGRiP officials and the reinsurance underwriter, the term ‘regulated’ was used, since it was felt they could more easily discern the true intent of the question based on their broader experiences. The overall responses generally reflected that yes, pools are influenced by reinsurers, as suspected. But, how are they influenced, and to what extent? The influence appears to be to the point of reinsurer governance, although freely accepted by the carriers. However, this is only part of the story. The initial responses are broken down into four key areas of influence: Underwriting, Claims, Finance/Solvency, and General/Miscellaneous.

1. Underwriting

The survey participants emphasized underwriting as a main area where reinsurers had the most influence and this is where the most specific examples arose. In other areas, examples tended to be less definitive and more conjectural. This is likely because, by its nature, underwriting is more of a science, unlike claim operations, which tend more towards an art form.

A senior official with the Missouri Housing Authorities Property and Casualty, Inc.,⁹⁸ discussed underwriting influence due to the necessity of reinsurance and pricing as being key factors. She indicated:

The impact upon the pricing and availability of reinsurance . . . is on my mind, influencing each and every decision that I make . . . [s]ince approximately [one-third] of members’ annual contributions pay for ceded coverage at our pool, it is vitally important to keep the cost down, to the extent that we can. While I am fairly new to pooling, I learned the impact that a major loss can have on

As a senior official with the Texas Association of School Boards, Inc., stated when asked about this issue: “Most pools are outgrowths of their membership and therefore have always thought of themselves as governmental in nature, rather than insurance-like. I think the notion that a governmental self-insurance entity would be subject to insurance regulation just didn’t make sense . . . Pools do NOT consider themselves insurance companies, so to be regulated like one would be really anathema to them.” E-mail from senior official, Texas Ass’n of Sch. Bds., Inc. to Assistant Dir., TASB, Inc. (the author) (Mar. 23, 2013, 8:26 PM CST) (on file with author).

⁹⁸ The Missouri Housing Authorities Property & Casualty, Inc., website is available at <http://www.mhapci.org/> (last visited Dec. 27, 2014).

reinsurance premium early in my career [as a senior official]. In May, 2011, one of our [m]embers suffered a catastrophic loss of life and property.⁹⁹ The total incurred loss [for our pool] exceeded \$8,000,000.

When we went out into the reinsurance market for the ensuing policy year, the reinsurance cost increased by 43%, due in part to a 32% increase in the total insured value of our properties, which also resulted from a reinsurance-influenced decision. Following this loss and a couple of other big losses that followed closely on its heels, we learned that on the whole, our members' replacement cost property estimates and property insurance limits were low and that in many cases member properties were inadequately covered. Not only did we notice this, but the issue must also have come to the attention of our reinsurers who, for perhaps the first time in our history, established a margin clause¹⁰⁰ of 100%. In other words, in the event of a loss, the reinsurer would not pay any more than the estimated replacement cost. Following the 2012 reinsurance placement cycle, I went to the Board with a recommendation that the Board hire an insurance valuation company to measure unique buildings and secure a replacement cost valuation for each and every building that the pool covers. This decision resulted in our ability to negotiate a 130% margin clause for 2013 coverage, as the reinsurers were more confident that they were collecting the right amount of premium.

⁹⁹ See *Joplin Tornado Event Summary*, NAT'L WEATHER SERVICE, http://www.crh.noaa.gov/sgf/?n=event_2011may22_summary (last visited Dec. 27, 2014).

¹⁰⁰ A margin clause is defined as, "[a] nonstandard commercial property insurance provision stating that the most the insured can collect for a loss at a given location is a specified percentage of the values reported for that location on the insured's statement of values." *Margin Clause*, INT'L RISK MGMT. INST., RISK AND INS., <http://www.irmi.com/online/insurance-glossary/terms/m/margin-clause.aspx> (last visited Dec. 27, 2014).

Another example of the reinsurer influence occurred around 2005. My predecessor was informed that blanket coverage would no longer be available and was provided a timetable to convert to property scheduling by individual building in order for continued availability of reinsurance by long-standing reinsurance partners. The pool had to go out to the membership and get a listing with square footage and values for each and every building. This was a time-consuming, expensive and controversial proposition that was accomplished to ensure availability of reinsurance. [However,] I have not received any reinsurer . . . suggestions [as to] what coverages to offer or underwriting criterion.¹⁰¹

This senior official's experience shows the availability of reinsurance was in danger without substantial action by the pool, which shows a great deal of underwriting influence by a reinsurer. As this official indicated, every decision is influenced by the pricing and availability of reinsurance. Since the pool was willing to do what was necessary to show utmost good faith and transparency in underwriting, the reinsurer also felt confidence in the pool's leadership and agreed to favorable terms moving forward. But their reinsurer focused on the exposure, rather than the individual coverages, so that evidences a belief that, if the base information could be corrected, an agreement could be reached that was beneficial for both.

Similarly, a senior official with the Texas Association of School Boards, Inc.,¹⁰² also discussed direct influence from reinsurers, specifically regarding underwriting of property and workers' compensation coverages, but mentioning other areas in general:

I do think [pools] are greatly influenced . . . by their reinsurers' wishes. That is particularly true for those pools that have very low retentions and therefore pass off most of the risk to their reinsurers. In those instances, claims

¹⁰¹ E-mail from senior official, Mo. Hous. Auths. Prop. & Cas., Inc., to Assistant Dir., TASB, Inc. (June 13, 2013, 3:00 PM CST) (on file with author).

¹⁰² This organization's website, as the third party administrator for the TASB Risk Management Fund, can be found at <http://www.tasbrmf.org/> (last visited Dec. 27, 2014).

handling, exposure collection, financial matters, even underwriting criteria can be dictated by the reinsurer. Even with our very high retentions, we experience this from time to time. For example, after [hurricanes] Katrina, Rita and Wilma hit [the Gulf Coast],¹⁰³ the reinsurance community became very concerned about the quality of construction of the buildings they were reinsuring. They imposed significantly more detailed reporting requirements on the types of structures we were covering, what they were built out of, how old they were, etc. Where before we were able to just include the address and a general description of our buildings on the schedule of values we submitted to the reinsurers, all of a sudden we were required to obtain very specific COPE¹⁰⁴ information on every building. That required us to significantly change the way we collect and maintain our exposure information.

The second example is the requirement by our [workers' compensation] reinsurer to start providing information on the concentration of risk—the number of employees at any one location. That change was implemented after the Joplin tornado and the Alabama tornadoes hit a couple of years ago. Workers' compensation reinsurers realized that

¹⁰³ See generally *Hurricanes in History*, NAT'L WEATHER SERVICE, <http://www.nhc.noaa.gov/outreach/history/> (last visited Dec. 27, 2014).

¹⁰⁴ COPE is "an acronym that stands for the four property risk characteristics an underwriter reviews when evaluating a submission for property insurance: Construction (e.g., frame, masonry, masonry veneer, superior construction, mixed—masonry/frame); Occupancy (how the building is being used for commercial property and whether it is owner-occupant or renter-occupied for homeowners and the number of families for which the building is designed); Protection (e.g., quality of the responding fire department including whether it is paid or volunteer, adequacy of water pressure and water supply in the community, distance of the structure to the nearest fire station, quality of the fire hydrant, and the distance of the structure to the nearest hydrant); and Exposure (risks of loss posed by neighboring property or the surrounding area, taking into consideration what is located near the property, such as an office building, a subdivision, or a fireworks factory)." COPE, INT'L RISK MGMT. INST., RISK AND INS., <http://www.irmi.com/online/insurance-glossary/terms/c/cope.aspx> (last visited Dec. 27, 2014).

they may not have accurate information on the number of total people exposed to a devastating event, especially if they write several large employers in a single community. So now, we are providing information by location and address of the number of employees working at each location.¹⁰⁵

While her examples mention underwriting influence in both workers' compensation and property, she does feel there is a broader influence, including claims and finances. The examples the official gave were both exposure oriented. Note the reinsurers insisted on detailed information, which they had not previously required, a new parameter for the relationship. It was provided willingly by the pool, since the relationship was more valuable than the expense or trouble to obtain the information. In exchange, the pool retained the necessary reinsurance coverage.

A senior official with the County Commissioners Association of Pennsylvania,¹⁰⁶ emphasized underwriting influence, noting:

We do have lots of discussion [with our reinsurer] about coverage issues and underwriting. A recent example was the conversion of the entire Equipment Breakdown (Boiler and Machinery) section of our Coverage Document, which was outdated and was based on wording provided by a prior [re]insurer. Our current reinsurer assisted us with wording to match their reinsurance coverage, and reviewed the results before we sent the Coverage Document to the membership . . . [we] have our own Coverage Document and we review the changes we would like to make in the document with them. They are trusted advisors.¹⁰⁷

¹⁰⁵ E-mail from senior official, TASB, Inc., to Assistant Dir., TASB, Inc. (May 8, 2013, 10:05 AM CST) (on file with author).

¹⁰⁶ The County Commissioners Association of Pennsylvania website is available at <http://www.pacounties.org/Insurance/Pages/default.aspx> (last visited Dec. 27, 2014).

¹⁰⁷ E-mail from senior official, Cnty. Comm'rs Ass'n of Pa., to Assistant Dir., TASB, Inc. (June 13, 2013, 8:50 AM CST) (on file with author).

This official focused on the coverages, and worked with the reinsurer to verify that the reinsurer could use their coverage agreement to follow the carrier's fortunes accurately. The pool accepts their input, even to the point of considering the reinsurer a business advisor. This appears to be an accepted form of governance as to this pool.

A senior official with the Park District Risk Management Agency¹⁰⁸ indicates underwriting influence as well. Additionally, he makes a specific point that underlies many of the responses—that reinsurer influence occurs over a period of years in the relationship, rather than reinsurers making specific demands. He notes:

For PDRMA, the influence of reinsurers has accumulated over time as opposed to a specific reinsurer telling us that we needed to do certain things in order to procure reinsurance coverage. For example, we have refined the data we collect from our members over the years in order to have the 'right' data so that an underwriter can understand our exposures and properly price them. That 'right' data varies from reinsurer to reinsurer and can also vary with market cycles, i.e. hard¹⁰⁹ versus soft market.¹¹⁰

This points to the same focus as felt by the Missouri pool, although it happened over a number of years. The reinsurer used their influence to get the carrier to obtain the 'right' (by that reinsurer's standards) data. This official also mentions that the data collected can vary by reinsurer or market conditions—regardless, the reinsurer is affecting the pool (by dictating what data is collected), which complies in order to obtain the product.

¹⁰⁸ The Park District Risk Management Agency website is available at <https://www.pdrma.org/> (last visited Dec. 27, 2014).

¹⁰⁹ A hard market is one side of the insurance market cycle that is characterized by high rates, low limits, and restricted coverage. *Hard Market*, INT'L RISK MGMT. INST., RISK AND INS., <http://www.irmi.com/online/insurance-glossary/terms/h/hard-market.aspx> (last visited Dec. 27, 2014).

¹¹⁰ A soft market is one side of the insurance market cycle that is characterized by low rates, high limits, flexible contracts, and the high availability of coverage. INT'L RISK MGMT. INST., RISK AND INS.: *Soft Market*, <http://www.irmi.com/online/insurance-glossary/terms/s/soft-market.aspx> (last visited Dec. 27, 2014); E-mail from senior official, Park Dist. Risk Mgmt. Agency, to Assistant Dir., TASB, Inc. (July 6, 2013, 1:38 PM CST) (on file with author).

Other pooling executives felt there was less underwriting influence by reinsurers. A senior official at Ashton Tiffany, LLC, the third party administrator for the Arizona School Risk Retention Trust, Inc.,¹¹¹ mentions the interaction and exchange regarding underwriting. He indicated:

It depends on the maturity of the pool and the experience level of the pool staff, but we have a balanced scale of give and take with our reinsurers. The . . . Trust is a mature property and casualty pool with over twenty years' experience . . . negotiating with reinsurers.

The Trust has our own coverage agreements which are reviewed and adjusted each year based on our claims experience and evolving case law. We forward the draft revised coverage agreement to our lead reinsurance partners and ask for their feedback. Although we do not always incorporate their suggestions, we appreciate and value their feedback. We believe this provides multiple viewpoints on coverage and also creates a solid working relationship with our [reinsurers]. We also ask for their feedback with emerging issues coming from the reinsurers' book of business other than our account specifically. This helps us to be proactive with coverage issues for our members instead of being reactive . . .

As a mature pool, our reinsurers typically do not try to influence us on our underwriting decisions. The only influence our reinsurance carriers have on underwriting procedures is if certain exclusions are adopted into the agreement with the Trust. Recently, we had this very situation arise regarding high-level ropes courses offered by some of our members. One reinsurer wanted to exclude coverage for all ropes courses. We stood firm and reasoned with them that it would require additional time to remove the exposure and, if not removing the exposures, we would provide extensive loss control measures to

¹¹¹ The Arizona School Risk Retention Trust, Inc., website is available at <https://www.svc.the-trust.org/> (last visited Dec. 27, 2014).

reduce the exposure. The agreement resulted in the reinsurer dropping their proposed exclusion.¹¹²

While this official felt there was minimal influence, he also noted the depth of the relationship necessary to get to that point. It is unlikely a new reinsurer of the Trust would be willing to cede all influence until they were comfortable with the Trust's operation. Additionally, while he feels influence is minimal, it does not appear so. He mentions a fair amount of ongoing interaction between his staff and the reinsurer, as well as the value of their feedback. Feedback that is valued and sought seems to indicate a greater influence than a simple commodity transaction. Note how the relationship is always there, affecting every transaction. While this official might not characterize it as such, this level of interaction appears to be reinsurer governance.

A senior official with the Maryland Association of Boards of Education¹¹³ felt there was less influence in his operation as well. He notes:

Our pools are influenced somewhat by reinsurers . . . Our Pool [School Board Legal] coverage is a manuscript policy. When we first went to this reinsurer they 'blessed' the policy with a couple of minor changes we were fine with and we just handle our claims . . . The only influence was on our School Board Legal policy whereas the reinsurer came on the risk they indicated they would not reinsure an exposure we covered, so we changed our policy to be in conformance with what they wanted. It was actually a small matter which has not caused any specific issues.¹¹⁴

While not initially noting influence, it appears that their policies are reviewed by reinsurers to make sure the reinsurer wishes to follow this

¹¹² E-mail from senior official, Ashton Tiffany, LLC, to Assistant Dir., TASB, Inc. (June 24, 2013, 10:19 PM CST) (on file with author).

¹¹³ The Maryland Association of Boards of Education website is available at <http://www.mabe.org/insurance-programs/> (last visited Dec. 27, 2014).

¹¹⁴ E-mails from, senior official, Md. Ass'n of Bds. of Educ., to Assistant Dir., TASB, Inc. (June 14, 2013, 1:37 PM CST, 2:31 PM CST) (on file with author).

pool's fortune. As we will see later, this is not the last word from this official about the importance of the relationship.

A senior official from the Idaho Counties Risk Management Program¹¹⁵ felt there was little influence. He stated:

Our experience at ICRMP and in my discussion with peers, regarding reinsurance relationships, leaves me with the impression reinsurers do not influence pools directly. We have not had specific requests to amend coverage . . . or otherwise alter our pool operations to fit reinsurer's needs. Certainly there is underwriting exposure data that must be provided such as payroll, property values, and other basic underwriting info and claims must be reported to reinsurers, however, ground level operations are left up to the pool.¹¹⁶

While this official felt there was no influence on pools *directly*, he did not say there was none at all. He notes the underwriting data "that must be provided" and considers it ordinary. Nevertheless, these seem to be similar requests made of other pools (perhaps not as detailed) and those officials felt they were influenced by such requests. While this official may feel no direct influence outside the expected underwriting issues, it appears those very underwriting influences form the core of the influence. If the underwriting information were no longer transmitted as required, it appears from these comments that reinsurance would no longer be offered. This seems like voluntary governance—if this data is not provided, the reinsurance product will cease to be available, or certainly more costly.

A senior official with the Alabama Trust for Boards of Education¹¹⁷ self-funded pool mentioned underwriting, stating:

My observations have been that reinsurers influence pool formation and operations in areas of financial management, underwriting, and claims management. [Reinsurers] are . .

¹¹⁵ The Idaho Counties Risk Management Program website is available at <http://www.icrmp.org/> (last visited Dec. 27, 2014).

¹¹⁶ E-mail from senior official, Idaho Cntys. Risk Mgmt. Program, to Assistant Dir., TASB, Inc. (June 17, 2013, 3:47 PM CST) (on file with author).

¹¹⁷ The Alabama Trust for Boards of Education website is available at <http://www.dwighthester.com/ATBE.html> (last visited Dec. 27, 2014).

. concerned from an underwriting standpoint about nature and scope of coverage, as well as pricing for coverage.¹¹⁸

While this official's comments are more general, his impression is that reinsurers do influence pool underwriting operations, mostly from the coverage standpoint, which relates back to the follow the fortunes aspect. The reinsurer has to make sure the cedent's interests align with theirs.

As to reinsurers' underwriting influence, the current senior official of AGRiP indicates a wide range of influence:

Pools absolutely have accepted input from the reinsurers to influence their practices, operations – even policies. This can be very subtle. For example, a reinsurer might ask, when underwriting a pool, if they have policies and procedures for cancelling or non-renewing a member that will not comply with loss control requirements. I have known pools without such formal procedures to develop them, not because their reinsurer 'required' it, but because they recognized [the procedure] as a good proactive [policy], and they wanted to make themselves *more* attractive to reinsurers in the future. Other areas I have seen influenced by reinsurers include rating and pricing; building and holding adequate surplus; better claim management procedures; and coverage issues, to name a few.¹¹⁹

These comments appear to verify that even suggestions from reinsurers, because of their broader market knowledge and experience, take on a great deal of influence, even though they were not requirements. This official continues:

Reinsurers . . . have provided pools with general advice through forums, [such as] AGRiP conferences. For

¹¹⁸ E-mail from senior official, Ala. Trust for Bds. of Educ., to Assistant Dir., TASB, Inc. (June 20, 2013, 2:44 PM CST) (on file with author).

¹¹⁹ E-mail from current senior official, Ass'n of Governmental Risk Pools (AGRiP), to Assistant Dir., TASB, Inc. (Apr. 29, 2013, 11:09 AM CST) (on file with author).

example, reinsurers have produced [conference] sessions on how to effectively partner with your reinsurer. The sessions gave input on things to include in the underwriting submission, such as: evidence of pool policies that require members to embrace loss control advice or risk being non-renewed; information about rating plans that include experience rating to incent better risk management; [and] operational structures that demonstrate an alignment of incentives between staff or vendors with the goal of reducing losses, as opposed to a managing general underwriter structure where the vendor is incented to grow the top line with no skin in the game for the bottom line.¹²⁰

These conference programs appear to be the first truly indirect form of reinsurer influence discussed by a participant.¹²¹ While understandably, reinsurers give such presentations to assist pools in becoming more efficient and more able to be reinsured (and to raise the reinsurers' visibility), they are also attempting on a broader scale to influence pools in general. This training potentially makes the reinsurance market more accessible to pools, and more expansive and profitable for reinsurers.

As to underwriting, the former senior official with AGRiP indicated:

[Underwriting] suggestions generally are subtle 'strong hints', such as reinsurers indicating they could lower the premium by X dollars if members were required, under the coverage agreement, to confer with a pool designated defense counsel before taking any adverse employment actions. Or, for example, if coverage excluded diving boards over five meters high. Or, if coverage excluded playground equipment on hard surfaces such as asphalt or concrete.¹²²

¹²⁰ E-mail from current senior official, AGRiP, to Assistant Dir., TASB, Inc. (June 10, 2013, 7:11 AM CST) (on file with author).

¹²¹ Arguably, these presentations take a similar form as the "University of Farmers" insurance commercials.

¹²² E-mail from former senior official, AGRiP, to Assistant Dir., TASB, Inc. (May 24, 2013, 2:26 PM CST) (on file with author).

All of the examples are incentive-based; while assisting the pool in having fewer losses, they also minimize severity, and the chance the reinsurers' thresholds are broken. However, this appears to be the same type of influence as when your local government offers lower water rates per gallon for more frugal usage. Also, note the use of the term 'subtle' by both AGRiP officials. This will be seen next as well.

A reinsurer underwriter for the Government Entities Mutual, Inc.,¹²³ indicated reinsurers did have a substantive impact on pools. He focused on the underwriting influence:

I would say over time, reinsurers are moving from direct influence to indirect influence. This seems to be a function of the market conditions, and in this extended soft market (since post-9/11), reinsurers' demands of their reinsureds are becoming more and more requests. This is, of course, related to not wanting to give up market share [or] being perceived . . . that [reinsurance] coverage is based on a set of operational demands.

[As to influence], Government Entities Mutual, Inc. has a pricing methodology that includes schedule credits which reward/penalize our member pools for practicing 'good' risk behavior and not practicing 'bad' risk behavior. A little more about this: the [reinsurance underwriting] categories allow up to +/-15% debits/credits. The several categories are both subjective and relatively objective. The metrics for each category are definitely subjectively chosen by GEM staff. For instance: being AGRiP 'recognized'¹²⁴ affords -1% off the written premium. GEM has determined that going through the self-evaluation process of the AGRiP recognition process is an indicator of a good risk pool. Remember, GEM is assessing the risk of the pool, while pools are assessing the risk of its members. So, the fact that we have correlated risk with

¹²³ The Government Entities Mutual, Inc., website is available at <http://www.gemre.com/> (last visited Dec. 27, 2014).

¹²⁴ See generally ASS'N OF GOVERNMENTAL RISK POOLS, www.agrip.org (last visited Dec. 27, 2014) (for a detailed discussion of debits and credits).

AGRiP recognition is relatively objective, but the metric of -1%/0/+1% [for varying categories] is subjective.

Speaking outside of GEM, I know that reinsurers pricing models have a lot more 'wiggle' room than GEM's +/- 15%. Some up to 40%. The rationale for this is the limited ability of their experience and exposure based pricing methods, usually blaming the pool's lack of experience in the reinsurance layers [for] not being able to credibly predict risk and therefore [being able to] predict pricing. Each reinsurer has their own 'wiggle' methodology, but ultimately they are looking to assess the soft risk elements versus the cold, hard black and white of the losses and exposure counts. Specifically, I know other reinsurers collect a lot of the same soft data that GEM collects, such as claims audits, tort climates, and underwriting guidelines.

Specific input might come in the way of reinsurer audits. For instance, most reinsurers want at least a claims audit and underwriting audit of the reinsured before they write the business. Within the audits are pros and cons of the reinsured's operations, as well as ways to improve. When subsequent audits are performed, the first thing an auditor usually looks at are the 'management recommendations' from the previous audit. These point to whether management has been responsive to the reinsurers recommendations. The majority of the reinsurers want financially solvent pools, so they target the major contributors to that end. Underwriting and claims are the biggest two, followed by loss control and accounting. Because a well-functioning pool has [their own] long term underwriting and rating standards, and [these pools] attempt to minimize claims payouts by proactively defending frivolous and calamitous claims.¹²⁵

¹²⁵ E-mails from reinsurance underwriter, Gov't Entities Mut., Inc., to Assistant Dir., TASB, Inc. (Apr. 30, 2013, 11:12 AM EST and May 9, 2013, 3:08 PM CST) (on file with author).

This underwriter outlines a very good overview of how reinsurer incentives operate. Reinsurers want to give premium discounts, as this assists reinsurers in their influence of pools. Reinsurers are attempting to influence pools to have lower loss ratios, since, under the follow the fortunes doctrine, this is optimal for both parties, although more so for the reinsurer. This underwriter seems to encourage transparency and good faith in the underwriting process for the benefit of both. This appears to be a very substantial argument for reinsurer underwriting influence on pools.

As to the underwriting influence overall, the general characterization of reinsurer influence was characterized by the participants as ‘indirect.’ However, while the influence is not as direct as it could be, being influenced by reinsurers’ suggestions, even subtle ones, appears to be a form of direct influence, unlike the indirect influence of conference programs. There appears to be, direct or subtle, very much a governance aspect to the reinsurers’ actions.

2. Claims

The area of claims differs from underwriting in that it is more subjective, from a reinsurer’s standpoint. The reinsurer influence varies based on many more factors in claims, as can be seen from participant’s responses.

The senior official for the Alabama Trust for Boards of Education indicated:

[Reinsurers] are particularly interested in how claims are managed and by whom. They are interested enough in [the pools’] claims management that they typically conduct regular, periodic audits of all claim files that may in any way pose exposure to the re-insurance layer of coverage.¹²⁶

The claim audits are a theme that will arise repeatedly. Because reinsurers can’t get an objective view of claims by reserve numbers or claim counts, they must actually touch the files to ensure that the pool is overseeing the claims in a reasonable fashion. Additionally, pool personnel must meet with reinsurer personnel—this is partly for explanations of files,

¹²⁶ E-mail from senior official, Ala. Trust for Bds. of Educ., to Assistant Dir., TASB, Inc. *supra* note 118.

as well as to investigate the capabilities of the claim staff. These oversight actions are governance (or regulatory) in nature.

The senior official for the County Commissioners Association of Pennsylvania indicated:

In our experience, [influence] is not about specific operational matters and never about specifics of personnel. But it could be about staffing (levels of loss control services for example) and, since we provide claims services, [reinsurers] are interested in our claims staff performance. We provide member satisfaction survey results and copies of claims audits so they can have factual information about our service quality.¹²⁷

Here we see interest in claim staff performance again—the reinsurer wishes to oversee, to some degree, the subjective, and the pool agrees to this oversight.

A former senior official with the Washington Schools Risk Management Pool¹²⁸ emphasized some reinsurance influence on claim operations, indicating:

Pools influenced by reinsurers . . . it depends. We take recommendations from any reinsurer claims audit very seriously, especially as it relates to claims industry practices. We just had our two reinsurers complete their annual claims audit and we are following up on a recommendation to tighten up on reserve documentation. The reserve documentation was in the form of a recommendation and not as a strict requirement. But I do think it is important to maintain a good working relationship with our reinsurer and would comply with

¹²⁷ E-mail from senior official, Cnty. Comm’rs Ass’n of Pa., to Assistant Dir., TASB, Inc., *supra* note 107.

¹²⁸ The Washington Schools Risk Management Pool website is available at <http://www.wsrmp.com/> (last visited Dec. 27, 2014).

their recommendations if they make good business sense, as the reserve documentation recommendation was.¹²⁹

As this official indicates, they take the audits “very” seriously from their reinsurer, and it appears annual audits are required. The recommendation arising from the audit was not put forth as a requirement. The recommendation was a formal suggestion, and the pool gave it consideration because it made sense, but also indicated acceptance because of the need for a good working relationship. While this official may feel less influence, regularly accepted audits (even if contractually required) and a desire to maintain the relationship (which are not contractually required) indicates a fair degree of influence from the reinsurer.

A senior official with the Montana School Group Insurance Authority,¹³⁰ the administrator for the Montana School Board Association’s program, felt both underwriting, in coverage offerings, and claim operations were most influenced, but focused on the claim operations as an example. He said:

Pools are influenced by reinsurers. The right reinsurance partner is critical for the long-term success of the primary pool. The ability to provide stable and competitive reinsurance costs [is] one of the largest pieces of the primary pool’s pricing formula which in turn has a direct impact on [how] competitive the primary pool can be in its membership market space. The other is the right reinsurance products for the primary pool. Often one reinsurance carrier will not provide the right type of coverage, coverage structure, or limits needed. So, to find the perfect fit takes some work on the primary pool’s part. For some pools that is a mono-state arrangement, others it is multi-state, and some are countrywide. The influence a reinsurance relationship has on the primary will drive certain procedural behaviors with regard to both

¹²⁹ E-mails from former senior official, Wash. Sch. Risk Mgmt. Pool, to Assistant Dir., TASB, Inc. (June 12, 2013, 12:09 PM EST and 3:34 PM CST) (on file with author).

¹³⁰ The Montana School Group Insurance Authority website is available at <http://www.msgia.org/> (last visited Dec. 27, 2014).

policy and procedural development in the areas that will be impacted by the reinsurance pricing.

The best example is claim handling procedures and related policies. Because the reinsurance submission process is becoming more formalized as pooling development has evolved, the primary pools are much more carefully crafting claim handling procedures and policies which model what they believe to be national best practices in this area. The submission process involves sharing the detailed outside or third party claim audit reports of your operations with your reinsurance partner as well as your own state and local pool claim guidelines and procedures. A reinsurer then analyzes these procedures and compares them with the outcomes seen in the claim data sets acquired from the primary pool as part of the reinsurance submission process. While the reinsurance does not have any direct control over the primary pool with regard to mandates for changes in the primary pool procedures, suggestions are offered. The reinsurers I have worked with provide those based on multiple operations they have worked with and offer what they believe to be the best practices. So, it is the indirect influence or regulator feel provided through the reinsurance relationship that creates certain behaviors in pooling operations. The larger the pool, the more procedures and staff that are involved, [then] the larger the interactions [are] between the reinsurance carrier and the primary pool.

Influence on coverage issues I have still seen [are] driven by the type of reinsurance/excess contract, with the reinsurance style contracts affording the settlement authority to the primary pools. Our pool, as do many, still involve the reinsurer as the claim progresses and even in the final decision making process of settlement versus continued defense. Reporting requirements in the contracts with the reinsurers ensures they get to be involved prior to

the self-insured retention¹³¹ being breached for most instances. We have been involved with several liability claims where we have received very good input from the reinsurance legal group regarding ways to approach and structure defenses for our primary pool members. Our defense counsel for the pool has usually been very receptive to that type of input.¹³²

Note how this senior official continues to go back to the benefits of the relationship, the early involvement of the reinsurer, and the claim specific advice. He mentions “suggestions are offered” that “create certain behaviors”; governance creates certain behaviors as well. Regardless of the example of influence he is discussing, or if one would consider it direct or indirect, it is very apparent both parties perceive their relationship to be one of utmost good faith, rather than the arms-length relationship contemplated by some reinsurance commentators previously documented.

A senior official with the North Carolina School Boards Association, the third party administrator for the North Carolina School Boards Trust¹³³ felt there was reinsurer claims influence:

Yes, [there is influence], at least to some extent. I think the level of reinsurer influence is in part dependent on the sophistication level of the pool staff and also probably the size of the pool.¹³⁴ Smaller pools with less experienced, less sophisticated staff are likely to be more receptive to

¹³¹ A self-insured retention (SIR) is defined as: “A dollar amount specified in a liability insurance policy that must be paid by the insured *before* the insurance policy will respond to a loss. Thus, under a policy written with a SIR provision, the *insured* (rather than the insurer) would pay defense and/or indemnity costs associated with a claim until the SIR limit was reached. After that point, the *insurer* would make any additional payments for defense and indemnity that were covered by the policy.” *Self-Insured Retention (SIR)*, INT’L RISK MGMT. INST., <http://www.irmi.com/online/insurance-glossary/terms/s/self-insured-retention-sir.aspx> (last visited Dec. 27, 2014) (emphasis in original).

¹³² E-mail from senior official, Mont. Sch. Grp. Ins. Auth., to Assistant Dir., TASB, Inc. (June 18, 2013, 10:34 AM CST) (on file with author).

¹³³ The North Carolina School Boards Trust website is available at, <http://www.ncsba.org/risk-management/the-north-carolina-school-boards-trust/> (last visited Dec. 27, 2014).

¹³⁴ This factor will be seen again.

reinsurer suggestions on changes to improve internal claim procedures or with handling coverage and reservation of rights issues, or other internal changes.¹³⁵

While this official did not seem to be referring to her own pool, it seems natural that less experienced pools would be more willing to accept guidance from business partners, using reinsurers' governance to their advantage.

The senior official from the Park District Risk Management Agency mentioned claims in detail:

The reinsurers do review our claims procedures, but mainly from the point of view that they want to be confident that we have competent staff, have specific internal controls in place, and the process is documented. While we write our reinsurance agreements so that, in most cases, PDRMA retains the ability to control the claim, we do have specific reporting procedures to the reinsurer and in some cases need written approval prior to settling a claim. We comply with those requirements and try to be much more proactive and cooperative with the reinsurers when they may be paying on a claim.¹³⁶

This certainly is direct influence; the most interesting example is the reinsurer's insistence to go beyond 'follow the fortunes', in that in some instances the reinsurer must sign off on certain settlements. These reinsurer 'requirements' are complied with proactively by the pool, and appear to be behavior changing influence, governing in nature. Again, this influence, or governance, is freely accepted by the pool.

The senior official representing the Arizona School Risk Retention Trust, Inc., discussed the large amount of interaction their claim personnel had with their reinsurer:

¹³⁵ E-mail from senior official, N.C. Sch. Bds. Ass'n, to Assistant Dir., TASB, Inc. (July 8, 2013, 2:48 PM CST) (on file with author).

¹³⁶ E-mail from senior official, Park Dist. Risk Mgmt. Agency, to Assistant Dir., TASB, Inc., *supra* note 110.

Our . . . lead liability claims adjuster, along with our lead defense counsel, meets with our reinsurers in person twice a year to conduct intensive case reviews. [The adjuster] also provides updates throughout the year as reserves change. We recently had three large liability claims that reached into the reinsurance layers. The ultimate settlements negotiated by our adjuster were less than the reinsurers reserves amounts by approximately 30% to 50% of the reinsurers' total reserves. These results build our credibility with the reinsurers and illustrate that we do not fall victim to unnecessary influence from the reinsurers.

Our lead property adjuster also has a terrific working relationship with our reinsurers. The Trust members have experienced some substantial and unusual claims in recent years. The lead property adjuster has spent many hours negotiating with our members and with the reinsurer. Arizona is a state that is much different from other states when it comes to weather which results in claims from our members. We recently have had some major hail damage and water intrusion claims that were closed for much less than the reinsurer expected. The lead property reinsurer had to explain how flooding in Arizona, which is typically sheet flooding, is much different than flooding in other states. Having a good working relationship with the reinsurer made for much smoother claims resolutions.¹³⁷

In allowing the heightened interaction to avoid 'unnecessary influence' (and to create a good business relationship), are pools, by this very act, allowing some measure of governance? While this official may not characterize it as such, this ongoing monitoring and level of interaction with the reinsurer appears to be a sign of reinsurer governance.

The senior official with the Maryland Association of Boards of Education felt there was little influence in his operation. He notes:

For the run of the mill claims we handle and know the value will not approach the retention, the reinsurer is

¹³⁷ E-mail from senior official, Ashton Tiffany, LLC, to Assistant Dir., TASB, Inc., *supra* note 112.

uninvolved. And the vast number of claims we handle are well below our retentions and therefore do not involve the reinsurers. We handle the claims, determine the coverage and extend authority without reinsurance involvement. The reinsurer only gets involved when the value of the claim makes it reportable to them or the claim meets certain criteria, sometimes for severity.¹³⁸

This official has seen much less influence in claims, indicating little of the interaction mentioned by others.

The current official with AGRiP noted claim audits and recommendations:

On the specific level [regarding claims], in meetings between the pool management and reinsurers, there is often discussion of specific claims, how they were handled, and how similar claims might be better handled in the future. Through reinsurer claim audits, specific recommendations of better staffing or supervisory models might be given. For example, one reinsurer requested that the pool hire a full time litigation manager to oversee the third party administrator and [outside] legal counsel to control litigation costs and improve outcomes. [Or], in the review of the coverage documents, concerns about interpretation of language might arise. One specific example that has come up several times in my experience relates to the determination of the date of loss and number of ‘events’ in situations such as sexual abuse in a school system, which led to clarification of language. Often the reinsurer might recommend things, and the pool may or may not make the change and the reinsurer may or may not continue to write the account.¹³⁹

This official sees specific claim handling input by reinsurers, even staffing requests. As she indicates, the pool might accept the recommendations or

¹³⁸ E-mail from senior official, Md. Ass’n of Bds. of Educ., to Assistant Dir., TASB, Inc., *supra* note 114.

¹³⁹ E-mail from current senior official, Ass’n of Governmental Risk Pools (AGRiP), to Assistant Dir., TASB, Inc., *supra* note 120.

might not, but if it does, it seems to be accepting a form of governance in the process.

The former AGRiP senior official gave a response that showed not only the method of influence, the pool's effort in a claims setting towards utmost good faith:

A secondary influence is what [reinsurers] establish as thresholds for reporting claims to them; and how reinsurers influence claims adjustment at the pool level. Reinsurers influence can be limited at times. For example, reinsurers seem to have a hard time understanding why public entity pools are willing to spend more money on defense than [third party] claim payments.¹⁴⁰ I remember years ago [at a previous employer] having a study done of our in-house Oklahoma Municipal Assurance Group¹⁴¹ litigation management program. The consultants said we were not doing a very effective job because we were spending \$7 for litigation for each \$3 in losses; when it should have been the other way - \$3/\$7. When I asked about how much we spent in total compared to others they replied, 'Oh, about one-third.' I was very pleased that our strategy was working so well.¹⁴²

This official, while acknowledging reinsurers can manipulate claim reporting and how claims are adjusted, also showed that by a pool demonstrating utmost good faith, the influence is lessened. Here, the pool showed their institutional reasoning and success in the defense of claims, and the reinsurer appears to have been accepting, showing utmost good faith in kind. But the governance is still present.

¹⁴⁰ It is the author's experience this is due to the common interests of pool members. Pools do not want certain types of claims to be settled, no matter how economically feasible because governmental entity settlements are well publicized. Settlements can also cause ripple effects of further litigation against other similarly situated pool members, where members feel there is no liability in a particular situation or members are defending a common policy position, such as dress codes.

¹⁴¹ The Oklahoma Municipal Assurance Group website is available at <http://www.omag.org> (last visited Dec. 27, 2014).

¹⁴² E-mail from former senior official, AGRiP, to Assistant Dir., TASB, Inc., *supra* note 122.

The underwriter for the Government Entities Mutual, Inc., spoke of claim audits as well:

[W]e determine the effectiveness of a GEM member [pool's] claims operation by assessing [our] claims audit. [W]e correlate the risk to the reinsurance layer to the effectiveness of the claims operation. [In the claims] category, its measure and metric are much more subjective, since all claims operations behave very differently.¹⁴³

The GEM underwriter points out the subjective nature of reinsurance oversight of claim operations. It appears this very subjectivity allows for governance to be asserted and accepted by the pools.

The senior official with the Missouri Housing Authorities Property and Casualty, Inc., noted:

I have not received any reinsurer suggestions on claim procedures, coverage issue handling, or authority . . . these matters are handled in accordance with and subject to the pool's coverage document, which is provided to the reinsurer in advance of its decision to enter into a treaty with the pool.¹⁴⁴

This appeared to be the least claim influence of those that opined; much less so than the underwriting influence this pool felt.

Due to the subjectivity in the reinsurer oversight of claim operations, reinsurers have more opportunities in claims for governance. Because of the imprecise nature of claim operations—which can vary widely based on claim philosophies, enforcement of those philosophies, experience of the personnel, and workload—reinsurers usually must have a greater hands-on approach when determining the amount of governance to insist upon. As most of the participants indicated, there was a great deal of interaction, which appears to be governance.

¹⁴³ E-mail from reinsurance underwriter, GEM, Inc., to Assistant Dir., TASB, Inc. (April 30, 2013, 11:12 AM CST) (on file with author).

¹⁴⁴ E-mail from senior official, Mo. Hous. Auths. Prop. & Cas., Inc., to Assistant Dir., TASB, Inc., *supra* note 101.

3. Finance/Solvency

While not as many comments discussed directly the financial aspect of pooling, or at least not that could be easily unwound from other subjects, the comments given showed finances of the pool and the profitability of the reinsurers as strong motivating factors for reinsurers to assert some form of governance over the pools.

The senior official with the Texas Association of School Boards, Inc., stated:

I also believe that most pools, like any organization, are driven by an inherent desire to survive, so financial viability is a powerful motivator . . . I think reinsurance plays an important part in the financial viability of a pool, but more from a funding and claims protection standpoint than a regulatory standpoint. Although, as stated earlier, reinsurers carry a big stick, so to the extent that they want to impose certain practices by a pool, the pool is likely to comply.¹⁴⁵

While this official mentions that the important part of a reinsurers influence is not regulatory in nature, it may only be semantically different. The imposition of certain practices is certainly governance in nature; ‘sway’ as the Oxford English Dictionary termed it.¹⁴⁶

The senior official of the Alabama Trust for Boards of Education discussed the reinsurers’ interest in the pools’ finances:

Because of the obvious financial self-interest, reinsurers are concerned about the financial condition and status of any pool, whether start-up or well-established . . . My personal observations concerning multiple pools of various sizes in multiple states is that, again, due to financial self-interest, re-insurers sometimes have more hands-on involvement and influence in the solvency and success of

¹⁴⁵ E-mail from senior official, TASB, Inc., to Assistant Dir., TASB, Inc. (April 30, 2013, 9:59 AM CST) (on file with author).

¹⁴⁶ “Governance” definition, *supra* note 2.

public entity pools that any insurance or administrative regulators would have.¹⁴⁷

As this official obliquely notes, state regulators are concerned about an entity's solvency in an abstract manner. For reinsurers, it is their money and their livelihoods at stake. This greatly increases the incentive to assert influence.

The GEM underwriter also noted reinsurers gaining a greater understanding of pools and an increased interest in writing pools:

Plain and simple: profit. Reinsurers, as any financial institution, [are] looking to make return with their capital. Pools and the risk of public entities have proved profitable. Pools, as an industry, have matured to the point with reinsurers [not being] as skeptical of them as they were at the beginning . . . Perhaps this is indirectly related to the 'suggestions' made by the reinsurers, or just a natural evolution of any industry.

There are new 'shops' set up recently trying to go after pool business. This means it is profitable. This also means that the reinsurance community is becoming more and more enamored of pools . . . [T]here is a comfort level with pools that has grown over time. I would say this is mostly restricted to the domestic marketplace, since on the international scene, most reinsurers are largely unaware of the public entity pooling industry.

Yes, there are strengths and weaknesses of pools just like any other risk. One opinion I have is that the insurance shortage crisis that existed back in the 80's, in which the pools were born,¹⁴⁸ is not likely to return. Insurers and reinsurers are well aware that public sector risk is a good book of business . . . I think this stems from two

¹⁴⁷ E-mail from senior official, Ala. Trust for Bds. of Educ., to Assistant Dir., TASB, Inc., *supra* note 118.

¹⁴⁸ Due to the insurance crisis, the 1980s saw the greatest expansion of pools, but as discussed above, governmental entity pooling was born in 1974 in Austin, Texas. *See* discussion, *supra* note 18.

components of pools. First, they are mutually owned by public entities, and most of the time are run in the best interest of the actual risk. Second, over the history of pooling, there have been far fewer insolvencies than the commercial insurance industry. As proof, in the last couple of years, there are three new reinsurance shops that have started writing public entity pools around the country. These are private companies who did not formerly write in the space, and it can only be deduced that there is profit to be made.¹⁴⁹

Based on the underwriter's comments, he believes pools have matured to the point that reinsurers' are interested in this segment of the market, which may be leading to less direct influence, as noted earlier. The more reinsurer competition, the less each reinsurer can assert its direct influence. However, because finances are growing stronger in the pooling industry, the reinsurers have every motivation to keep the pools as efficient as possible. It appears the reinsurers are matching the level of governance influence to individual pools, and the methods can vary as to how they achieve these goals.

Not everyone felt a close pooling-reinsurer relationship in the financial area. The senior official with the Idaho Counties Risk Management Program stated:

For better or worse, I predict pools' relationships with reinsurance . . . markets will continue to be more data driven and less personal. I also believe reinsurers will continue to view pool business more as a market to be in or out of and this will lead to service behaviors more in line with a commodity rather than a personalized financial product priced on the underlying pool's operational competence.¹⁵⁰

However, it seems clear the reinsurers' approach observed by this official would be less influential—after all, the less engagement,

¹⁴⁹ E-mails from reinsurance underwriter, GEM, Inc., to Assistant Dir., TASB, Inc., *supra* note 125.

¹⁵⁰ E-mail from senior official, ICRMP, to Assistant Dir., TASB, Inc., *supra* note 116.

the less influence that can be asserted from a distance. If reinsurers were to trend towards less engagement, it would be counter-productive to the overall reinsurance process.

4. General/Miscellaneous

There were a few comments of a more general nature, but enlightening nonetheless.

The senior official with the County Commissioners Association of Pennsylvania said:

Yes, I think this is somewhat natural [that pools are influenced by reinsurers], if pools believe as we do, that reinsurers are partners in our program. There are not a large number of reinsurers interested in public entity exposures, especially some of the more niche coverages like law enforcement (police, jails, probation) and nursing home professional liability. Pools cannot afford to treat reinsurers like they are just another vendor, which can easily be replaced. We expect our members to view our pool as a long-term commitment, and we extend that same philosophy to our reinsurers. We meet with them every year to discuss the renewal, but just as importantly to get their feedback, to find out what is new in the industry.¹⁵¹

Note that there is organizational commitment passed through from the member to the pool to the reinsurer. Additionally, this senior official indicates the preference to have reinsurers as partners, rather than as a commodity. Because of their differing roles, a certain amount of influence inevitably occurs when reinsurers have a financial interest in the pools' performances. Much like neighbors looking after each other's houses, there is some inherent interest in making sure all is well.

The underwriter for the Government Entities Mutual, Inc., the reinsurer, indicated:

I don't think it is possible to influence specific behavior of pool employees/third party administrator personnel, but

¹⁵¹ E-mail from senior official, Cnty. Comm'rs Ass'n of Pa., to Assistant Dir., TASB, Inc., *supra* note 107.

[reinsurers can influence the] general goals and metrics for the entire company. For instance, we offer a discount on premiums for financial loss ratios being under, say, 100%. There are a number of ways to achieve this, including loss control requirements, claims management procedures, coverage offerings/issues, and/or rate adequacy. So, by offering that carrot, we are incentivizing a steady business model and solvent pools, but how the pool accomplishes that, and with what employees, is their decision.¹⁵²

Again, this is the softer approach that yields potentially broader results by agreement with the pools. But all of his examples are regulatory in nature, even if voluntarily accepted.

As a final note for Part A, the former senior official with AGRiP stated:

As I have observed and worked with pools the past 34 years, I came to the realization that reinsurers do in fact ‘call the shots’ for the vast majority of pools; although a number of pool officials would argue to the contrary. But since most pools assume very little risk they are at the mercy of the reinsurance community when developing coverage terms and rates.¹⁵³

This statement encompasses a great deal of the initial findings for this Part regarding the impact of reinsurers on pools generally, and specifically on their underwriting, claims and finance operations. “Calling the shots”, as this official described it, and the pools’ acceptance of this approach, certainly seems to be reinsurer governance.

In this sub-Part, there were various characterizations by the participants of reinsurers’ influence on pools, mostly in underwriting and claims. However, these interviews, to this author, demonstrate that the governance effect—the behavior changing ability—by reinsurers has been substantively felt among the pooling market. The degree of influence may

¹⁵² E-mail from reinsurance underwriter, GEM, Inc., to Assistant Dir., TASB, Inc. (May 9, 2013, 3:08 PM CST) (on file with author).

¹⁵³ E-mail from former senior official, AGRiP, to Assistant Dir., TASB, Inc., *supra* note 122.

be situational, but seems constant as to most pools. As we will see in this next sub-Part, there is a great deal more consensus as to the core of the relationship, the utmost good faith concept.

B. DUTY OF UTMOST GOOD FAITH

A second point, “utmost good faith,” arose from this examination of reinsurer influence. In an era when courts are struggling with the traditional concept of utmost good faith between reinsured and reinsurer, are the parties to reinsurance contracts themselves moving away from the utmost good faith concept of long intertwined relationships built on trust? Are we seeing a move throughout the industry towards an arms-length transaction between two sophisticated parties? Are cedents pushing reinsurers away from simple treaty agreements and towards sophisticated reinsurance agreements?¹⁵⁴ Simply put, are cedents treating reinsurance like a commodity, and moving away from engaging in utmost good faith?

While the term “utmost good faith” was not used in any survey questions, most of the respondents, unprompted, described the transparency, trust and long-term relationships they felt with their current reinsurers, as well as the engagement, education, and assistance they received from their reinsurers—all hallmarks of *uberrima fides*. Utmost good faith still appears to be a vibrant element in pooling. This seems to show that utmost good faith is not only still relevant in this market, but also necessary for the success of the relationship. Additionally, the pools generally had the same high level of transparency and depth with their reinsurers they had with their own members, the same “utmost good faith” in both transactions. While some courts and authors believe that the utmost good faith doctrine in reinsurance has gone past its usefulness,¹⁵⁵ the author’s research with pools indicates the concept of utmost good faith is expanding, and is necessary for both parties to gain from the relationship. Indeed, this advantage goes well beyond financial gain in pooling, for both cedent and reinsurer.

¹⁵⁴ It seems obvious that reinsurers who suspect their cedents are playing “hide the ball” in violation of the spirit of utmost good faith are later going to take legal steps to *not* follow the fortunes of their cedent.

¹⁵⁵ OSTRAGER & VYSKOCIL, *supra* note 69 at 3-22 (citing Unigard Sec. Ins. Co. v. N. River Ins. Co., 4 F. 3d 1049, 1066, 2d Cir. (1993)). *See also* Thomas, *supra* note 81.

The current senior official of AGRiP said: “Over time, either a good professional relationship of trust and mutual respect emerges, or not, and this influences who does business with who.”¹⁵⁶ Again, while there is reinsurer influence, long-term relationships are what makes this truly beneficial for both parties. This official indicates that if both parties cannot influence the relationship, then perhaps they should not be in business together.

The senior official for the North Carolina School Boards Trust stated:

Another factor that may increase the level of reinsurer influence (which is true in our case) is the length of the reinsurer/pool relationship. We have worked with our current reinsurer for the past six years, and over that timeframe a mutual trust and respect has developed between [the NCSB] Trust staff and reinsurer staff about our programs and processes, as well as reinsurance expectations. Because of the positive working relationship that we have developed, both parties seem interested in helping the other. When we have annual renewal meetings, our reinsurer is very helpful in responding and providing input to our plans for coverage changes and other programmatic changes we might be contemplating, without being too imposing or forcing changes on us. The working relationship has been extremely positive, and even though we initially felt that some of their reporting expectations were a bit onerous, we now have a better understanding of why they require us to report the way we do. Generally, we have found the input from our reinsurer to be helpful, and we try to accommodate them to continue the positive relationship that we have with them. By the same token, I think they try to accommodate us in certain ways because they find the relationship worth the effort.¹⁵⁷

¹⁵⁶ E-mail from current senior official, AGRiP, to Assistant Dir., TASB, Inc., *supra* note 120.

¹⁵⁷ E-mail from senior official, N.C. Sch. Bds. Ass’n to Assistant Dir., TASB, Inc., *supra* note 135.

Here, the reinsurer is seen as a valued partner, one with whom there is mutual trust and respect, as well as a source of industry information. This pool came to accept *and understand* the governance exerted by the reinsurer. This realization of understanding the needs of the reinsurer made the pool's acceptance much easier, and led to a better relationship. This greater interaction shows utmost good faith in the flow of information.

The former senior official with AGRiP stated:

[I] have also concluded that most in the reinsurance community who are committed to the long-term success of pools work very hard to appreciate the unique characteristics of public entity exposures and finances. This has developed as a symbiotic relationship, although, in my opinion, reinsurers exert more influence than pool officials generally are willing to concede. In the late 70's and early 80's, I experienced any number of reinsurance business executives who "knew better than the public administrators" as to how to conduct an insurance operation. Perhaps they did, but the public administrators knew how to manage diversity – leading to the long-term success of pooled risk management for public entities, of which the "insurance" is just one component. One of my signature phrases is "public entities cooperating together to manage their risks is what differentiates pooling from traditional insurance."¹⁵⁸

While mentioning the effect of reinsurer influence again, this is the first mention of the "symbiotic" relationship, a concept that will come up again later. It is this symbiosis that makes this relationship work; requiring utmost good faith, as well an understanding of each other's business interests.

The senior official with the Maryland Association of School Boards indicated:

We have always thought that providing reinsurers with accurate data on the front-end will make us a pool they can trust and work with. We work very hard to provide them

¹⁵⁸ E-mail from former senior official, AGRiP, to Assistant. Dir., TASB, Inc., *supra* note 122.

with the data they need, so as to make it easy to write our account.¹⁵⁹

Again, this official solidifies the notion of trust as being paramount in this relationship.

Transparency, a vital element of utmost good faith, seemed to be very much on the respondents' minds. The underwriter from GEM attributed it to the origin of governmental entity pooling, when asked if pools were more transparent than traditional insurers, from his reinsurance point of view:

Absolutely. The first and obvious reason is that many pools fall under various states' freedom of information acts, while traditional insurers are constantly developing innovative and propriety products to beat their competition. Secondly, although I have only been in pooling for 8 years, it seems the culture of transparency has been around since the beginning. This includes transparency within the membership of each pool, as well as within the pooling community around the country.¹⁶⁰

It is this transparency that leads to the concept of utmost good faith being not only possible, but embraced.

Transparency was again mentioned by the senior official from the Texas Association of School Boards, Inc. She felt, like others, this transparency began with the basis of pooling, open governments:

I believe most pools started out of a governmental mind-set. They were started either by governmental associations or by government employees. As a result, I think there was an inherent sense of open operations, similar to open government. That awareness that anyone can come in and look at your operations, coupled with a general desire to

¹⁵⁹ E-mail from senior official, Md. Ass'n of Bds. of Educ., to Assistant Dir., TASB, Inc., *supra* note 114.

¹⁶⁰ E-mail from reinsurance underwriter, GEM, Inc., to Assistant Dir., TASB, Inc. (July 9, 2013, 10:17 AM CST) (on file with author).

‘do good’ resulted in a self-governance mind-set for most pools.¹⁶¹

The transparency described is key to utmost good faith thriving—just the knowledge by a reinsurer that the pool has this inherent philosophical outlook builds confidence on the part of the reinsurer.

Probably the most interesting comment on the pool-reinsurer relationship was from the senior official with the Montana School Group Insurance Authority. Perhaps unknowingly, he addressed the doctrine of utmost good faith in his detailed discussion of high-level relationships with reinsurers:

The reinsurers seek what many of the primary pools seek with their members—a long-term relationship with a downstream member (customer) that is willing to listen to the risk and claim management advice of their upstream partner. If all three of the players in the relationship share and deploy best practices with regard to these two disciplines, then the relationship is bound to generate a profitable relationship for all. Having a reinsurer that is willing to get to know the primary pool operations, long-term goals and the management team can go a long way with primary pool reinsurance pricing and willingness to offer needed structural elements to meet the coverage needs. Trust and relationships is as much a part of this level of the business as the raw data sets. Both are important but if you have the trust that your partner will do the right things over the long-term to benefit all parties, many times we can work through some of the years when large claims arise and we get to know our reinsurance partners in a manner closer than sometimes we would like.¹⁶²

¹⁶¹ E-mail from senior official, TASB, Inc., to Assistant Dir., TASB, Inc., *supra* note 105.

¹⁶² E-mail from senior official, Mont. Sch. Grp. Ins. Auth., to Assistant Dir., TASB, Inc., *supra* note 132.

This official has embraced the doctrine of utmost good faith, and shown that it has the potential to benefit all, rather than be a burden, as previously indicated by some commentators.

The current AGRiP senior official notes the benefits of this two-way relationship as well:

However, I must note, I likewise know that pools have influenced reinsurers' understanding of, and underwriting requirements for, writing pools. They have had to learn that the pools' mission is to reduce risk, not create underwriting profit, and this has changed reinsurance practices for those who really have a stake in pooling.¹⁶³

This official has seen the broader influence of the utmost good faith effect—an entire section of the market can be better understood by this open communication. This brings more reinsurer interest to pooling, which benefits the pools' members through more reinsurance products and greater competition.

C. HAVE POOLS BECOME MORE ACCOMMODATING TO REINSURERS' INPUT?

A third key finding was regarding whether pools have become more accommodating to reinsurers in the last decade.¹⁶⁴ The general answer was yes. Again, the responses varied, but they leaned towards pools being more accommodating or remaining equally accommodating in the past ten years as the relationships between the two industries matured. There was a true willingness of the pools to open up their operations, not based on just the necessity to obtain reinsurance, but out of a sincere desire to have reinsurers understand their operations *and* missions. This act of openness

¹⁶³ E-mail from current senior official, AGRiP, to Assistant Dir., TASB, Inc., *supra* note 120.

¹⁶⁴ Ten years was used by the author because many officials would not have the experience with any longer period, and any shorter period might not be significant enough, or too subject to market conditions. Additionally, for accuracy (*supra* note 94), the author should have asked the broader question (*see* Apps. A.¶ 2., B.¶ 5., and C.¶ 8): have pools become more *or less* accommodating? However, based on the thoroughness of the responses, there was little indication that pools had recently been less accommodating to the wishes of the reinsurers—only that accommodation had remained constant or increased.

itself is an accommodation, although some officials did not perceive it as such. However, the officials overall wanted their reinsurers to understand they were *not* insurers, but risk management pools. Most participants felt a sense of partnership with reinsurers, cultivated that relationship on a long-term basis and did not feel as though reinsurance was just another commodity.

The senior official from the County Commissioners Association of Pennsylvania answered:

Absolutely [pools are more accommodating]. I think a lot of this is because there are so few [reinsurance] companies to choose from. Once you develop a long-term relationship with a reinsurer, and they know your processes, philosophy and people, you want to be able to continue that relationship. If you have to change reinsurers, you know there will be a large investment of time educating the new reinsurer and working out all the kinks. This is not to say I would remain with a reinsurer if they were overcharging me. Price is important but it is not the be all and end all. We once changed our work comp reinsurer because the pool board was attracted by the shiny objects – a small savings in premium and a two year rate guarantee – and we ended up going back to the reinsurer we left because the shiny objects [reinsurer] did not understand public entities.

[Reinsurer] input is definitely valuable. In pooling we sell the added value of all the pool services, things our members cannot get elsewhere. I expect the same added value from our reinsurers. They provide speakers for our training sessions for our members. They advise us on coverage issues. It is much more than just giving us a reinsurance certificate. And I also think this helps them understand that we are serious about our business and want to do a good job.¹⁶⁵

¹⁶⁵ E-mail from senior official, Cnty. Comm'rs Ass'n of Pa., to Assistant Dir., TASB, Inc., *supra* note 107.

Again, we see the same discussion pattern about long-term relationships, and the good faith activity it takes for both parties to get to that comfort level and depth of understanding. But this pool expected some greater accommodation from the reinsurer as well.

The senior official with the Montana School Board Group Insurance Authority indicated for all the reasons he cited as to how reinsurers did have influence, those were the same reasons that pools had become more accommodating in the past ten years.¹⁶⁶ As can be seen, many of these concepts, and the responses to them, can be quite interrelated.

The senior official for the Arizona School Risk Retention Trust, Inc., indicated that the last ten years had not affected the level of accommodation, but attributed that to long-term relationships:

In our case, I would not say we have had to become more accommodating due to reinsurer's input, unless the market absolutely dictated a change was necessary, i.e. higher pricing. The Trust has sought the opinions of our reinsurers for many years because we value their input and in most cases, it has proven to be helpful. With the recent large liability losses our pool has experienced, we were firm in our belief that our reserve numbers were more accurate than what the reinsurers were suggesting. We proved we were correct when the cases settled well below the reinsurers' reserve amounts. This is a factor of our claims staff being more familiar with the local judicial atmosphere and specifically, cases involving our industry (education), than the reinsurers.

Our philosophy and actual demonstration of long-term partnerships makes the Trust attractive to insurers, more so than trying to accommodate reinsurers based on input they provide on how we should operate. One of our reinsurance partners has been with us for over twenty years.

We also believe that if a reinsurance carrier has paid out more in losses than they have received from us in

¹⁶⁶ This senior official stated, "The answer is yes . . . for the reasons described above." E-mail from senior official, Mont. Sch. Grp. Ins. Auth., to Assistant Dir., TASB, Inc., *supra* note 132.

premium, we will do what we can to remain a partner with that reinsurance carrier so that they are made whole over time. Conversely, due to the recent competitive marketplace with several reinsurers vying for market share, it puts the pool in a powerful position to not necessarily be as accommodating to reinsurer's input, if a particular reinsurer is suggesting unrealistic terms and conditions or rates.¹⁶⁷

While there was no increased accommodation on his pool's part, it is very clear this was due to an ongoing and developed reinsurer relationship that made further accommodation unnecessary for his pool. Note the willingness to stay with a reinsurer if the reinsurer had sustained losses. This willingness shows a great deal of accommodation—and one that the pool hopes will come back to benefit them. Obviously, it took a great deal of time and effort to get to that point.

Similarly, the senior official with the Maryland Association of School Boards felt that the accommodation level had not increased or decreased:

I do not think that we have become more accommodating over the past 10 years. We have always tried to work together with our reinsurance partners and continue to do that.¹⁶⁸

Again, there is a commitment from the pool over a period of years. While this does not indicate an increase in accommodation, neither does it appear there a decrease.

The senior official with the Idaho Counties Risk Management Program, however, indicated there was no need to be more accommodating:

We have found our reinsurers being much less demanding than ten years ago so we don't need to accommodate much. I don't know if this experience is true for other

¹⁶⁷ E-mail from senior official, Ashton Tiffany, LLC, to Assistant Dir., TASB, Inc., *supra* note 112.

¹⁶⁸ E-mail from senior official, Md. Ass'n of Bds. of Educ., to Assistant Dir., TASB, Inc., *supra* note 114.

pools, however, the current reinsurance market seems much less interested in understanding our operations than 10 years ago. I believe reinsurance underwriters today focus more on loss experience and exposure data and less on the personnel and perceived operational competence of the pool than they did a decade ago. Evidence for this is found in the decreasing frequency of personal meetings we have with the markets and the lack of inquiry into anything other than loss runs and exposure data.¹⁶⁹

This official's experience may be an anomaly, or may be that his pool has run so well that the reinsurer feels no need for greater involvement.

The former senior official with the Washington Schools Risk Management Pool gives his view on accommodation to reinsurers, regardless of their influence:

Pools more accommodating to reinsurers . . . I know we haven't. We left [our previous reinsurer] because they started writing our competition. I told them to choose—us or them, so they chose them and we did not renew. If anything, our current reinsurer . . . has been accommodating to us, seeking our input on head concussion claims, asking what resources they can provide to assist us, and taking part in our annual meetings . . . [As to reinsurers writing our competition,] I view it as an arms dealer who supplies both sides of the war. I do not want my claims/underwriting information leaked out to the other side and I don't trust a vendor who doesn't see a conflict. I also want to maintain a competitive edge, so I want my vendor to give me something the other [pool] can't. The question I've asked myself is, at what point does this become meaningless—do I stop shopping at Wal-Mart just because my competition shops there?¹⁷⁰

¹⁶⁹ E-mail from senior official, ICRMP, to Assistant Dir., TASB, Inc., *supra* note 116.

¹⁷⁰ E-mails from former senior official, Wash. Sch. Risk Mgmt. Pool, to Assistant Dir., TASB, Inc., *supra* note 129.

While this official feels that he has limited his accommodation to the point of even terminating a reinsurance relationship, we will see later on that he also strongly believes in the relationship, which may be why he ultimately terminated his reinsurer.

The senior official with the Park District Risk Management Agency did not feel that pools were more accommodating or less accommodating in the last ten years, but felt there was a continued level of accommodation. He stated:

I have only been actively involved in placing the reinsurance for the past 8 years and I haven't seen a significant change in the time frame at PDRMA. I think we have been relatively accommodating/receptive to the reinsurers input and made changes suggested, both because it is useful and because it makes us more attractive to the reinsurers. Two specific examples: Three years ago we undertook a significant project to identify all of the land, including open undeveloped land, that our members own/lease so that we could continue with the pollution coverage we offer to the members. While the program is a commercial insurance policy that we purchase on a group basis with a high deductible, it is similar in concept to reinsurers having influence on the data we collect. We could have continued to procure the coverage without the updated information, but there would have likely been restrictions on the coverage.

Second example is when skate parks became popular in our area about 8-10 years ago, the reinsurers were very concerned that we were going to have large influx of claims from those parks. They wanted specific data on how many parks were in our membership and how the risks were being controlled. The data was easy to collect because we only had a few parks and our loss control staff had been working with the members to develop risk management guidelines so we had what the reinsurers wanted. Fast forward 10 years, there are very few skate park claims and none that have reached the reinsurance

layers so this exposure has become a non-issue and the reinsurers pay little attention to skate parks now.¹⁷¹

Here, the PDRMA took the necessary steps required for the reinsurance underwriting, rather than make it a difficult issue for both parties. The cooperation and transparency paid off for the pool in the end. Again, while there is no mention of increased accommodation, it does not appear it has lessened.

The senior official with the North Carolina School Boards Association noted accommodation levels can vary based on circumstances. She said:

I think pools are probably more accommodating of reinsurers input, if they respect their reinsurer. I suppose that in a circumstance where a pool may have no other reinsurance option available, the accommodation of reinsurer input is more out of necessity. Thankfully, that has not been our situation over the last 10 years.¹⁷²

This is another indication of reinsurer long-term relationships being worthwhile for both parties.

A senior official with the Washington State Transit Insurance Pool¹⁷³ felt that, because of the growth of pooling, it was the reinsurers that were more accommodating to the pools. He said:

It is more likely that the reinsurers' have moved to accommodate pooling than the other way around. More than 80% of the public entity market is engaged in some pooling relationship. I'm sure the commercial reinsurers realize the significant market pooling is and they need to

¹⁷¹ E-mail from senior official, Park Dist. Risk Mgmt. Agency, to Assistant Dir., TASB, Inc., *supra* note 110.

¹⁷² E-mail from senior official, N.C. Sch. Bds. Ass'n, to Assistant Dir., TASB, Inc., *supra* note 135.

¹⁷³ The Washington State Transit Insurance Pool website is available at <http://www.wstip.org/default.aspx> (last visited Dec. 27, 2014).

adjust to our process and mindset more than pooling to theirs.¹⁷⁴

This official's perception, that reinsurers have become more accommodating to pools, is likely true, based on the desire for greater pooling market share discussed previously. However, this did not directly answer if pools, regardless of the reinsurers' positioning, have become more accommodating as well—perhaps a meeting in the middle in this case.

A senior official with the New Hampshire Public Risk Management Exchange¹⁷⁵ discussed less involvement by their reinsurer, but noted their lengthy successful relationship underpinning the views of both parties. This official stated:

Regarding influence, we have not had much involvement by our reinsurer, with whom we have had a long-term relationship. Our reinsurer is looking at our losses from a different lens than we are. . . . [I] think we have had favorable results with our reinsurer from a terms and conditions standpoint, so the influence is minimal, other than when there is a loss that reaches the reinsurance layer. Then our concern is whether we can reach a consensus on the claim with the reinsurer.¹⁷⁶

Here, it appears the official feels the current need for accommodation has not been at a high level due their favorable results over time.

The AGRiP senior officials, both current and former, had general observations regarding pools being more accommodating in the past ten years. The current senior official stated:

I can't speak for all pools, but the ones I work with certainly have. I believe pools are better served by recognizing that there are partners out there—even for-

¹⁷⁴ E-mail from senior official, Wash. State Transit Ins. Pool, to Assistant Dir., TASB, Inc. (July 2, 2013, 10:39 AM CST) (on file with author).

¹⁷⁵ The New Hampshire Public Risk Management Exchange website is available at <http://www.nhprimex.org/> (last visited Dec. 27, 2014).

¹⁷⁶ E-mail from senior official, N.H. Pub. Risk Mgmt. Exch., to Assistant Dir., TASB, Inc. (July 2, 11:26 AM CST) (on file with author).

profit reinsurers!—who have expertise to share, along with capital to “rent.” [As for those pools that have not been as accommodating to reinsurers], I believe that some in the pooling industry retain a distrust of for profit ‘vendors’ and the insurance/reinsurance industry, in particular. They have seen [reinsurers] run from the market, withhold claim reimbursements, deny claims, even go under, and the [pool executives] get cynical. Likewise, reinsurers have seen some pools hit them with big claims and [drop their reinsurance coverage] the next year, or [pools] be less than forthcoming and timely with information. There are always examples of bad business practices on both reinsurer and pools’ parts. There are many more examples of excellent, long term partnerships; they just don’t garner as much attention.¹⁷⁷

In other words, the individual cases of lack of faith are the ones that get discussed, due to lawsuits and lingering bad feelings, but the ongoing and symbiotic relationships do not warrant much discussion individually. She continues:

Yes, I think the influence of all of the service providers/partners vary by pool and individuals employed by the pools and their willingness to engage with their reinsurers as partners. One of the reasons AGRiP seeks to educate pools is so that pools are on a more equal footing with their service providers—reinsurers, actuaries, auditors—because there is much “art” to managing risk and risk financing, and when the pool and the subject matter expert partner as ‘peers’ to solve problems, all are better served. Some pool managers don’t share this perspective; some reinsurance partners don’t embrace it. But, in my experience, pool leaders have overall been evolving toward a more collaborative operating model with their reinsurers (and other partners), and this is a good thing.¹⁷⁸

¹⁷⁷ E-mail from current senior official, AGRiP, to Assistant Dir., TASB, Inc., *supra* note 120.

¹⁷⁸ *Id.*

This official notes the necessity for pools' engagement of the reinsurers—to gain a better understanding of the reinsurance process, and to use pool cooperation as leverage for a better reinsurance product. While she mentions being 'peers,' the act of engagement brings the influence of the reinsurer to a greater level. Such an engagement, while done in the spirit of partnership, appears to be concession to governance. This official has seen why accommodations happen, and why they do not.

The former senior official of AGRiP opined about accommodation:

There does not seem to be as much of an adversarial relationship between pool officials and reinsurers as in the first 20 years of pooling. However, some pools have not been as accommodating because they continue to have a bad taste in their mouth due to fraudulent reinsurance schemes they were placed in or because of reinsurer insolvency. Both sides have matured and developed a greater appreciation for their mutually dependent relationships.

[Another reason some pools may not have been as accommodating to reinsurers, and] I realize this is a broad overstatement, but: it seems the greater the influence of elected officials over a pool, the greater the pool considers its importance and wants to operate like a big fish in a small pond. In reality, all pools are small fish in big ponds. The fewer elected officials involved, the more rational the decision-making. But I never SAID this [previously]; just theorized about it.¹⁷⁹

This official notes why some pools (seemingly in the minority) have *not* been as accommodating, and the reasons seem less than productive. It does appear this official is pointing out both parties must enter into, and continue, the relationship in good faith, act rationally based on their respective positions, and follow through on their commitments.

The reinsurer underwriter with GEM, on recent pooling accommodation, felt that pools continued to mature with the help of

¹⁷⁹ E-mail from former senior official, AGRiP, to Assistant Dir., TASB, Inc., *supra* note 122.

reinsurers, although some continue to resist. Have pools become more accommodating? The answer, from a reinsurer's standpoint, was:

Yes. I have been actively involved in pooling for eight years and when I first came within the industry, I was amazed at the general naiveté of pools' financial acumen. Some pools were still community rated by non-actuarial practitioners. Some pools felt comfortable reserving until their retention and no more. Some reserved on a stair-stepping basis. These are all simplistic ways to deal with risk transfer, but have become antiquated practices of recent. I can't say it was only reinsurer's influence, but more reinsurers took more pools seriously as their operations become more palatable [to reinsurers].

Some pools remain unfazed (and even annoyed) at reinsurer's 'suggestions.' These fiercely independent pools and pool leaders are clinging on to the purity of pooling back 20-30 years ago. Fortunately for [those particular] pool[s] and [their] members, 20 to 30 years of success permit the incontrovertible argument against fixing something that isn't broken.¹⁸⁰

Of course, the objective of regulation is to ensure solvency (which can never be guaranteed, regardless of the level or type of regulation), and these 'pure' pools are solvent. They continue to serve their public entity members in the best possible way. And, neither the added cost of government controlled regulation, nor the 'suggestions' of the reinsurers, are changing the level of risk the pool presents to the consumer.¹⁸¹

¹⁸⁰ Of course, lucky is not an excuse for a lack of objectivity and business prudence. As F. Scott Fitzgerald said, "Nothing is as obnoxious as other people's luck." Peggy Hayes, *Letters to Scottie, Letters to Us*, THE MISCELLANY NEWS, Oct. 2, 1981, at 6.

¹⁸¹ E-mail from reinsurance underwriter, GEM, Inc., to Assistant Dir., TASB, Inc., *supra* note 149.

This reinsurer seems to feel that the basis for greater accommodation by pools is, through maturation, a greater appreciation by the pools of those benefits the reinsurer can bring.

From the input of the participants documented here, there is general agreement that accommodations do exist, even if there is some dispute about whether it is increasing or not. As the GEM underwriter previously pointed out, reinsurers need to be careful as to the approaches taken pursuing this influence and the desire for pool accommodation, since this market is getting more competitive for reinsurers. It does seem that accommodations appear to be a form of voluntarily accepted reinsurer governance.

D. DOES REINSURER INFLUENCE VARY ACCORDING TO EXTERNAL FACTORS?

Lastly, the evidence showed that reinsurer influence with pools varies, as seen in some of the responses. Financial strength and pool sophistication, two elements often intertwined, were the two greatest factors that determined the level of reinsurer involvement. Did these officials believe reinsurer influence varied based on factors such as financial size or condition, perceived sophistication or experience of the pool administrators, or any other factors? Again, the answers diverged somewhat, but seemed to come back to financial strength of the pool as being the most specific factor. Nevertheless, more interesting was the officials' insistence on speaking to the relationship as the intangible factor that might be the most determinative of all in the debate regarding governance.

First, the senior official with the Texas Association of School Boards, Inc., stated:

I think the influence of the reinsurers varies greatly based on the financial condition, size, age, 'sophistication' and experience of the pool. The smaller, younger, financially weak or more outsourced a pool is, the greater the perceived risk for the reinsurer and the greater their involvement and imposition of certain requirements. For example, I can't remember the last time a reinsurer imposed or even reviewed . . . who [the TASB Risk Management Fund] can write and at what price. That's because we are very well established, have a proven track record and assume a large retention on every risk. So they

tend to leave us alone. However, if we were new, had an unproven track record, weren't as financially solid, the picture would be very different. The reinsurers would impose much greater underwriting and claims oversight than they do for us.¹⁸²

Finances appear to be the pivotal factor as to reinsurer governance, and influence seems to vary based on the relative strength of the pool. Because this pool is very substantial in comparison to its exposures, the reinsurers have fewer concerns or need for influence.

The former senior official with the Washington Schools Risk Management Pool felt that excellent financial condition of the pool lessened influence of the reinsurers:

Influence based on size . . . absolutely; with us self-insuring the first \$1 million and having the surplus to take more if necessary, I think we have more options and flexibility than a small pool with limited surplus and small retention. I think the Texas Association of School Boards has even greater clout with the reinsurance market.¹⁸³

It appears again that, regardless of the perception of reinsurer influence, reinsurers are much more willing to follow the fortunes of a well-managed, financially strong pool using less reinsurer influence.

The senior official with the Maryland Association of Boards of Education had similar sentiments about financial strength, but also sophistication of the administration:

[The] reinsurer would have a lot more confidence dealing with property from a pool that has accurate property values vs. a pool that can only estimate its property values.¹⁸⁴ And a reinsurer is obviously concerned about a pool's

¹⁸² E-mail from senior official, TASB, Inc., to Assistant Dir., TASB, Inc., *supra* note 105.

¹⁸³ E-mail from senior official, Wash. Sch. Risk Mgmt. Pool, to Assistant Dir., TASB, Inc., *supra* note 129.

¹⁸⁴ As the senior official with the Missouri Housing Authorities Property & Casualty, Inc. discovered, and corrected. E-mail from senior official, Mo. Hous. Auths. Prop. & Cas., Inc., to Assistant Dir., TASB, Inc., *supra* note 101.

finances. They obviously would rather write strong well-funded pools than those with inadequate reserves and/or surplus. I spoke with one of our reinsurers who advised me that our program secured great comparative rates because they trusted our submissions knowing our representations of data, claims and resources were accurate and our financial position was strong.¹⁸⁵

Again, finances, along with trust of the pool's representations, lessened the amount of reinsurance governance necessary. Reinsurers have a larger degree of faith and certainty in pools operating at a high level. This trust comes from the pool's transparency.

The senior official for the Arizona Risk Retention Trust, Inc., said that the factors leading to a well-established pool lessened the influence of the reinsurer:

Yes, the less mature pools may feel they are inexperienced and look to the reinsurer for guidance and advice. The less mature pools may also be less attractive to the reinsurers because of the lack of stability and the financial strength of a more mature pool. The more mature pools may be less influenced by the reinsurer, but may have strong working relationships with them which help keep the pool strong and attractive to other [re]insurers.¹⁸⁶

This is another example of the inverse relationship between pool strength and reinsurance governance. The stronger the pool, the less the reinsurer is able, or needs to, influence the pool.

The senior official with the Montana School Group Insurance Authority continued on the same theme of reinsurance influence waning as the pools financial strength grew. Can reinsurer influence vary?

Yes again. Size does matter with regard to the primary pool level. The large pools usually have greater depth and put more primary pool effort into the reinsurance

¹⁸⁵ E-mail from senior official, Md. Ass'n of Bds. of Educ., to Assistant Dir., TASB, Inc., *supra* note 114.

¹⁸⁶ E-mail from senior official, Ashton Tiffany, LLC, to Assistant Dir., TASB, Inc., *supra* note 112.

submission process. While smaller pools rely to a greater extent on the assistance provide by the insurance placement brokerage firm staff for the best items to include [as well as] how to organize the information for the reinsurance carrier. Many brokers will actually ‘pretty up’ the raw data from the smaller primary pool and provide a more organized package or submission for the reinsurance carrier on behalf of their [small pool] client.

[However], the larger pools often . . . need access to certain reinsurance markets because of specialty risks they need to insure such as Tier 1 wind,¹⁸⁷ Flood zone A¹⁸⁸ & V,¹⁸⁹ or just the raw size of their program limit needed. Thus, not just any reinsurance carrier is going to do, so the [reinsurance] influence, although still indirect, is more present than ever given the factor of primary pool size.¹⁹⁰

This official points out an interesting diminishing returns dilemma for successful pools. If a pool is successful and needs a reinsurer willing to reinsure large amounts, or a pool specializes in a niche market (which many governmental entity pools inherently must), the market for reinsurance products actually decreases. This can result in the increased influence of the remaining reinsurers on such pools; a greater level of governance because of the increased or unusual exposures and limited selection of reinsurers.

¹⁸⁷ Those coastal areas are prone to windstorms and hurricanes, thus specialized coverage is needed. For example, in Texas these coastal areas are listed in TEX. INS. CODE § 2210.003(4) (West 2009).

¹⁸⁸ Areas subject to inundation by the one-percent-annual-chance flood event generally determined using approximate methodologies. *Zone A*, FED. EMERGENCY MGMT. AGENCY, <http://www.fema.gov/floodplain-management/zone#0> (last visited Dec. 27, 2014).

¹⁸⁹ Areas along coasts subject to inundation by the one-percent-annual-chance of flood event with additional hazards associated with storm-induced waves. *Zone V*, FED. EMERGENCY MGMT. AGENCY, <http://www.fema.gov/national-flood-insurance-program-2/zone-v#0> (last visited Dec. 27, 2014).

¹⁹⁰ E-mail from senior official, Mont. Sch. Grp. Ins. Auth., to Assistant. Dir., TASB, Inc., *supra* note 132.

The senior official with the Idaho Counties Risk Management Program felt that while reinsurers do exert more or less influence based on varying pool factors, other external factors played a role as well:

I do believe reinsurers are influenced [by financial size or condition, perceived sophistication or experience of the pool administrators]. However, reinsurance markets continue to be driven by financial modeling and national and international corporate strategy rather than by personal perception of individual pools. Allianz¹⁹¹ provided a large and popular property market for pools until three years ago. ICRMP had been a client for 10 years and was extremely profitable. Allianz's corporate strategy was to exit the public entity market place and resulted in a large number of pools changing property markets. Allianz's decision is an example of a global corporation's market strategy taking precedent over the local underwriter's impressions of an individual pool.¹⁹²

This official's experience was that the pooling market was still not large enough to make an overall impression on large reinsurers. However, it appears other reinsurers are taking their place, as the GEM reinsurer underwriter indicated.

The senior official with the County Commissioners Association of Pennsylvania took a more relationship-centric view to the question regarding various factors affecting influence, and this became a trend in the responses:

I think it [is] more about the philosophy of the management of the pool. This includes the [pool's] board but I would say it is as much about the pool's staff. If the pool's staff believes reinsurance is just a mere commodity, then the relationship will be very different and can even be combative. If the relationship is collaborative, even a rough claims issue can be resolved. We did have one bad

¹⁹¹ See generally *Property Insurance*, ALLIANZ GLOBAL CORP. & SPECIALTY, <http://www.agcs.allianz.com/services/property/> (last visited Dec. 27, 2014).

¹⁹² E-mail from senior official, ICRMP, to Assistant Dir., TASB, Inc., *supra* note 116.

situation with a reinsurer who abandoned us because of our [then] financial condition (which is much stronger now). They were new to our pool and did not want to invest the time to see if we would turn the finances around.¹⁹³

Notice the term “commodity” arose, as a definite negative to a pool. It is apparent to this official that the more reinsurance is a commodity for a pool, for whatever reason, the less beneficial the relationship is for the pool, and the less good faith is shown by all.

The senior official with the Park District Risk Management Agency noted:

I do think perceived sophistication/experience and financial conditions can influence a reinsurers’ view of a specific pool. The reinsurers regularly review our financials as part of the annual renewal process and they want to know details about any changes. A pool that significantly under prices exposures for the members may create additional risks for the reinsurers.¹⁹⁴

In other words, if a reinsurer believes a pool is underpricing its coverage, the reinsurer will charge higher premiums or may walk away altogether. Under-pricing exposures is very detrimental to the creation and maintenance of an atmosphere of utmost good faith, and makes it extremely difficult for a reinsurer to willingly follow the fortunes of the pool. More sophisticated pools are better able to price their exposures accurately.

The former senior official of AGRiP had comments that are more general:

Yes, just as with other insurers or in any other business relationship where there are degrees of separation between “size, perceived sophistication [and] experience, financial condition or other factors” between the parties. But reinsurers, as a general proposition, are seeking long-term

¹⁹³ E-mail from senior official, Cnty. Comm’rs Ass’n of Pa., to Assistant Dir., TASB, Inc., *supra* note 107.

¹⁹⁴ E-mail from senior official, Park Dist. Risk Mgmt. Agency, to Assistant Dir., TASB, Inc., *supra* note 110.

financial success, not just one profitable year at the expense of their clients.¹⁹⁵

This official notes that while all of those factors are important, the reinsurers generally do not want a one-term relationship. It appears this is much like gambling—reinsurers have to win over time; otherwise, they are dependent upon quick strike luck at pools' expense, and will soon run out of willing clients. The relationship aspect matters most, regardless of what factors drive it and how much governance is necessary.

The underwriter from the reinsurer GEM had this to say—and note his use of the term 'symbiotic relationships,' which is mentioned unprompted more than once by various pooling officials:

GEM is in a unique position on this, since we are owned by pools. Our best interest is our pools best interest, and vice versa. I think a reinsurer's influence does vary, somewhat based on the items you list, but also based on the reinsured's acceptance of "advice." Because reinsurance as a regulator is de facto at best, without legal authority or mandatory regulations, the reinsured needs to both accept and value the suggestions made by the reinsurer. This type of trust is built either by mutual interested (such as with GEM), or long-term symbiotic relationships (as with other commercial reinsurers).¹⁹⁶

This reinsurance underwriter encapsulates much of the theory of this paper—the cedent has no statutory obligation but willingly accepts operational governing parameters to obtain a product. This governance is best appreciated and grown through long-term symbiotic relationships.

The senior official with the Washington State Transit Insurance Pool continued the symbiotic theme, mentioning the need for these solid relationships, regardless of his feelings on influence:

The questions on the relationship of a reinsurer to the conduct of our pool are mutual. Before we would even

¹⁹⁵ E-mail from former senior official, AGRiP, to Assistant Dir., TASB., Inc. (July 11, 2013, 12:07 PM).

¹⁹⁶ E-mail from reinsurance underwriter, GEM, Inc., to Assistant Dir., TASB, Inc., *supra* note 149.

entertain the prospect of any engagement we'd make sure they know our business, they are comfortable with our best practices and claims handling and final they share our long term vision.

Pooling as a whole is finally beginning to ideologically move from the mindset of a 'country-club attitude' to a small mutual insurance enterprise. Pools relationship to the mutual insurance world is no different than a credit union is to being a bank.

Our business is one of relationships. Pools need to foster a cohesive, professional and mutual understanding with their respective partners including reinsurers, captives and excess markets.¹⁹⁷

This is another relationship-centric focused comment that indicates the governance is beyond any one factor of reinsurer influence.

The senior official with the New Hampshire Public Risk Management Exchange emphasized reinsurer relationships as well:

As to the relationship between reinsurers and pools, it is critical. It is critical for the reinsurer to know the pool is proactive in risk management and claims mitigation, and that the pool has the appropriate expertise on staff to deal with that. I think there is work by the claim staff that can be done to keep the loss from ever getting into the reinsurance layer, so staff expertise and skill level is important to reinsurers. From the pool's perspective, it is vital the reinsurer understands the unique nature of public entity pooling and the unique exposures that come with that. The relationship has to be symbiotic, as this is important to enable both parties to succeed.¹⁹⁸

¹⁹⁷ E-mail from senior official, Wash. State Transit Ins. Pool, to Assistant Dir., TASB, Inc., *supra* note 174.

¹⁹⁸ E-mail from senior official, N.H. Pub. Risk Mgmt. Exch., to Assistant Dir., TASB, Inc., *supra* note 176.

There is striking continuity in this relationship theme. This official feels that symbiosis is critical for success.

The senior official with the North Carolina School Boards Association felt strongly as well about the relationship aspect:

I think it is helpful to have the reinsurer as a resource of information and to use as a guide in deciding which direction a pool might go with certain programs, if the pool respects the reinsurer and its staff. For example, this year we engaged our reinsurer in discussions about how our pool planned to address the issue of law enforcement liability coverage for our members. Of course, a topic such as this has direct implications on the reinsurer, depending on how the coverage is written, and having them involved in the discussion from the beginning was good for everyone. If the mutual respect/positive relationship does not exist between the reinsurer and the pool, then it is difficult to move forward as a team in planning which way a pool program may decide to go.¹⁹⁹

The senior official with the Missouri Housing Authorities Property and Casualty, Inc., echoed the same sentiments about the pool-reinsurer relationship:

The pool-reinsurer relationship is a valuable and necessary partnership. I believe that good and timely communication, together with consistency in the handling of claims is key to negotiating the optimal arrangement for future years. Relationships matter a lot.²⁰⁰

The current senior official with AGRIP felt that reinsurers gaining a greater understanding of pooling was a key factor—but it often depended on the underwriters:

¹⁹⁹ E-mail from senior official, N.C. Sch. Bds. Ass'n, to Assistant Dir., TASB, Inc., *supra* note 135.

²⁰⁰ E-mail from senior official, Mo. Hous. Auths. Prop. & Cas., Inc., to Assistant Dir., TASB, Inc., *supra* note 101.

It depends on the individual [underwriter], more than the reinsurance company. Some individual underwriters at reinsurers that have developed a real understanding of pools will tell you they truly prefer pool partners than other insurance companies. They embrace the mission-driven risk control purpose. They appreciate the stability of the pool's book of business. But underwriters with no such experience really don't know there is a difference. I don't mean to sound philosophical, but I truly believe that pooling, done right, is a different animal—a different paradigm—than insurance. There are underwriters that specialize in pools at a variety of reinsurers who 'get this', and sell [their] senior management on this [concept]. But, that doesn't mean the reinsurance company as a whole prefers pools to insurers; they are just two separate client groups.²⁰¹

Much like the operation of GEM, which is a reinsurer owned by its member pools, the senior official with the County Commissioners Association of Pennsylvania mentioned his own captive reinsurer,²⁰² a system that creates and encourages the long-standing relationships:

We are members of one of our reinsurers – County Reinsurance Limited (CRL). Two of our pools work with CRL for coverage (work comp and liability). CRL is a Vermont based captive owned by the county pools, which are reinsured by it. This is the next step in pooling, gaining greater control and specificity of knowledge about our exposures. This is working exceedingly well for us.²⁰³

²⁰¹ E-mail from current senior official, AGRiP, to Assistant Dir., TASB, Inc., *supra* note 120.

²⁰² See generally Donald J. Riggin, *Things to Know about Captive Insurance Companies*, INT'L RISK MGMT. INST. (Nov. 2008), <http://www.irmi.com/expert/articles/2008/riggin11-risk-finance-captives.aspx>.

²⁰³ E-mail from senior official, Cnty. Comm'rs Ass'n of Pa., to Assistant Dir., TASB, Inc., *supra* note 107.

While the senior official with the Maryland Association of School Boards previously mentioned he did not feel there was much in the way of influence by reinsurers, he felt the relationship aspect was necessary:

[F]or us, working with reinsurers is just like working with other vendors. Trust, transparency and diligence go a long way to creating a positive mutually beneficial relationship.²⁰⁴

The senior official with the New Hampshire Public Risk Management Exchange probably capped this discussion most succinctly:

We need reinsurance. We need that level of protection. Its whether or not the reinsurers will see the opportunity, with what is happening in the market, to stay competitive with small to medium sized risks, like pools.²⁰⁵

Towards the end in this last sub-Part, the officials' thoughts were left without this author's comment, as they seemed to speak for themselves. As can be seen, even though the question presented to the officials involved factors that might vary influence (and thus governance), most redirected back to, and passionately argued for, the need for symbiotic relationships over the long-term. Without these close relationships, it appears, reinsurers would have no influence (other than purely contractual) for governance to protect their exposures, and pools would have little incentive to accommodate the reinsurers.

V. CONCLUSION

Based on this research, it seems clear there is a form of reinsurance influence or 'governance,' in the largely unregulated world of self-insured pools, and it seems to manifest itself mostly in underwriting and claim reinsurer influence. Rather than state regulation, which takes the all too familiar form of statutes, administrative regulations, and litigation, this 'governance' imposed by reinsurers is centered on relationships and the

²⁰⁴ E-mail from senior official, Md. Ass'n of Bds. of Educ., to Assistant Dir., TASB, Inc., *supra* note 114.

²⁰⁵ E-mail from senior official, N.H. Pub. Risk Mgmt. Exch., to Assistant Dir., TASB, Inc., *supra* note 176.

business needs of both parties. Pools are free to unburden themselves from any oversight or influence by reinsurers, and reinsurers are free to not accept pools' risks. Nevertheless, in both doing so, pools lose the opportunity to rent capital to expand their market share or limit risk, and reinsurers lose premium dollars and their own market share.

While some pools feel reinsurers have no real impact, and perhaps some reinsurers might feel they have great control, the reality for both lies more towards the middle. Depending on the pool, the advantage is more likely towards the reinsurer, or, when dealing with experienced and well-funded pools, perhaps more towards equilibrium. Reinsurers currently do not conduct business with pools with a stick, but a carrot—the promise of lower rates and/or more favorable terms if the pools concede to certain reinsurer input or improve transparency. Thus, as many above have put it, the reinsurer is essentially *given* influence on the process by the pools. All pools want lower reinsurance rates to help lower the overall cost to their members. In order to obtain this benefit, the pools willingly accept reinsurer's governance to gain the advantages possible in the relationship.

Moreover, by pools *giving* this influence to their long-term partner reinsurers, this author argues the governance effect is not necessarily 'silent' as Professor Abramovsky labels it, at least in the pooling segment, but an open and recognized influence. Because this concept of 'agreed-upon governance' between cedents and reinsurers is a fairly new one, or at least not well documented, it may be that more pools and reinsurers will have different perspectives on the relationship as time goes on. Even the term 'influence' seems to mean different things to these diverse entities. What one pool views as ordinary underwriting requests by reinsurers might be viewed by another pool as overreaching and burdensome, much in the way some people have varying views of taxation.

However, it appears from this research there is a reinsurer 'governance effect' on pools in this relationship. Since the behavior of the pool changes based on the relationship, the degree of adjustment does not matter for the effect to cross the line into apparent governance, however mild. While there may be a contractual agreement in place among the parties, that cannot change the fact that, if reinsurance was always available and at a set price, pools would likely not alter their behavior, unless forced to do so by other internal or market conditions. Since the majority of pooling officials noted underwriting and claims accommodations, it certainly appears they agree that a form of governance is present, whether they wish to characterize it that way themselves or not.

Therefore, even if pools would prefer not to call it 'regulation' as it makes them think of state administrative regulation and all its negative

implications, this governance effect, even if very subtle compared to state regulation, is there. Reinsurers do shape the approach, to varying degrees, of how most pools operate.

This reinsurance influence does not have to be antagonistic, and as most survey participants agreed, is not. As the pooling officials admitted, they willingly agreed on some issues or bore the expense of more transparency since it helped them run a better business and gain the financial and marketing advantages of reinsurance. The opportunity of reinsurance gives the pools the flexibility to write new markets or expand current ones, limit risk and gain market knowledge—opportunities that might not have otherwise arisen had the pool not engaged in the reinsurance process.

The more interesting finding was the utmost good faith aspect that almost seemed inherent with this segment of the market. While other sectors of reinsurance may indeed be moving away from this concept and focusing on arms-length transactions, pooling seems to be going the opposite direction by embracing the relationship. From this admittedly small sample of the approximately 500 pools currently operating in the United States, it appears that, rather than becoming a commodity to each other, reinsurers and pools are engaging the strengths of each and forging long-term business bonds.

This adherence to the concept of utmost good faith through symbiotic relationships appears to arise inherently here, and, to this author, is the more important finding. This research did not set out to show whether utmost good faith was still abundant; however, the discovery of this is a satisfying underpinning to the main point of reinsurer influence. Does reinsurer governance arise because the concept of utmost good faith is adhered to by the pools, or does inherent reinsurer influence force the concept of utmost good faith onto the pools? In the end, it is neither. Pools *allow* the reinsurer to have influence to the extent necessary in order to obtain the best product and service possible for their members, and pools embrace utmost good faith because it is the most efficient route to that end in the long term.

Based on this research, these industry professionals outline the influence of reinsurers on pools, and the governance that arises from this influence. This regulatory influence, hypothesized by Professor Abramovsky, is demonstrated by this research. This reinsurer governance, whether characterized as direct or indirect, or regulatory or not in nature, is governance ('sway', as the governance definition also called it) accepted by the pools. This acceptance, shown in the form of utmost good faith by the pools, results in utmost good faith being returned by the reinsurers. These interdependent experiences strengthen the relationship, and the prospects, for both cedent and reinsurer, and are possible because of reinsurer governance.

VI. APPENDICES

A. INITIAL QUESTIONS TO POOL OFFICIALS

1. Do you think pools are influenced by reinsurers? If so, does this influence get into operational level matters affecting employees conduct, such as reinsurer suggestions on claim procedures, coverage issue handling, or authority—can you give any specific examples? If it is general influence rather than specific, such as what coverages to offer or underwriting criteria, can you give examples of that?

2. Do you think pools have become more accommodating in the past 10 years to reinsurers' input, either because the input is helpful or because it is necessary to make the pool more attractive to insurers? Or for any other reason?

3. Do you think reinsurers' influence on individual pools can vary based on factors such as the size of the pool, perceived sophistication/experience, financial condition or other factors?

4. Any other comments about the pool—reinsurer relationship from your experience?

B. INITIAL QUESTIONS TO AGRIP OFFICIALS

Assuming that reinsurance is a vital component of most pools' financial viability:

1. Do you believe pools have practices or operational procedures in place as a result of suggestions or requirements from reinsurers? Or, in other words, do you think pools believe they are directly or indirectly "regulated" in a fashion or largely influenced by their reinsurers' underwriting and examination of their operations?

2. If not, do you think pools believe their inherent financial viability requires them to focus on internal procedures (or to self-regulate without insurance department oversight), or is it more about their fiduciary and contractual obligations to members, rather than the influence of reinsurance? Or is it another reason?

3. As to the type of reinsurance typically taken out by pools, do you see most pools taking out treaty reinsurance or facultative reinsurance? More importantly, do you think most pools take out excess of loss reinsurance versus proportional reinsurance? I have a feeling pools are generally like the TASB Fund, with treaty reinsurance/excess of loss reinsurance.

4. I am very interested in your thoughts into those examples of pools attempting to be more attractive to reinsurers, and the subtle influence of reinsurers suggestions, regarding loss control requirements, claim management procedures and coverage issues. Specifically, I am interested in how reinsurers input affects the actual conduct of pool/TPA personnel. I am trying to nail down if reinsurers give general input, or does it tend to be more specific on the operational level? Additionally, what kinds of examples have you seen as it relates to claim management or coverage issues? Did reinsurers make suggestions generally about claim management focus, or was it more specific as to daily operations, structure, caseloads, or authority? As to coverage, were the suggestions more general in nature, such as types of coverage offered, or more specific/operational, such as suggestions on coverage question investigations or coverage decisions? Any examples of reinsurer influence you can give me that affect a large number of pools would be helpful.

5. Do you feel that pools have generally become more accommodating in the past decade to reinsurers input, either because the input is helpful or because of the attempt to make the pool attractive to reinsurers?

6. For any pools that have not been as accommodating, do you have any thoughts as to why, and do you think these pools are limiting their ability to grow (with the lack of capacity/capital)?

7. Do you think reinsurers currently feel more of a partnership with pools versus insurers, or is it just different?

C. QUESTIONS TO REINSURANCE UNDERWRITER

1. Do you believe pools have practices or operational procedures in place as a result of suggestions or requirements from reinsurers? Or, in other words, do you think pools are directly or indirectly “regulated” in a fashion or largely influenced by their reinsurers’ underwriting and examination of their operations?

2. Do reinsurers believe they directly or indirectly regulate or largely influence pools’ behavior through underwriting and operations reviews, more so than standard primary carriers?

3. If so, do reinsurers believe this influence is necessary because of the limited regulation or unregulated nature of pools? And is it more about pools’ financial stability or operational ability, or other factors?

4. If not, do reinsurers just feel pools are a risk like any other carrier, with inherent strengths and weaknesses?

5. Overall, do reinsurers support pools' efforts to remain outside of governmental regulation, and why?

6. As to the type of reinsurance typically taken out by pools, do you see most pools taking out treaty reinsurance or facultative reinsurance? More importantly, do you think most pools take out excess-of-loss reinsurance versus proportional reinsurance? I have a feeling pools are generally like the TASB Fund, with treaty reinsurance/excess of loss reinsurance.

7. I am very interested in your thoughts into those examples of indirect influence on pools by reinsurers' suggestions. Some areas of influence might be loss control requirements, claim management procedures and coverage offerings/issues. Specifically, I am interested in how reinsurers input affects the actual conduct of pool/TPA personnel. I am trying to nail down if reinsurers give general input, or does it tend to be more specific on the operational level? Can you give me examples of how reinsurers have tried to affect pools' behavior? Any examples of influence that affects the majority of pools would be helpful.

8. Do you feel that pools have generally become more accommodating in the past decade to reinsurers input, either because the input is helpful or because of the attempt to make the pool attractive to reinsurers?

9. For any pools that have not been as accommodating, do you have any thoughts as to why, and do you think these pools are limiting their ability to grow (with the lack of capacity/capital)? Or less accommodating because reinsurers are more interested lately in the public entity pooling market, and pools don't have to work as hard to find reinsurance?

10. As reinsurers gain a greater understanding of pools—reduction of risk versus underwriting profit—do you think reinsurers currently feel more of a partnership with pools versus insurers, or is it just different?

11. Why do you believe there has been renewed interest by reinsurers in writing pools?

D. SAMPLE INTERLOCAL PARTICIPATION AGREEMENT

**TASB RISK MANAGEMENT FUND
INTERLOCAL PARTICIPATION AGREEMENT**

Pursuant to the Texas Interlocal Cooperation Act, Chapter 791 of the Texas Government Code, this Interlocal Participation Agreement (Agreement) is entered into by and between the Texas Association of School Boards Risk Management Fund (Fund) and the undersigned local government of the State of Texas (Fund Member). The Fund is an administrative agency of local governments (Fund Members) that cooperate in performing administrative services and governmental functions relative to risk management.

TERMS AND CONDITIONS

In consideration of the mutual covenants and conditions contained in this Agreement and other good and valuable consideration, including, without limitation, the agreement of the Fund and Fund Members to provide risk management programs as detailed in this Agreement, the receipt and sufficiency of which are hereby acknowledged, Fund Member and the Fund, intending to be legally bound, and subject to the terms, conditions, and provisions of this Agreement, agree as follows:

1. **Authority.** Fund Member hereby approves and adopts the Restatement of Interlocal Agreement, dated May 20, 1997, which restated the Interlocal Agreement dated July 2, 1974, establishing the predecessor of the Fund. The Restatement of Interlocal Agreement is incorporated into this Agreement by reference and is available from the Fund upon request. This Agreement serves to outline the relationship between the Fund and Fund Member. While the Texas Interlocal Cooperation Act provides the overarching basis for the Fund, certain Fund programs are further authorized pursuant to various statutes, such as Chapter 205 of the Texas Labor Code, pertaining to unemployment compensation; Chapter 504 of the Texas Labor Code, pertaining to workers' compensation; and Chapter 2259,

Subchapter B, of the Texas Government Code, pertaining to other risks or hazards.

2. **Program Participation.** This Agreement enables Fund Member to participate in one or more of the Fund's available programs, including but not limited to, property, liability, auto, workers' compensation, and unemployment compensation coverage. Because this is an enabling Agreement, Fund Member must also execute a separate Contribution and Coverage Summary (CCS) for each Fund program from which it seeks coverage and/or administrative services. Only a valid CCS will confer the right to participate in a specific program and each CCS shall be incorporated into this Agreement. Through participation in any Fund program, Fund Member waives none of its immunities and authorizes the Fund, or its designee, to assert such immunities on its behalf and on behalf of the Fund or its designee.
3. **Term of Agreement.** This Agreement shall be effective from the date of the last signature below and shall remain in effect unless terminated as provided in this Agreement. This Agreement will automatically terminate if Fund Member ceases to participate in at least one of the Fund's programs (due to the expiration of a CCS participation term or the valid termination of same) or fails to meet the membership qualifications of the Fund as provided in this Agreement and as determined by the Fund in writing.
4. **Termination.** Unless this Agreement is automatically terminated as described above, this Agreement, and/or any component CCS applicable to Fund Member, can be terminated as set forth below. However, the termination of any single Fund program under a CCS shall not also result in the automatic termination of another pending CCS, or this enabling Agreement if any other CCS is still in force for Fund Member. Rather, each Fund program can only be terminated as provided in this Agreement.

- a. **By Either Party with 30 Days Notice before Renewal.**
Any CCS may be terminated by either party with termination to be effective on any successive renewal date by giving written notice to the other party no later than 30 days prior to automatic renewal.
- b. **By Fund Member upon Payment of Late Notice Fee.** If Fund Member fails to terminate a CCS as provided above, it may still terminate participation in any Fund program prior to the renewal date by paying a late notice fee as herein provided. If Fund Member terminates the CCS before the renewal date, but with fewer than 30 days' advance written notice, Fund Member agrees to pay the Fund a late notice fee in the amount of 25% of the annual contribution for the expiring participation term. Fund Member expressly acknowledges that the late notice fee is not a penalty, but a reasonable approximation of the Fund's damages for the Fund Member's untimely withdrawal from the program identified in the CCS. However, once the renewal term of a CCS commences, Fund Member can no longer terminate the CCS by paying a late notice fee; the CCS shall renew and Fund Member shall be bound thereby.
- c. **By the Fund upon Breach by Fund Member.**
 - 1) The Fund may terminate this Agreement or any CCS based on breach of any of the following obligations, by giving 10 days' written notice to Fund Member of the breach; and Fund Member's failure to cure the breach within said 10 days (or other time period allowed by the Fund):
 - 2) Fund Member fails or refuses to make the payments or contributions required by this Agreement;

- 3) Fund Member fails to cooperate and comply with any reasonable requests for information and/or records made by the Fund;
- 4) Fund Member fails or refuses to follow loss prevention or statutory compliance requirements of the Fund, as provided in this Agreement; or
- 5) Fund Member otherwise breaches this Agreement.

If the Fund terminates this Agreement, or any CCS, based on breach as described above, Fund Member agrees that the Fund will have no responsibility of any kind or nature to provide coverage on the terminated Fund program post-termination. Further, Fund Member shall bear the full financial responsibility for any unpaid open claim and expense related to any claim, asserted or unasserted and reported or unreported, against the Fund or Fund Member, or incurred by the agents or representatives of Fund Member.

In addition to the foregoing, if termination is due to Fund Member's failure to make required payments or contributions, Fund Member agrees that it shall pay the Fund liquidated damages in the amount of 50% of the annual contribution for the participation term identified in the terminated CCS.

5. Contributions.

- a. **Agreement to Pay.** Fund Member agrees to pay its contribution for each Fund program in which it participates based on a plan developed by the Fund. The amount of contribution will be stated in the relevant CCS and will be payable upon receipt of an invoice from the Fund. Late fees amounting to the maximum interest allowed by law, but not less than the rate of interest authorized under Chapter 2251, Texas Government Code, shall begin to accrue daily on the first day following the

due date and continue until the contribution and late fees are paid in full. If Fund Member owes the Fund payments under this Agreement, including any CCS, the Fund may offset such amounts from any Fund Member funds held by the Fund, regardless of program.

- b. **Estimated Contribution.** In specified situations, the amount of contribution shown in the CCS will be identified as an estimate. The Fund reserves the right to request an audit of updated exposure information at the end of the CCS participation term and adjust contributions if Fund Member's exposure changes during the CCS participation term. As a result of the exposure review, any additional contribution payable to the Fund shall be paid by Fund Member, and any overpayment of contribution by Fund Member shall be returned by the Fund. The Fund reserves the right to audit the relevant records of Fund Member in order to conduct this exposure review.

Upon expiration of each participation period, Fund Member may request a contribution adjustment due to exposure changes. Such request must be made in writing within 60 days after the end of the participation period. Fund Member must provide documentation as requested by the Fund to demonstrate that the exposure change warrants a contribution adjustment.

- c. **Contribution Adjustment.** Should the Fund's underwriting income for any program within a given program year be inadequate to pay the ultimate cost of claims incurred for that year, the Fund may collect an adjusted contribution from any current or former Fund Member if that Fund Member's contribution is inadequate to pay the Fund Member's claims incurred during that year.

6. **Contribution and Coverage Summary.** Fund Member agrees to abide by each CCS that governs its participation. A CCS will incorporate the program specific coverage document, if any, which sets forth the scope of coverage and/or services from the Fund. A CCS for a Fund program will state the participation term. After Fund Member's initial execution of a CCS, the CCS will automatically renew annually, unless terminated in accordance with this Agreement. Any renewal containing a change in the amount of contribution or other terms will be subject to the Amendment by Notice process described in this Agreement.
7. **Loss Prevention.** The Fund may provide loss prevention services to Fund Member. Fund Member agrees to adopt the Fund's reasonable and customary standards for loss prevention and to cooperate in implementing any and all reasonable loss prevention and statutory compliance recommendations or requirements.
8. **Other Duties of Fund Member.**
 - a. **Standards of Performance.** Time shall be of the essence in Fund Member's reporting of any and all claims to the Fund, payment of any contributions or monies due to the Fund, and delivery of any written notices under this Agreement.
 - b. **Claims Reporting.** Notice of any claim must be provided to the Fund no more than 30 days after Fund Member knows or should have known of the claim or circumstances leading to the claim, unless a different reporting requirement is required by law or provided for in the CCS. Failure by Fund Member to timely report a claim may result in denial of coverage or payment of fines or penalties imposed by law or regulatory agencies. If the Fund advances payment of any fine or penalty

arising from Fund Member's late claim reporting, Fund Member will reimburse the Fund for all such costs.

9. **Administration of Claims.** The Fund or its designee agrees to administer all claims for which Fund Member has coverage after Fund Member provides timely written notice to the Fund. Fund Member hereby authorizes the Fund or its designee to act in all matters pertaining to handling of claims for which Fund Member has coverage pursuant to this Agreement. Fund Member expressly agrees that the Fund has sole authority in all matters pertaining to the administration of claims and grants the Fund or its designee full decision-making authority in all matters, including without limitation, discussions with claimants and their attorneys or other duly authorized representatives. Fund Member further agrees to be fully cooperative in supplying any information reasonably requested by the Fund in the handling of claims. All decisions on individual claims shall be made by the Fund or its designee, including, without limitation, decisions concerning claim values, payment due on the claim, settlement, subrogation, litigation, or appeals.
10. **Excess Coverage/Reinsurance.** The Fund, in its sole discretion, may purchase excess coverage or reinsurance for any or all Fund programs. In the event of a substantial change in terms or cost of such coverage, the Fund reserves the right to make adjustments to the terms and conditions of a CCS as allowed by the Amendment by Notice process under this Agreement. If any reinsurer, stop loss carrier, and/or excess coverage provider fails to meet its obligations to the Fund or any Fund Member, the Fund is not responsible for any payment or any obligations to Fund Member from any reinsurer, stop loss carrier, or excess coverage provider.
11. **Subrogation and Assignment of Rights.** Fund Member, on its own behalf and on behalf of any person entitled to benefits under this Agreement, assigns all subrogation rights to the

Fund. The Fund has the right, in its sole discretion, without notice to Fund Member, to bring all claims and lawsuits in the name of Fund Member or the Fund. Fund Member agrees that all subrogation rights and recoveries belong first to the Fund, up to the amount of benefits, expenses, and attorneys' fees incurred by the Fund, with the balance, if any, being paid to Fund Member, unless otherwise specifically stated in the Agreement. Award of funds to any person entitled to coverage, whether by judgment or settlement, shall be conclusive proof that the injured party has been made whole. Fund Member's right to be made whole is expressly superseded by the Fund's subrogation rights. If Fund Member procures alternate coverage for a risk covered by the Fund, the latter acquired coverage shall be deemed primary coverage concerning that risk.

12. **No Waiver of Subrogation Rights.** Fund Member shall do nothing to prejudice or waive the Fund's existing or prospective subrogation rights under this Agreement. If Fund Member has waived any subrogation right without first obtaining the Fund's written approval, the Fund shall be entitled to recover from Fund Member any sums that it would have been able to recover absent such waiver. Recoverable amounts include attorneys' fees, costs, and expenses.
13. **Appeals.** Fund Member shall have the right to appeal any written decision or recommendation to the Fund's Board of Trustees, and the Board's determination will be final. Any appeal shall be made in writing to the Board Chair within 30 days of the decision or recommendation.
14. **Bylaws, Policies, and Procedures.** Fund Member agrees to abide by the Bylaws of the Fund, as they may be amended from time to time, and any and all written policies and procedures established by the Fund (which are available from the Fund upon written request). If a change is made to the Fund's Bylaws, written policies or procedures which conflicts with or

impairs a CCS, such change will not apply to Fund Member until the renewal of such CCS, unless Fund Member specifically agrees otherwise.

15. **Payments.** Fund Member represents and warrants that all payments required under this Agreement of Fund Member shall be made from its available current revenues.
16. **Cooperation and Access.** Fund Member agrees to cooperate and to comply in a timely manner with all reasonable requests for information and/or records made by the Fund. Fund Member further agrees to provide complete and accurate statements of material facts, to not misrepresent or omit such facts, engage in fraudulent conduct or make false statements to the Fund. The Fund reserves the right to audit the relevant records of Fund Member to determine compliance with this Agreement.
17. **Fund Member's Designation of Coordinator.** Fund Member agrees to designate a coordinator (Program Coordinator) for Fund Member on this Agreement or any CCS executed by Fund Member. Fund Member's Program Coordinator shall have express authority to represent and to bind Fund Member, and the Fund will not be required to contact any other individual regarding matters arising from or related to this Agreement. Fund Member reserves the right to change its Program Coordinator as needed, by giving written notice to the Fund; such notice is not effective until actually received by the Fund. Notice provided to the Chief Executive Officer of Fund Member shall also serve as notice to the Program Coordinator.
18. **Security of Documents.** Under this agreement the Fund may grant Fund Member access to sensitive or protected information. Fund Member agrees to assume the responsibility for maintaining the security of this information and to take all reasonable steps to avoid unauthorized disclosure of this information.

19. **Insurance Terminology.** The Fund is not “insurance”, but is instead a mechanism through which eligible governmental entities join together to collectively self-insure and administer certain risk exposures. Any reference in this Agreement to an insurance term or concept is coincidental, is not intended to characterize the Fund as “insurance” as defined by law, shall be deemed to apply to self-insurance, and is not to be construed as being contrary to the self-insurance concept.
20. **Representation.** Fund Member authorizes the Fund to represent Fund Member in any lawsuit, dispute, or proceeding arising under or relating to any Fund program and/or coverage in which Fund Member participates. The Fund may exercise this right in its sole discretion and to the fullest extent permitted or authorized by law. Fund Member shall fully cooperate with the Fund, its designee, and the Fund’s chosen counsel, including, without limitation, supplying any information necessary or relevant to the lawsuit, dispute, or proceeding in a timely fashion. Subject to specific revocation, Fund Member designates the Fund to act as a class representative on its behalf in matters arising out of this Agreement.
21. **Members’ Equity.** The Fund Board, in its sole discretion, may declare a distribution of the Fund’s members’ equity to Fund Members. Members’ equity belongs to the Fund. No individual Fund Member is entitled to an individual allocation or portion of members’ equity.
22. **Entire Agreement.** This Agreement, together with the Restated Interlocal Agreement, Bylaws and CCSs that are in effect as to Fund Member from time to time, represent and contain the complete understanding and agreement of the Fund and Fund Member, and there are no representations, agreements, arrangements, or undertakings, oral or written, between the Fund and Fund Member other than those set forth

in this Agreement duly executed in writing. In the event of conflict between the terms of this Agreement and the Restated Interlocal Agreement, Bylaws or any CCS, the specific terms of the later adopted agreement shall prevail to the extent necessary to resolve the conflict. This Agreement replaces all previous Interlocal Participation Agreements between the Fund and Fund Member. Notwithstanding the foregoing, this Agreement does not supersede any unexpired participation term or pending claim under an existing agreement between Fund Member and Fund.

23. **Amendment by Notice.** This Agreement, including any of its component CCSs or coverage documents, may be amended by the Fund, in writing, by providing Fund Member with written notice before the earlier of (i) the effective date of the amendment or (ii) the date by which Fund Member can terminate without payment of late notice fees or liquidated damages. Unless this Agreement expressly provides otherwise, an amendment shall only apply prospectively and Fund Member shall have the right to terminate this Agreement, or a component CCS to which the amendment applies, before the amendment becomes effective, as provided in this Agreement. If Fund Member fails to give the Fund timely written notice of termination, Fund Member shall be deemed to have consented to the Fund's amendment and agrees to abide by and be bound by the amendment, without necessity of obtaining Fund Member's signature.

The Fund may amend this Agreement or any CCS effective upon renewal. Amendments may be for any reason including changes to the terms or contribution amount.

The Fund may also amend this Agreement or any CCS, effective during the term of a CCS, for any reason including but not limited to the following:

- a. State or federal governments, including any court, regulatory body or agency thereof, adopt a statute, rule, decision, or take any action that would substantially impact the rights or financial obligations of the Fund as it pertains to this Agreement, or any Fund program or CCS.
- b. The terms of the Fund's stop-loss or excess coverage or reinsurance change substantially.

If the Fund exercises the option to amend the Agreement or any CCS during the term of a CCS and prior to renewal, the Fund shall give Fund Member 30 days advance written notice. Fund Member will then have the right during the 30-day period to give the Fund written notice of termination of the applicable Fund program, effective upon the expiration of the 30-day notice period (or longer period if so provided by the Fund in writing).

24. **Severability; Interpretation.** If any portion of this Agreement shall be declared illegal or held unenforceable for any reason, the remaining portions shall continue in full force and effect. Any questions of particular interpretation shall not be interpreted against the drafter of this Agreement, but rather in accordance with the fair meaning thereof.
25. **Governing Law; Venue; Attorneys' Fees.** This Agreement shall be governed by and construed in accordance with the laws of the State of Texas, without regard to the conflicts of law principles of such state. Venue for the adjudication or resolution of any dispute arising out of or relating to this Agreement shall lie in Travis County, Texas, unless otherwise mandated by law. In the event of a lawsuit or formal adjudication between Fund Member and the Fund, the prevailing party is entitled to recover reasonable and necessary attorneys' fees that are equitable and just.
26. **Waiver.** No provision of this Agreement will be deemed waived by either party unless expressly waived in writing by

the waiving party. No waiver shall be implied by delay or any other act or omission. No waiver by either party of any provision of this Agreement shall be deemed a waiver of such provision with respect to any subsequent matter relating to such provision.

27. **Assignment.** This Agreement or any duties or obligations imposed by this Agreement shall not be assignable by Fund Member without the prior written consent of the Fund.
28. **Authorization.** By the execution of this Agreement, the undersigned individuals warrant that they have been authorized by all requisite governance action to enter into and to perform the terms and conditions of this Agreement.
29. **Notice.** Unless expressly stated otherwise in this Agreement, any notice required or provided under this Agreement by either party to the other party shall be in writing and shall be sent by first class mail, postage prepaid or by a carrier for overnight service or by electronic means typically used in commerce. Notice to the Fund shall be sufficient if made or addressed as follows: TASB Risk Management Fund, P.O. Box 301, Austin, Texas 78767-0301, or tasbrmf@tasbrmf.org. Notice to a Fund Member shall be sufficient if addressed to the Program Coordinator or Fund Member's Chief Executive Officer and mailed to Fund Member's physical or electronic address of record on file with the Fund.
30. **Signatures/Counterparts.** The failure of a party to provide an original, manually executed signature to the other party shall not affect the validity or enforceability of this Agreement. Either party may rely upon a facsimile or imaged signature as if it were an original. This Agreement may be executed in several separate counterparts, each of which shall be an original and all of which shall constitute one and the same instrument.

WHEREFORE, the parties agree to be bound by this Agreement by signing below.

For FUND MEMBER:

Fund Member Name: _____

By: _____
Signature of Fund Member's Authorized Representative

Date: _____

Printed Name of Fund Member's
Authorized Representative

For TASB Risk Management Fund Use Only

For TASB RISK MANAGEMENT FUND:

By: _____
Chair, TASB Risk Management Fund Board of Trustees

Date: _____

THE HARMONIZATION OF EUROPEAN CONTRACT LAW: THE CASE OF INSURANCE CONTRACTS

JUAN BATALLER GRAU¹

The harmonization of European Contract Law for consumers and businesses continues to progress; however, without some standardization of the insurance contract, it will be difficult to achieve a true single market. This Article chronicles the European Union's activities towards this goal, including the role of the Principles of European Insurance Contract Law, which provides a set of model rules for European legislators. The Article also analyzes: (i) the appropriate legal nature of the instrument of European Contract Law; (ii) the scope of that legal instrument (e.g. whether the instrument should cover both cross-border and domestic contracts, and whether it should include contracts between businesses and consumers or only those between businesses); and (iii) the most appropriate scope to answer the needs to be served.

The Article argues for the use of optional instruments as a key step towards a harmonized system and offers that the best way forward is to construct a regulatory system whose ultimate objective is to be globally applicable. Lastly, the Article concludes that the law of insurance contracts is a constituent part of contract law, and as such, the best legislative practice for the regulation of insurance contracts is to restrict its scope to those issues that differentiate insurance from the general theory of obligation and contract.

¹ Professor of Commercial Law, CEGEA, Universidad Politécnica de Valencia. Member of the Commission Expert Group on a European Insurance Contract Law. E-mail: jbataller@cegea.upv.es. The author of this Article has spent more than ten years working on this subject, has been involved with the various exercises in public consultation that were mentioned earlier, and was also present at the hearing that triggered the rulings of the European Social Council. Juan Bataller Grau, *Un Mercado Europeo del Seguro: Claves para una Re-visión*, in DERECHO PRIVADO EUROPEO 741 (Sergio Cámara Lapuente ed., 2003); Juan Bataller Grau, *¿Hacia la Unificación de la Normativa del Contrato de Seguro en Europa? Tópicos para un Debate*, in DERECHO PATRIMONIAL EUROPEO 40 (Guillermo Palao Moreno et al. ed., 2003); Juan Bataller Grau, *Los Principios de Derecho Europeo del Contrato de Seguro: la Técnica del Instrumento Opcional*, in DERECHO CONTRACTUAL EUROPEO 435 (Esteve Bosch Capdevila, ed. 2009).

I. THE GREEN PAPER ISSUED BY THE COMMISSION ON
OPTIONS FOR PROGRESS TOWARDS A EUROPEAN
CONTRACT LAW FOR CONSUMERS AND BUSINESSES

A. INTRODUCTION

The European Union activity in the insurance sector must be directed, as indicated in Article 2 of the Treaty establishing the European Community, to the achievement of a single market. However, a quick overview of the status of the Community rules on its three branches – the supervision of insurance companies and the market, the insurance intermediary and, as a central element, the insurance contract – shows developments with relevant differences. On the one hand, monitoring-based entities have enacted generations of directives, which have led to a uniform method of authorization across the entire Community ("European passport"). Such authorization must be sought from the supervisory authorities of the home Member State.² Similarly, Directive 2002/92/EC of the European Parliament and the Council on insurance mediation also establishes a single license for insurance intermediaries. By contrast, the harmonization of contract law has been less successful – except in the area of insurance automobile liability, as only there has there been a harmonization of conflict rules, regardless of the proposed Directive that failed.

This uneven development of regulation is not the result of a differentiated assessment of the role that the various elements of the insurance law are called to play in the achievement of a single market. Clearly, the rules of supervision and mediation, such as regulating access conditions, exercising insurance activity and distributing contracts in the market, is of paramount importance in this process, but the product offered is another pillar on which building any market rests. However, without some standardization of the insurance contract, it seems difficult to achieve a true single market. The current situation ultimately leads to a certain isolation of markets. Therefore it is easy to deduce that the state of European regulations has generated more criticism than adhesions.

So, on July 1, 2010, the Commission published the Green Paper on Options for Progress Towards a Uniform European Contract Law for

² See Directive 2009/138/EC of the European Parliament and of the Council of 25 November 2009 on the Taking-Up and Pursuit of the Business of Insurance and Reinsurance (Solvency II), 2009 O.J. (L 335) (EU).

Consumers and Businesses. This marks another milestone on the road to the elusive, but eagerly awaited, European Contract Law – a project on which great intellectual efforts are being expended³.

The internal European Union market, we note, consists of a multitude of contracts, which are subject to various different national contract laws. The differences between these national contractual laws can both add to the costs of transactions and cause considerable uncertainty for businesses about their exact legal position. This, in turn, undermines consumer confidence in the internal market. The differences in the regulations governing Contract Law can even force businesses to alter their conditions of contract. Furthermore, national legislation is rarely translated into other European languages, and hence those entering the market require the services of a lawyer who is familiar with the legislation of the legal jurisdiction under which they propose to operate.

Partly for these reasons, consumers and businesses, particularly small and medium enterprises (SMEs) whose resources are limited, are frequently reluctant to undertake cross-border transactions. This reluctance, in turn, inhibits cross-border competition – to the general detriment of society. Consumers and businesses in the small Member States can be at a particular disadvantage. The process that culminated in the Green Paper sought to address these concerns.

B. BACKGROUND

The origins of this process are found in “The Principles of European Contract Law” (Lando Commission), which was initiated in the 1960s, although it was not until the 1980s that it began to operate.⁴ This project prepared the ground for further academic works: Study group for a European Civil Code⁵/ Research Group on EC Private Law (Acquis

³ JOINT NETWORK ON EUROPEAN PRIVATE LAW (COPECL), <http://www.copec1.jura.uni-osnabrueck.de/copec1/dms/copec1/dms.php> (last visited Dec. 27, 2014).

⁴ PRINCIPLES OF EUROPEAN CONTRACT LAW, PARTS I AND II (Ole Lando & Hugh Beale eds., 2000); PRINCIPLES OF EUROPEAN CONTRACT LAW, ART. III (Ole Lando et al. eds., 2003).

⁵ STUDY GROUP ON A EUROPEAN CIVIL UNION, <http://www.sgecc.net> (last visited Dec. 27, 2014).

Group),⁶⁷ European Contract Code (the Pavia group),⁸ and “Restatement of European Insurance Contract Law.”⁹

However, this is more than just an academic project, as is demonstrated by the interest shown by Community institutions. First, the European Commission has played an important role, as evidenced by: the Communication from the Commission to the Council and to the European Parliament on a European Contract Law,¹⁰ which was followed by the Communication by the Commission to the Council and to the European Parliament, on Greater Consistency in European Contract Law, an Action Plan,¹¹ and finally the Communication from the Commission to the Council and to Parliament, on a European Contract Law and an Assessment of Existing Community Law: Perspectives for the Future.¹²

Secondly, the European Social and Economic Committee has also played a part by issuing the following reports: the first on “European Insurance Contracts”¹³ and the second with the title, “The 28th Regime: An Alternative to Allowing Less Lawmaking at Community Level.”¹⁴ Nor should we overlook mentioning the European Parliament Resolutions.

⁶ ACQUIS GROUP: EUROPEAN RESEARCH GROUP ON EXISTING EC PRIVATE LAW, <http://www.acquis-group.jura.uniosnabrueck.de/> (last visited Dec. 27, 2014).

⁷ PRINCIPLES, DEFINITIONS AND MODEL RULES OF EUROPEAN PRIVATE LAW: DRAFT COMMON FRAME OF REFERENCE (DCFR) (Christian von Bar & Eric Clive Sellier eds., 2009).

⁸ EUROPEAN CONTRACT CODE PRELIMINARY DRAFT (Universita Di Pavia ed., 2004).

⁹ *Project Group: “Restatement of European Insurance Contract Law”*, UNIVERSITÄT INNSBRUCK, <http://www.uibk.ac.at/zivilrecht/restatement/> (last visited Dec. 27, 2014); PRINCIPLES OF EUROPEAN INSURANCE CONTRACT LAW: A MODEL OPINION INSTRUMENT (Helmut Heiss & Mandeep Lakhan eds., 2011).

¹⁰ *Communication from the Commission to the Council and the European Parliament On European Contract Law*, COM (2001) 659 final (Nov. 7, 2001).

¹¹ *Communication from the Commission to the Council and the European Parliament a More Coherent European Contract Law An Action Plan*, COM (2003) 68 final (Dec. 2, 2003).

¹² *Communication from the Commission to the Council and the European Parliament European Contract Law and the Revision of the Acquis: The Way Forward*, COM (2004) 651 final (Nov. 10, 2004).

¹³ Opinion of the European Social & Economic Committee on ‘The European Insurance Contract’ (EU) No. 157/2005 of 26 June 2005, 2005 O.J. (C 157) 1.

¹⁴ Opinion of the European Economic and Social Committee on ‘The 28th Regime – An Alternative Allowing Less Lawmaking at Community Level’ (EU), 2011 O.J. (C 21).

The next step of this process crystallized these policies into the Green Paper from the Commission on Policy Options for Progress Towards a European Contract Law for Consumers and Businesses.¹⁵

C. PUBLIC CONSULTATION

The main long-term objective of the Green Paper was to define possible ways to strengthen the internal market, develop proposals for European Contract Law, and initiate public consultation on these proposals.

Public consultation has focused on deciding three important issues. The first problem is to elucidate what juridical form the new legal instrument for contract law should take. The proposed options range from a simple statement of the results, to the promulgation of a regulation to create a European Contract Law. Intermediate options center on using the results as a model to follow in future reforms of European legislation, but without implementing it; a simple recommendation to Member States that they should incorporate into in their respective legislation a regulation which would adopt Contract Law as an optional instrument; or a regulation on European Contract Law.

The second issue is limited to defining the scope of the legal instrument. Here there are two separate issues: first, whether the instrument would be applicable just to contracts between businesses, or whether contracts between businesses and consumers should also be included; second, whether it should govern only cross-border transactions, or whether it would also extend to domestic transactions.

Finally, we come to the decision as to which is the most appropriate scope to answer the needs to be served. Consequently, should we opt for recommending a legal instrument which would be restricted to what would be (more or less) a general theory of obligations and contracts; or, slightly more broadly, should we also seek to regulate extra-contractual responsibility, the restitution, acquisition and loss of assets, and the guarantee of property ownership rights; or even go a step further, to include specific contracts.¹⁶

¹⁵ *Commission Green Paper on Policy Options for Progress Towards a European Contract Law for Consumers and Businesses*, COM (2010) 348 final (Jan. 7, 2010).

¹⁶ Including Liability and Life insurance, as a first step.

II. THE CASE OF INSURANCE CONTRACTS: THE CONTRIBUTION OF THE “RESTATEMENT OF EUROPEAN INSURANCE CONTRACT LAW” RESEARCH GROUP

Within this process of progress towards a European Contract Law, in 2009 the “Restatement of European Insurance Contract Law”¹⁷ project group published “Principles of European Insurance Contract Law” (PEICL),¹⁸ the fruit of more than ten years’ work. These principles encompass the general provisions applying to all insurance contracts (except reinsurance) and the special provisions applicable to indemnity insurance and insurance of fixed sums.

The principles of European insurance contract law (PEICL) are designed to provide European legislators with a set of model rules, which have been developed building on a comparative law analysis of the various national regulations, as well as existing Community insurance law. They have been drawn up as an “optional instrument,” which allows insurers and policyholders to choose these principles, including mandatory rights, instead of national insurance contract law. Adopting the principles of European insurance contract law would enable insurance companies to offer their services throughout the internal market using a single, standard set of rules, which provide a high level of protection to policy holders, and at the same time enable European citizens to purchase non-national insurance products. In short, there has been an attempt to establish the basis for what we might call a EUROPOLICY.

A. WHAT IS AN OPTIONAL INSTRUMENT?

An optional instrument is so called because its application is dependent on the wishes of the parties in the contract.¹⁹ Its purpose is not to provide a regulation to replace national laws covering insurance contracts, but rather to make an alternative available which could be incorporated as a new regime, distinct from those that already exist in European Union member states.

¹⁷ Project Group: “Restatement of European Insurance Contract Law”, *supra* note 9.

¹⁸ PRINCIPLES OF EUROPEAN INSURANCE CONTRACT LAW, *supra* note 4.

¹⁹ D. Staudenmayer, *Ein optionales Instrument im Europäischen Vertragsrecht?*, ZEITSCHRIFT FÜR EUROPÄISCHES PRIVATRECHT, 2003, at 828, ff.

There are two types of optional instruments. In the first type, known as opt-in, the instrument's applicability is dependent on the express willingness of the contracting parties to be subject to its provisions; the second type, the opt-out instrument, applies unless the parties expressly state their wish not to be bound by it. In other words, with an opt-in instrument, the absence of any mention of its applicability means that the national regulations are automatically in force; meanwhile, with the opt-out, the opposite is true: the instrument, not the national rules, is in force.

One example of an opt-in instrument that is rather famous in commercial circles, even though it does not fall within Contract Law, may be found in the Regulation of European trade mark or in the Regulation on European industrial design. On the other hand, the Vienna Convention on International Sales of Goods, whose Article 6 allows the parties to a contract to declare that the Convention does not govern their particular contract, is an example of the second type of instrument.

Which model to choose has been the subject of some debate, although those who argue for the advantages of the opt-in instrument appear to be winning, and this is especially true within the insurance community. In effect, the opt-out type of instrument is more suitable for wholly non-mandatory regulations, while, as we know well, insurance contracts generally do – in fact must – contain a mandatory guarantee of at least some minimal rights for the insured. In turn, it has been pointed out that if an instrument is constructed on the opt-in model, then there is a risk that such an instrument could remain side-lined and completely marginal to the insurance market, since as a regulation it would appear artificial and entirely foreign in the eyes of those in the national legal systems. In my view, this latter argument is not a conclusive basis for a decision, since an optional instrument may play an extremely important role in the European Union insurance sector through the advantages it brings to those engaged in it.²⁰

B. CHARACTERISTICS OF AN OPTIONAL INSTRUMENT

An optional instrument replaces national law once the parties have decided, by means of the contract, that it is the legal framework that will govern their legal relationship. In consequence, when the parties to an insurance policy decide to place themselves under its scope, the contract is governed exclusively by the optional instrument and by clauses of the

²⁰ J. Basedow, *Ein optionales Europäisches Vertragsgesetz – opt-in, opt-out, wozu überhaupt?*, ZEITSCHRIFT FÜR EUROPÄISCHES PRIVATRECHT, 2003, at 1, ff.

contract, as is natural in contract law. Here, it is essential to clarify that national law ceases to provide a minimum standard of universal protection in this State. Incorporation of the optional instrument through the contract does not concede to the regulation's contractual nature. National law does not pre-empt the optional instrument when the latter provides lower protection. The parties' choice decides that one of the two regulatory frameworks will be applied wholly and hence, exclusively. Consequently, accepting the authority of the optional instrument entails displacing national law, thus incorporating all the mandatory rules that this instrument contains. To act otherwise would severely compromise the central function of an optional instrument, which is to achieve uniformity of application throughout the territory of the European Union.²¹

The derogation of the mandatory right that was promulgated in national legal regime for the protection of the insured needs to be accompanied by the institution of new regulations to provide a high standard of protection to those insured.²² An optional instrument must never become an easy escape route for insurance companies. The alternative of the two types of regulation must guarantee that there is a lowest common denominator: a high level of protection. However, once these protective rules for policyholders' rights are established, the remaining issues remain subject to free choice by the contracting parties; the optional instrument cannot interfere with the development of new products, nor restrict the freedom of the parties to determine for themselves the remaining clauses of any contract.²³

Optional instruments have to be independent, so that they do not become enmeshed with the national law of the different states. As we shall now see, their interpretation, incorporation, and integration cannot be accomplished through the different national legal regime. What is needed is a set of rules that is completely independent of the regulation of the different states of the European Union. This is the only way to accomplish the desired objective of harmonization. To act differently would be to recreate the very problems that we have set out to avoid.

²¹ Jürgen Basedow, *Insurance Contract Law as a Part of an Optional European Contract Act*, 4 ERA-FORUM 56, 61, 62 (2003), available at <http://link.springer.com/article/10.1007%2Fs12027-003-0007-0>.

²² Opinion of the European Social & Economic Committee on 'The European Insurance Contract', *supra* note 13, at 6.2.

²³ Malcolm A. Clarke & Helmut Heiss, *Towards a European Insurance Contract Law? Recent Developments in Brussels*, J. BUS. L., Sept. 2006, at 605.

C. ADVANTAGES OF OPTIONAL INSTRUMENTS

The first advantage of an optional instrument lies precisely in the fact that there is no detriment to the different national legal systems. There would be no need to modify the contracts that are already in use, thus eluding this high cost for insurers. In the same way – and this is not to be scorned – the continued existence of the various separate national regimes also means that another set of problems (of major importance in the failure of the Directive on insurance contracts) is avoided: the great difficulty that is encountered when attempting to reconcile different judicial philosophies or principles, particularly with common law and civil law.²⁴ This is by no means an idle argument if we consider the economic implications of reform, the inevitable result of a confrontation between two highly developed markets (Continental industry vs. British industry),²⁵ where a change in the product available – the insurance contract – (which is precisely the implication of a change in the regulatory framework governing insurance contracts) could lead to a competitor gaining a competitive edge of an unpredictable financial magnitude.²⁶

The second contribution relates to achieving a uniform regulatory framework throughout the European Union. In my judgement, it is precisely here, with the enormous practical usefulness of such a development, that the real benefit of implanting the optional instrument in the insurance market lies – rather than in the intrinsic benefit of the move towards harmonization. These benefits are of three different types.²⁷

1) A harmonized system would allow insurance companies to devise marketing strategies for the whole of the European Union. Let us

²⁴ Patrick Pearson, Opening Address to Int'l Ins. Contract Law in the EEC: Proceedings of a Comparative Law Conference Held at the European Univ. Inst., Florence 1, 3 (Fritz Reichert-Facilides & Hans Ulrich Jessurun d'Oliveira eds., 1993) (explaining the impossibility of negotiating a restatement between the different legal systems in Europe).

²⁵ Colin Crody & Rob Merkin, *Doubts About Insurance Codes*, J. BUS. L., Nov. 2001, at 587; Malcolm Clarke, *Doubts from the Dark Side - The Case Against Codes*, J. BUS. L., Nov. 2001, at 605; Patrick Griggs, *Insurance Codes- A Middle Way*, J. BUS. L., Nov. 2001, at 616.

²⁶ If a regulatory change compelled British insurers to change their policies – and therefore change their legal system-, continental insurers would have a relevant competitive advantage in the market, the consequences of which would be difficult to foresee.

²⁷ E.g., Basedow, *supra* note 21, at 62.

consider, for example, the possibilities that an optional instrument would open up marketing via Internet sites. This new set of rules would mean that it would be possible to draw up insurance contracts that would be available to clients in any Member State of the European Union.

2) Exchange of all types (commercial, sporting, cultural, etc.) is becoming more and more common in frontier areas. Overcoming the compartmentalization that comes with separate national legal systems would allow insurance brokers to offer their policies on either side of a frontier. This is a possibility that insurance companies do not currently allow, since policies are written in conformity to a single legal regulation. Similarly, this would bring a solution to the difficulties encountered by numerous citizens who live in one country but frequently travel to another – for example, to work or engage in business – with the insurance coverage problems that this inevitably brings.

3) European Union citizens who frequently change their country of residence suffer great inconvenience since they are continually obliged to change insurance policies. This implies not only difficulties of a legal nature, but also increased premiums. Insurance companies would be able to design policies to cover the entire territory of the European Union if there were a single regime.²⁸

There then arises the crucial question of whether the optional instrument should apply only to cross-border business, or whether it should be presented as an alternative to national law, and therefore generally available for all types of contract. As I have already argued, the second option would seem preferable.²⁹ It seems to me rather difficult to justify the limitation of applicability to only cover cross-border business. If the continuity of coverage is itself a positive value – and that is the view I take – it would not be correct to deprive the policyholder of coverage simply on the criterion of whether the contracting is cross-border or internal. The decision as to which law applies must reside in the freedom of choice of the contracting parties.

All in all, with an optional instrument, national legal rights are untouched, and it is left to the market to decide how useful the new regulatory regime is. Only those insurance companies which decided, of

²⁸ Helmut Heiss, *Mobilität und Versicherung*, in *VERSICHERUNGSRECHT* 448 (Gerlinde Weilinger ed., 2006).

²⁹ Bataller Grau, *¿Hacia la Unificación de la Normativa del Contrato de Seguro en Europa? Tópicos para un Debate*, *supra* note 1, at 63, ff.

their own free will, to place themselves under its scope would need to underwrite the associated transaction costs.

D. THE SOURCE OF THE MOST APPROPRIATE LEGAL FRAMEWORK

The Commission's Communication to the Council and to the European Parliament on a More Coherent European Contract Law: An Action Plan,³⁰ dated 12 February 2003, signalled the difficult choice of whether an optional instrument should take the form of a recommendation or of a regulation. In the subsequent debate on this question it was claimed that the non-binding nature of a recommendation would make its designation as a regulation very unclear, and cause the problems in international law that selecting a recommendation as the applicable law might entail. For all these reasons it seems most appropriate to incline towards a regulatory framework which contains alternative regulation to national laws.³¹

It has also been suggested that the PEICL could be useful without having to be promulgated as a regulatory act by Community institutions. As is the case with other texts drawn up by international institutions to be used in international contracts (e.g. UNIDROIT), the simple fact of acceptance of the authority of its articles, on the part of contracting parties, could be sufficient for it to be in force. However, this idea conflicts with the regulation contained in article 7³² of the Regulation (EC) no. 593/2008

³⁰ *Communication from the Commission to the European Parliament and the Council, a More Coherent European Contract Law, an Action Plan*, at 61, COM (2003) 68 final (Dec. 2, 2003).

³¹ Jürgen Basedow, *Der Versicherungsbinnenmarkt und ein optionales europäisches Vertragsgesetz*, in KONTINUITÄT UND WANDEL DES VERSICHERUNGSRECHTS, FESTSCHRIFT FÜR EGON LORENZ 101, 102 (Egon Lorenz ed., 2004).

³² Commission Regulation 593/2008, of the European Parliament and of the Council of 17 June 2008 on the Law Applicable to Contractual Obligations (Rome I), art. 7, 2008 O.J. (L 177) (EU):

1. This Article shall apply to contracts referred to in paragraph 2, whether or not the risk covered is situated in a Member State, and to all other insurance contracts covering risks situated inside the territory of the Member States. It shall not apply to reinsurance contracts.

2. An insurance contract covering a large risk as defined in Article 5(d) of the First Council Directive 73/239/EEC of 24 July 1973 on the coordination of laws, regulations and administrative provisions relating to the taking-up and pursuit of

the business of direct insurance other than life assurance (2) shall be governed by the law chosen by the parties in accordance with Article 3 of this Regulation.

To the extent that the applicable law has not been chosen by the parties, the insurance contract shall be governed by the law of the country where the insurer has his habitual residence. Where it is clear from all the circumstances of the case that the contract is manifestly more closely connected with another country, the law of that other country shall apply. 3. In the case of an insurance contract other than a contract falling within paragraph 2, only the following laws may be chosen by the parties in accordance with Article 3:

(a) the law of any Member State where the risk is situated at the time of conclusion of the contract;

(b) the law of the country where the policy holder has his habitual residence;

(c) in the case of life assurance, the law of the Member State of which the policy holder is a national;

(d) for insurance contracts covering risks limited to events occurring in one Member State other than the Member State where the risk is situated, the law of that Member State;

(e) where the policy holder of a contract falling under this paragraph pursues a commercial or industrial activity or a liberal profession and the insurance contract covers two or more risks which relate to those activities and are situated in different Member States, the law of any of the Member States concerned or the law of the country of habitual residence of the policy holder.

Where, in the cases set out in points (a), (b) or (e), the Member States referred to grant greater freedom of choice of the law applicable to the insurance contract, the parties may take advantage of that freedom

To the extent that the law applicable has not been chosen by the parties in accordance with this paragraph, such a contract shall be governed by the law of the Member State in which the risk is situated at the time of conclusion of the contract.

4. The following additional rules shall apply to insurance contracts covering risks for which a Member State imposes an obligation to take out insurance:

(a) The insurance contract shall not satisfy the obligation to take out insurance unless it complies with the specific provisions relating to that insurance laid down by the Member State that imposes the obligation. Where the law of the Member State in which the risk is situated and the law of the Member State imposing the obligation to take out insurance contradict each other, the latter shall prevail;

(b) By way of derogation from paragraphs 2 and 3, a Member State may lay down that the insurance contract shall be governed by the law of the Member State that imposes the obligation to take out insurance.

5. For the purposes of paragraph 3, third subparagraph, and paragraph 4, where the contract covers risks situated in more than one Member State, the contract shall be considered as constituting several contracts each relating to only one Member State.

of the European Parliament and the Council, dated 17 June 2008, on the law applicable to contractual obligations (Rome I).³³

E. MANDATORY CHARACTER

The regulations found in the PEICL are on some occasions mandatory, and on others semi-mandatory. Indeed, the first paragraph of its Article 1:103 establishes the mandatory nature of some PEICL Articles. Such Articles can never be altered by any party, because they are substantive. However, at the present time, these rules have yet to be specified.

The second paragraph of the same Article, establishes the semi-mandatory nature of the remaining precepts. In other words, the PEICL guarantees a minimum standard of protection, meaning that their Articles can only be derogated from when the resulting contractual clause is of greater benefit to the policyholder, insured, or beneficiary. This is all without prejudice to the necessary primacy of freedom of choice with respect to large risks (such as commercial lines).

The affirmation of its mandatory (or semi-mandatory) status may at first blush appear somewhat shocking, since it appears to contradict the very nature of an optional instrument. But these doubts disappear when a distinction is drawn between the different planes in which option and mandate, respectively, are located. The optional nature here alludes to the parties' freedom to be governed by the PEICL or by national law; the mandatory character, meanwhile, is predicated on the actual precepts that constitute it.

In my view, the mandatory nature of the precepts is essential if the object is to give legitimacy to an optional instrument whose purpose is to

6. For the purposes of this Article, the country in which the risk is situated shall be determined in accordance with Article 2(d) of the Second Council Directive 88/357/EEC of 22 June 1988 on the coordination of laws, regulations and administrative provisions relating to direct insurance other than life assurance and laying down provisions to facilitate the effective exercise of freedom to provide services (1) and, in the case of life assurance, the country in which the risk is situated shall be the country of the commitment within the meaning of Article 1(1) (g) of Directive 2002/83/EC.

³³ Helmut Heiss, *The Common Frame of Reference (CFR) of European Insurance Contract Law*, in *COMMON FRAME OF REFERENCE AND EXISTING EC CONTRACT LAW* 244, 245 (Reiner Schulze, ed., 2008).

install a regulatory structure governing insurance contracts within the European Union. It would be difficult to justify the different states' national laws providing a high degree of protection to policyholders, insureds and beneficiaries using precisely this legislative technique, while by contrast providing non-mandatory Community regulations whose purpose is to regulate risk for the many.³⁴ Certainly, the freedom of the parties is limited to the choice between an optional instrument and national law, but in both cases a high degree of protection is provided, since both sets of regulations are drawn up with precepts of a mandatory nature that accord some minimum rights to the insured.

The next unknown to be answered is how to be sure which of the two regulatory regimes provides the greater protection. It is reasonable to think that if the insurer has the choice of national law or the PEICL in each market, when the insurance company draws up the policy – it is they who in practice decide this matter – then the less protective regulatory regime will always be chosen. This equation does not have a single solution because the variable is unknown, so the different national laws need to be taken into consideration. However, I would confidently affirm that, for the majority of national laws, the difference in levels of protection between the two would not be substantial. It must be clearly understood that we are not asserting that in each of the subjects customarily considered in insurance contract law, that equidistance has been achieved between the PEICL and national law. The different alternatives that the various national laws contain for each subject mean that this is an unattainable goal. This assertion goes no further than the observation that in an overall evaluation of the two systems, we cannot escape the fact that we will find examples working in both directions. In some areas national law will offer greater protection, and in others the PEICL will provide a superior set of rules for defending the rights of the insured.

In the Spanish case, I would anticipate that certain precepts offer less protection than the Spanish laws. A first example is constituted in the admission, albeit restricted to clauses relating to termination of contract after damage or loss has occurred, that our Supreme Court has declared null and void. And the same occurs with precautionary measures, which allow the insurer to include clauses that prescribe specified behaviour on the part of the insured before any occurrence of an insured event; this can go so far as to even remove the insured's indemnity. (This is subject to the clause conforming to the stipulations laid down in article 4:103.)

³⁴ *E.g.*, Basedow, *supra* note 31, at 101–02; Heiss, *supra* note 33, at 247–48.

On the other hand, other PEICL precepts go further than Spanish insurance contract law, as is evidenced in the chapter devoted to the duties of the insurer to provide information before contract, and especially article 2:202 of the PEICL, which includes the insurer's duty to warn about the inconsistencies that it observes in the coverage provided. In fact, as is specifically provided for in the aforementioned precept, at the moment of conclusion of the contract, the insurer must advise the applicant of any inconsistencies that may exist between the coverage offered and the applicant's needs of which the insurer is or ought to be aware, taking into account the circumstances and mode of contracting, and in particular, if the applicant was assisted by an independent intermediary. In the event of a breach of this duty, either the insurer must indemnify the policyholder against all losses resulting from the breach of this duty to warn, unless the insurer acted without fault, or the policyholder shall be entitled to terminate the contract by written notice given within two months after the breach becomes known to the policyholder. An additional example of regulation offering higher protection is found in Article 5:104, in which the principle of divisibility of premium is explicitly recognized; this obliges insurance companies to reimburse the premium in the event of early termination of the contract.

F. SUBSTANTIVE SCOPE OF APPLICATION

Article 1:101 of the PEICL lays down that the principles we have mentioned apply to private insurance in general, including mutual insurance. However, reinsurance is specifically excluded. As far as types of insurance which are governed by special sets of regulations, such as maritime and aviation insurance, are concerned, these do fall within its scope, although since these are classified as large risks (i.e., commercial risks), freedom of choice will take primacy given the relatively equal bargaining power of the two contracting parties.

G. STRUCTURE

1. The Sections of the PEICL

The PEICL are structured in four main sections: the first sets out the general regulations which apply to all insurance contracts; the second covers the general regulations applying to indemnity insurance; the third relates to the general regulations for insurance of fixed sums; and the fourth

contains the regulations which will apply to specific branches of insurance. The sections are divided into chapters, and these are subdivided into rules.

We begin by pointing out that in this first version of the PEICL, there is as yet no detail in the fourth section mentioned above. The Commission's suggestion that the document should be delivered as a work-in-progress, together with the belief that the general regulations (in the first three sections) are in themselves substantive, are behind the decision to publish the PEICL without the fourth section. At a later date a second, complete version of its principles will be delivered, containing the completed fourth part – and perhaps some minor amendments to the general regulations.

2. The PEICL Rules

The rules, a very brief document which contains the text of the regulations, have a different structure from that of a national regime. The scientific rather than political origin of the current text means that the simple regulatory mandate that we are accustomed to encounter in regulations issued by our national legislatures is completed by the addition of comments and notes. Consequently, each rule consists of three parts: the rule itself, which is completed with a brief commentary and some endnotes.

The purpose of the commentaries is to clarify the rules' content, to make their interpretation easier by those who use them. The aim is, by this means, to consolidate juridical certainty in a text which poses two obvious difficulties: first, the fact of its novelty – which means that there is no legal precedent, no previous judgment to guide decision; second, the fact that it is conceived as of universal application, which is to say that it intended to be applied by those working in quite different legal traditions. The comments are, then, complementary to the rules: although they do not carry statutory force, they nevertheless must play a key role in ensuring that a uniformly consistent interpretation of the PEICL is arrived at.

The notes provide the reader with information about the different regulatory stances that have been adopted in relation to this problem in national law. Thus, the PEICL make a major positive contribution to comparative insurance contract law. Furthermore, the notes also contribute to the interpretation of each rule; by locating it in the specific context of a legislative solution, this helps us to understand its meaning and extent of applicability. We should remember that the rules were drawn up using the results of a comparative study of bodies of legislation relating to insurance contracts currently in force in Europe, and also – where it exists on this particular issue – existing Community Law.

H. LANGUAGE AND TERMINOLOGY

The PEICL are written in English. There are now translations available in several languages, but the only version that has official status, and that continues to be updated, is the one in English (all this, it goes without saying, is without prejudice to any future developments within Community institutions).

However, the terminology employed is not that used in English Law. Quite the contrary, the intention has been to use terminology of an international nature as much as possible. In particular, the PEICL have been drawn up with the intention that in the drafting of the rules, the authors should draw on terminology that has already been devised and established within the Principles of European Contract Law and in other existing Community Law.³⁵

Moreover, Articles 1:201 and 1:202 of the PEICL provide an index of the most commonly used terms in each set of regulations governing insurance contracts, specifying them conceptually, in order to achieve greater clarity. In this way, terms such as the insured, beneficiary, and the sum insured are defined, such that in any subsequent use of the terms the user understands all their connotations precisely and fully.

I. INTERPRETATION

The usefulness of the PEICL when it comes to achieving its objectives is not assured by the text of the regulation itself, but rather rests additionally on its uniform application by the courts. For this purpose, Article 1:104 of the PEICL lays down the principles of interpretation to be observed in the following terms:

The PEICL shall be interpreted in the light of their text, context, purpose and comparative background. In particular, regard should be had to the need to promote good faith and fair dealing in the insurance sector, certainty in contractual relationships, uniformity of application and the adequate protection of policyholders.

³⁵ *E.g.*, Heiss, *supra* note 34, at 239.

We see, then, that these criteria are to play an important role in the uniform application of the PEICL, providing a precept which will determine which of them should be used for all involved with these legal matters, especially the courts. So, the rules are not only accompanied by comments and notes to assist in their interpretation, but, in a further effort to ensure consistent application of the PEICL, there are also explicit hermeneutic criteria that should be used in connection with them. In relation to this, it should be emphasized that the PEICL establish consistency of its application as the interpretative rule, and in this way makes the related objective itself a principle.

In relation to issues of a different order, the appropriateness of the participation of the European Court of Justice in drawing up these criteria for consistency of interpretation has been posited. Article 234 of the European Union Treaty authorizes the interpretation of legal orders issued by European institutions to be submitted to the Court as a pre-judicial matter. Consequently, such participation requires prior promulgation of the PEICL by the Community's legislature.³⁶ However, the resolution of this pre-judicial issue would help to achieve greater uniformity in the application of optional instruments.

J. THE LAW OF INSURANCE CONTRACTS AS A CONSTITUENT PART OF CONTRACT LAW: PROBLEMS OF INTEGRATION

An insurance contract, though it is covered by extensive sets of regulations in the majority of national laws, is not an independent document peripheral to Contract Law. Furthermore, I consider the best legislative practice for the regulation of insurance contracts is to restrict ourselves to those issues and characteristics that differentiate insurance from the general theory of obligation and contract. Nothing can be gained by interfering with the numerous areas that are already subject to general regulation, and where insurance is simply another contract.³⁷

This proposition caused another set of problems when it came to drawing up the PEICL, created with the intention of being a text whose application should be consistent across the whole territory of the European Union. In truth, although the PEICL provide uniformity of regulation for the particular features applying only to insurance contracts, the remaining issues of general theory could not be settled by recourse to the different

³⁶ *Id.*

³⁷ *E.g.*, Basedow, *supra* note 21, at 58–59.

national legislation, because then the risk would again arise of a distinct implementation of optional instruments in each member State. On the contrary, devising a text that would be all encompassing, such that on its own it could also resolve questions of general theory, was an enormous and overly-ambitious undertaking. The way out of this dilemma was to draw up the PEICL, limiting the coverage to those aspects pertaining specifically to insurance, and to take as a general principle the theory that is already written in the Principles of European Contract Law. As a result, the PEICL are located as a particular contract within the Principles of European Contract Law, which means that their incorporation is by recourse to this further regulatory text which also was devised to be uniformly applied throughout the territory of the European Union.

In Article 1:105 of the PEICL, the regulations covering issues related to their incorporation is where this idea is expounded: it is forbidden to have recourse to national law in order to restrict or to complement the PEICL, while at the same time the Principles of European Contract Law are invoked to cover any gaps which need to be reconciled with the general theory of obligations and contracts. However, this mandatory instruction does not entirely resolve the problems associated with the incorporation of the PEICL. In order to achieve this, two more references are introduced to the process.

First, however scrupulously one attends to detail when drawing up insurance contracts, there always remain issues that require regulation. Furthermore, there is an essential role played by freedom of choice in the insurance market when it comes to offering new products. However, these issues, which are proper to insurance law precisely because they are a special case, cannot be resolved by recourse to general theory. For this reason, Article 1:105 of the PEICL explicitly allows an exception to the general principle of omission of national law: it is permitted to apply national regulations if they are mandatory and specifically devised to apply to the branch of insurance in question – always supposing that there are no special rules contained in the PEICL.

Second, playing a similar role to that played by general principles in Spanish Law, a final closure to the system is provided by means of the reference to the general principles which are common to the Law of the Member States. The previous recourses now being exhausted, incorporation takes place through inferring the existence, in the different legislation of the member states of the European Union, of a general principle which permits a judge to resolve the question that is placed before him or her. This last rule is hermeneutic, designed to play only a residual role.

III. A CONSISTENT OPINION ABOUT THE GREEN PAPER

Let us next look at the arguments from the perspective of the insurance market.

A. WHAT SHOULD BE THE LEGAL NATURE OF THE INSTRUMENT OF EUROPEAN CONTRACT LAW?

The directives route needs to be supplanted by the use of optional instruments: this would be a step towards a harmonized system, which can never be achieved with directives. Adopting the harmonization approach offers the advantage that it is supported by a more solid history of practice, since this solution has been adopted for other types of contract, which will at least go some way towards building consensus – which in itself is a difficult thing to achieve. However, as the Commission's Communication to the Council and to the European Parliament on European Contract Law pointed out, the use of abstract terminology in Community legislation may give rise to inconsistent administration of Community Law and of national measures. Moreover, purely internal legislation enacted by Member States to apply European Union directives is based on internal national understanding and definitions of those abstract terms. In the light of what has been expounded here, it is easy to deduce that the most desirable option to adopt, from a technical point of view, is harmonization, since this is the solution that comes closest to the objective, namely standardized application of the product being sold.

The Commission's Communication to the Council and to the European Parliament, dated 12 February 2003, proposed a more consistent European Contract Law: an action plan pointed to the difficulty over whether optional instruments should take the form of recommendations, or alternatively of regulations. In the subsequent debate on this question, it was claimed that the non-binding nature of a recommendation would be deleterious to its being considered as having regulatory force – to say nothing of the problems in international private law that might be entailed by the choice of a recommendation as the law to be applied. For all these reasons, the most appropriate course would seem to be to opt for a set of rules that contains an alternative regulation to national laws.

I do not believe, either, that it is feasible to advance towards a regulation that would impose a European Contract Law in all the territories of the European Union, because of the problems this would bring and the resistance that it would meet. I believe that the voluntary character of the

optional instrument is a positive aspect that should be taken into consideration.

All in all, I consider that the best course to adopt is to promulgate a regulation which would create an optional instrument, and preferably in opt-in form. Thus, the different national laws would remain unchanged, and a new one would be created, whose authority would be accepted voluntarily by the parties.

B. SHOULD THE INSTRUMENT COVER BOTH CROSS-BORDER AND DOMESTIC CONTRACTS?

One option that recurs in this debate is that of limiting the use of European Contract Law to cross-border business. Thus, when all the elements of the insurance are linked together by a single legal regime, national law would be applied, allowing each State's regulations to remain unchanged, whereas in the other case, a contract that included a foreign element would be subject to international regulations. Such a model, it can be said, protects the autonomy of the parties in an international contract, and ensures fair and equal competition, since a single law would govern all international contracts, as well as providing a uniform level of protection in the different Member States. This means that a party could act without fear in foreign markets, knowing that the level of protection would be similar to that enjoyed under the laws of the home country. Furthermore, those who defend such an approach understand that actual harmonization just of the rules of international insurance contracts would mean enhanced legal security thanks to the establishment of an actual law specifically for this type of insurance, thus avoiding all the problems arising out of a contested project for harmonization.

However, as even those who would seek to advance this thesis must recognize, the problem will then shift to the question of how to organize and express the relationship between the two regulations. This problem, in our view, is impossible to resolve. In the first place, if the nationality of the insurance company were to be the determining criterion, there would be great uncertainty regarding the governance regime that would in the end be applicable. And without saying that in member states like Spain, where there is a marked presence of foreign insurance companies, it would be the exception, not the rule, to apply Spanish law. It would be equally problematic if the policyholder were the defining criterion, since if the level of protection depended on the policyholder's nationality, then grievances of a comparative nature would inevitably arise. A final proposal, that is more nuanced than the preceding ones, would be to

start from the regulations relating to directives, but introducing the possibility of being governed by supranational regulation where there is no obligation to be governed by the law of the State in which the risk is incurred or the commitment formalized. An objection to this thesis is that the creation of a system of regulation for the making of supranational contracts would be another available possibility, but it would neither reduce diversity nor enhance legal certainty, while it would give rise to discriminatory treatment. Perhaps the dysfunction resides in the difficulty in reconciling the concept of a single market with a transnational space.

In conclusion, it seems to me that the best way forward, at least in terms of desirability, is to undertake the construction of a system of regulation whose ultimate objective is to be globally applicable, in this way avoiding the drawbacks that have been pointed out.

C. SHOULD THE INSTRUMENT COVER BOTH BUSINESS-TO-CONSUMER AND BUSINESS-TO-BUSINESS CONTRACTS?

It is well known in the insurance market that there is a well-established distinction between large risks and mass risks. The first category is strongly internationalized because of the nature of the contracted risk itself, insurance companies themselves having been engaged in developing standard contract clauses based on the principle of the pre-eminence of freedom of choice. Because of this, we can already talk of a *lex mercatoria* which has been developed through the general conditions that are employed in the making of international contracts. Two examples will suffice: reinsurance and marine insurance.

The next step to be taken if we wish to progress further in this direction is to establish a European insurance contract law that would apply to mass risk. This would lead to the positive effects that have already been set out, and would give consumers the benefits of the system, especially those benefits which would be generated by a marketplace that would be more competitive as a result of its greater integration.

D. WHAT SHOULD BE THE MATERIAL SCOPE OF THE INSTRUMENT?

The solution to this final problem has almost already been answered by what we have set out so far. It is only possible to achieve the desired objectives if regulation of insurance contracts is included. The necessarily mandatory nature of such a set of regulations, if it is to provide the standard of protection that is required for mass insurance contracts,

requires a set of rules governing insurance contracts. This governance should at least consider the mechanisms for the protection of the insured, since it is not appropriate to be subject to contractual freedom, a provision which would leave the door open for insurance companies to infringe the different national regulations. Neither do I recommend remission to the different national regulations for contracts in specific branches of insurance, because we would then be creating a bigger problem than the one we are trying to solve. We would not achieve uniform consistency; and what is more, by trying to interpret European Contract Law and the respective laws concerning insurance contracts together, we would simply end up with greater legal uncertainty by trying to make two rules proceeding from differing origins and principles appear just and reasonable.

IV. CONCLUSION

The “Restatement of European Insurance Contract Law” project group is working on a 2nd edition of their “Principles of European Insurance Contract Law.” This 2nd edition adds regulation of liability insurance and life insurance.

The harmonization of European contract law has continued its way. The Commission created an Expert Group relationship with previous academic studies. On 3 May 2011 the Expert Group's feasibility study was published and interested parties were invited to give feedback.

Within this process of progress towards a European Contract Law, on October 11, 2011, the Commission adopted a proposal for a Regulation on a Common European Sales Law. The proposal facilitates cross-border trade for business and cross-border purchases for consumers by establishing a self-standing uniform set of contract law rules including provisions to protect consumers. Nowadays, the proposal proceeding continues as a co-decision procedure.

However, the main change at the heart of current insurance contracts has been the European Commission's initiative to establish the “Commission Expert Group on European Insurance Contract Law.”³⁸

³⁸ Commission Decision (EU) of 17 January 2013 on Setting up the Commission Expert Group on European Insurance Contract Law, 2013 O.J. (C 16/6) 6.

The Expert Group's task shall be to carry out an analysis in order to assist the Commission in examining whether differences in contract laws pose an obstacle to cross-border trade in insurance products.

If the Expert Group finds that differences in contract laws may pose obstacles to cross-border trade in insurance products, it shall identify the insurance areas which are likely to be particularly affected by such obstacles.

It is difficult to predict the future, but I believe that this beginning of the legislative process must lead to a future regulation of insurance contracts, as happened with the aforementioned Regulation on a Common European Sales Law. By the end of 2013, the Expert Group shall deliver to the Commission a report on its findings. Then we will appreciate the reactions of institutions, the industry and consumers and perhaps we can know then if this goal is attained.

TOWARDS A EUROPEAN SUPERVISORY AUTHORITY

JAVIER VERCHER-MOLL¹

Regulation (EU) no. 1094/2010, which established a European Insurance and Occupational Pensions Authority, may involve a major change to the management and supervision of private insurance in Spain and in the European Union. Thus, this Article analyzes the evolution from the original Insurance Committee, which boasted only advisory functions, to this new Authority, which has been given decision-making functions in addition to its advisory ones. The Article concludes by suggesting that in the future, this new Authority will be the sole supervisory body operating in all Member States, demonstrating a progression towards a new conception of supervision and regulation of insurance or perhaps another step towards Community-wide integration.

Key Words: European Insurance and Occupational Pensions Authority.

I. INTRODUCTION

The ideals which inspired the realisation of a common market and the creation, thereby, of the European Economic Community, have meant that the principle of harmonization has been a constant in the drawing up of both national and Community regulatory frameworks in many sectors. The relationship between Community law and the internal laws of each Member State has made it possible to distinguish four functional principles, which constitute the common central feature of the various different legislative reforms carried out within the European Union. The relationships of substitution, harmonization, coordination and coexistence between internal national law and Community law have determined the shape and reach of a European standard, as translated into Treaties, Regulations, and Directives.²

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² See FERNANDO DIEZ MORENO, MANUAL DE DERECHO DE LA UNIÓN EUROPEA 299-321 (5th ed, 2009); NIAL FENNELLY, THE PAST AND FUTURE OF EU LAW 37-

Within the broad spectrum of sectors of economic activity, we can find in the insurance sector a well-ensconced and clear distinction in terms of private and public law. On the one hand, the private relationships that arise between insurers and policyholders, insured parties, consumers, or users in general, are based on private law. This, in turn, is subject to the corresponding legal restrictions governing contracts, which may be established for the benefit of the latter parties. On the other hand, there is regulation of the insurers themselves; standard principles of public law that regulate and supervise insurance activity, and finally, norms governing the mediation or distribution of insurance risk.

The harmonization of the norms relating to financial services that has been carried out to date (which include those governing insurance) has had as its single objective the achievement of a Single Market in Financial Services³ as an essential part of the common market. This harmonization has only affected the standards concerned with supervision and regulation, not only by the creation of positive legislation, but also through the creation of Community institutions. However, this should not lead us to think that such a combination of standards is ideal, since the set of standards relating to supervision still retains features that are specific to each Member State's own system.⁴

With the aim of overcoming this imperfect coordination between national standards,⁵ major efforts have been made in the direction of bringing together and unifying the codes. Out of one of these has emerged Regulation (EU) no. 1094/2010 of the European Parliament and of the European Council of 24 November 2010, which establishes a European Supervisory Authority (European Insurance and Occupational Pensions Authority) as the highest authority overseeing the regulation and supervision of private insurance at Community level.

85 (Miguel P. Maduro et al. eds., 2010); ANTONIO CALVO HORNERO, ORGANIZACIÓN DE LA UNIÓN EUROPEA 174-84 (3rd ed. 2008).

³ See RYM AYADI & CHRISTOPHER O'BRIEN, THE FUTURE OF INSURANCE REGULATION AND SUPERVISION IN THE EU: NEW DEVELOPMENTS, NEW CHALLENGES 53-60 (2006).

⁴ See LUIS FERNANDEZ DE LA GANDARA & ALFONSO-LUIS CALVO CARAVACA, DERECHO MERCANTIL INTERNACIONAL: ESTUDIOS SOBRE DERECHO COMUNITARIO Y DEL COMERCIO INTERNACIONAL 217-24 (2d ed. 1995).

⁵ See Juan Bataller Grau, *Un Mercado Europeo del Seguro: Claves para una Re-visión*, in DERECHO PRIVADO EUROPEO 747-49 (Sergio Cámara Lapuente ed., 2003).

We should emphasize that the European Commission has played a major role in the achievement of this shared standard. The mechanism employed has been the creation of Committees as consultative bodies in respect of insurance and occupational pension issues, and supervision. This has led to the creation of a very useful body of material for overseeing the Community's insurance market. Together with this, we should also not overlook the Lamfalussy process,⁶ which was initiated in 2001 and aimed to facilitate the coordination of individual national legislations in terms of supervision.

Our objective in this study is to set out the juridical significance of the creation of this Authority and to determine, or at least clarify, the resulting situation with respect to national legislations on insurance supervision. The Article starts out by providing a chronological account of the sequence of distinct stages of regulation in the Community that have led to the Regulation, which is the object of the present study. This is why we dwell on an analysis of the most important community standards, as well as on reports, briefings on political contexts, and situations in which there has been an oversight of insurance in the European Union, leading up to the establishment of the new regulatory regime.

II. ANTECEDENTS

The European Council,⁷ in the knowledge that the directives relating to the insurance market had to be implemented, decided that it was necessary to create an institution to support the European Commission.⁸ In this respect, the Council Directive of 19 December 1991⁹ established that “*Whereas implementing measures are necessary for the application of Council directives on non-life insurance and life assurance; whereas, in particular, technical adaptations may from time to time be necessary to take account of developments in the insurance sector.*” This led to the creation of the first institution whose task was to advise the Commission on

⁶ For discussion of the Lamfalussy process, see *infra* Section VI.

⁷ See JUAN MANUEL URUBURU COLSA, *HISTORIA DEL CONSEJO EUROPEO*, 163–224 (2009); GUY ISAAC, *MANUAL DE DERECHO COMUNITARIO GENERAL* 63–70 (4th ed. 1997).

⁸ See Council Decision 87/373, art. 2, 1987 O.J. (L 197) 33, 35 (EC) (presenting procedures for implementing powers conferred on the Commission).

⁹ Council Directive 91/675, 1991 O.J. (L 374) 32, 33 (EC).

developing legislation in the insurance sphere: appositely named, 'the Insurance Committee.'¹⁰

The Insurance Committee was composed of representatives of the Member States and chaired by the representative of the Commission.¹¹ Its main function, beyond establishing its internal regulation, was to issue an opinion on the draft legislation that the Commission's representative would submit to it. In brief, the procedure was as follows: where the European Council, in the acts which it adopts in the field of direct non-life insurance and direct life assurance, confers on the Commission powers for the implementation of the rules which it lays down,¹² the Commission presents a draft of the measures, for which the Committee must deliver its opinion within a time limit, which the chairman of the Committee may lay down.¹³

Furthermore, the Committee held powers, beyond those we have already seen, to examine any question relating to the application of Community regulations relating to the insurance sector and, in particular, directives concerning direct insurance.¹⁴ It could issue opinions on matters on which it was consulted by the Commission on the basis of the new proposals that it intended to present to the Council in relation to coordination in the sectors of direct life assurance and direct non-life insurance. It had no powers, at any time or in any circumstances, to consider particular problems in connection with individual insurance companies, with the result that the Committee's direct intervention in the insurance market, through reports or recommendations, was precluded.¹⁵

The Commission Communication of 11 May 1999,¹⁶ entitled "Action Plan for a Single Financial Market," established a series of objectives and specific measures for improving the single market in

¹⁰ See JAVIER CAMACHO DE LOS RIOS, *ARMONIZACIÓN DEL DERECHO DE SEGURO DE DAÑOS EN LA UNIÓN EUROPEA* 38-39 (1996).

¹¹ Council Directive 91/675, art. 1, 1991 O.J. (L 374) 32, 33 (EC).

¹² *Id.* at art. 2.1.

¹³ *Id.* at art. 2.2.

¹⁴ The expression "direct insurance" is usually used to refer to the premiums obtained through direct contracting with the insured. It must be distinguished of reinsurance contract, because the reinsurance is based in giving protection between insurers. In the reinsurance, an insurer gives protection to another insurer if it cannot cover the risk assumed in the insurance contract with the insured.

¹⁵ Council Directive 91/675, art. 3, 1991 O.J. (L 374) 32, 33 (EC).

¹⁶ *Financial Services Commission Proposed Action Plan for Single Financial Market*, COM (1999) 327 final (May 11, 1999).

financial services.¹⁷ Strategic measures aimed to create a single market in wholesale financial services, the development of open, secure, retail financial service markets, to guarantee the stability of EU financial markets by using best practices in the matter of preventative and supervisory regulation, and finally, to eliminate the fiscal obstacles to financial market integration. One of the Commission's main objectives was to achieve conformity with the Framework for Action¹⁸ that the Commission itself had presented in October 1998, given that the introduction of the Euro was one of the main foundations on which the single market would be built. However, in addition, there was also the key matter of restructuring the financial services sector, since the conflicting national legislations did not provide a stable legal framework.¹⁹

Leading on from this, one of the immediate consequences of these was the harmonization of the different national legislations in those areas that, although not specifically concerned with financial services, were intrinsically related, since they affected the clients of these services. In effect, adaptation, specialisation, and technical and legal improvements have consistently characterized developments in consumer and user protection legislation right up to the present day.

III. THE CREATION OF NEW COMMITTEES

Continuing the historical progress, on 17 July 2000, the European Council set up the so-called Committee of Wise Men on the Regulation of European Securities Markets. In its final report, the Committee of Wise Men called for the establishment of a four-level regulatory framework in order to make the regulatory process for Community securities legislation more flexible, effective, and transparent.²⁰ In its Resolution, the Stockholm European Council of 23 and 24 March 2001 welcomed the report of the Committee of Wise Men and called for a four-level approach to be

¹⁷ *Id.* at 1 (quoting Mario Monti, the Financial Services Commissioner: it is "crucial that the Single Market for financial services delivers its full potential for consumers, in terms of a broad range of safe, competitive products, and for industry, in terms inter alia of easier access to a single deep and liquid market for investment capital, as well as for financial service operators themselves").

¹⁸ *Financial Services Commission Proposed Framework for Action*, COM (1999) 941 final (Oct. 28, 1998).

¹⁹ See PAUL P. CRAIG & GRAINNE DE BURCA, *E.U. LAW. TEXT, CASES AND MATERIALS* 604–35 (4th ed. 2008).

²⁰ For discussion of the Lamfalussy process, see *infra* Section VI.

implemented.²¹ The object of postulating these four levels was none other than to establish an integrated securities market which required action on legislation, on implementation measures, implantation in national law, and measures to ensure compliance with the laws issued by the competent Community authorities.

The organizations created by the European Commission were set up to establish appropriate teams of staff with the technical resources to carry out the task of producing recommendations and advice as to how the convergence of the national laws should be achieved. The gradual construction of this network of supranational institutions continued, and it was in June 2001 that the Commission adopted new Decisions,²² which established the Committee of European Securities Regulators and the European Securities Committee, respectively. Both Committees were designed to function as independent entities to reflect upon, debate, and provide advice about issues relating to securities for the Commission. They were also to contribute to the coherent, exact, and timely application of Community legislation in the Member States, ensuring more effective cooperation between national supervisory authorities, and carrying out evaluations with respect to consistency and good practice. They were to organize their own operating systems, and maintain close operating links with the Commission and the European Securities Committee. Finally, they were to set up their own internal regulations and fully respect both the institutional prerogatives and the institutional balance established by the Treaty.²³ Furthermore, in particular, the Committee of European Securities Regulators was charged with consulting widely and at an early date, with parties active in the market, the consumers and ultimate users, in an open and transparent manner.²⁴ As to their composition, with the aim of

²¹ For a more thorough discussion of the legal reasons in favor of establishing a new organizational structure for financial services committees, see Council Directive 2005/1, ¶ 1–4, 2005 O.J. (L 79) 9 (EU).

²² Commission Decision 2001/527, 2001 O.J. (L 191) 43, 44 (EC); Commission Decision 2001/528, 2001 O.J. (L 191) 45, 46 (EC).

²³ Compare Treaty on European Union, Feb. 7, 1992, 2010 O.J. (C 83) 1 with, Treaty of Nice, Feb. 25, 2001, 2001 O.J. (C 80) 1.

²⁴ Commission Decision 2001/527, (8)–(12), 2001 O.J. (L 191) 43 (EC) (“(8) The Committee of European Securities Regulators should serve as an independent body for reflection, debate and advice for the Commission in the securities field. (9) The Committee of European Securities Regulators should also contribute to the consistent and timely implementation of Community legislation in the Member States by securing more effective cooperation between national supervisory

facilitating regulatory convergence, the Commission indicated in both Decisions that membership of these organizations should consist of high-level representatives from the national public authorities competent in the field of securities.

As we can see, both the European Council and the Commission were of the view that the establishment of Committees made up of qualified national representatives represented a significant element in promoting the regulatory convergence of the different national bodies of legislation. The objective was clear: to smooth away difficulties with the aim of creating regulatory uniformity, and of drawing up a single text applicable in all Member States.

IV. THE GRADUAL CONSTRUCTION OF A SINGLE MARKET

The European Parliament has also pointed out, on numerous occasions, that the creation of a single market in financial services, consistent with an open market and free competition, is crucial for increasing economic growth and for the creation of employment in the Community. In 2002, it approved Resolutions for each,²⁵ which defined the regulatory framework for the four level approach concerning the regulation of European securities markets, and sought to broaden certain aspects of this approach to apply to the banking and insurance sectors, following the clear commitment on the part of the European Council to guarantee an appropriate institutional balance.

authorities, carrying out peer reviews and promoting best practice. (10) The Committee of European Securities Regulators should organise its own operational arrangements and maintain close operational links with the Commission and the European Securities Committee. It should elect its chairperson from among its members. (11) The Committee of European Securities Regulators should consult extensively and at an early stage with market participants, consumers and end-users in an open and transparent manner. (12) The Committee of European Securities Regulators should draw up its own rules of procedure and fully respect the prerogatives of the institutions and the institutional balance established by the Treaty.”). Commission Decision 2001/528, (9)–(10), 2001 O.J. (L191) 45 (EC) (“(9) The European Securities Committee should serve as a body for reflection, debate and advice for the Commission in the field of securities. (10) The European Securities Committee should adopt its own rules of procedure.”).

²⁵ See generally Resolution on Prudential Supervision in the European Union, EUR. PARL. DOC. (2001/2247 (INI)); EUR. PARL. DOC. (2002/2061(INI)).

The Resolution dated 5 February 2002, was extremely important in terms of legislative procedure, of transparency for the different parties operating in the financial services market,²⁶ and in the right of supervision. The Parliament itself urged, with a view to speed up the establishment of an integrated securities market, that the deadlines for the transposition of Community acts into national law should be reduced. Furthermore, in relation to transparency²⁷ it considered it essential that the general public should be able to access, particularly via the Internet, as much information as possible about all the legislative initiatives and activities of the committees, in particular those of the market regulators committee.

Regarding the second European Parliament Resolution, of 21 November 2002, this put forward the view that the series of financial scandals in the United States evidenced the failure of the United States' regulatory network to eliminate the risk of sudden and unexpected financial crises. Consequently, they concluded that there was absolutely nothing to suggest that Europe was immune to these dramatic crises, especially considering that Europe was in a transitional stage while in the process of moving from a fragmented system of individual national markets to a single unified financial market; a transition that today, with the first decade of the twenty-first century already in the past, is still not complete.

The Parliament understood that the supervision of insurance companies and pension funds should be brought together, without prejudicing the distinct characteristics of each, while respecting the national structures that were already optimal, since the ability of national banking and insurance systems to survive – or not – in the enormously volatile climate of those years would provide a useful indication of the relative efficiency of the national supervisory systems. Furthermore, with regard to the subject of the present study, the Parliament required that national supervisory agencies should focus on “real time supervision” of financial organizations but without succumbing to the temptation to constantly interfere with the business actually at hand, since this would both create obstacles to innovation and would place risks of an ethical nature before the senior executives of the institutions under supervision.

²⁶ See generally José Miguel Rodríguez Fernández, *Los Conglomerados Financieros y su Supervisión: Una Perspectiva en el Contexto de la Unión Europea*, 31 REVISTA DE ESTUDIOS EUROPEOS 71, 75–96 (2002), available at <http://uvadoc.uva.es/handle/10324/232>.

²⁷ See Commission Regulation 1049/2001, 2001 O.J. (L 145) 43 (EC).

Finally, on December 3, 2002, the European Council invited the Commission to apply these agreements in the areas of banking, insurance and occupational pensions, and to create new committees with a consultative remit in relation to these areas of activity as soon as possible. Subsequently, on 5 November 2003, the Commission adopted Decision 2004/9/EC,²⁸ which established the European Insurance and Occupational Pensions Committee. However, its implementation was also dependent on a Directive deleting the purely consultative functions of the Insurance Committee.²⁹

In conclusion, coupled with the creation of the Committees, it was imperative to acquire a firm commitment on the part of the Member States. In effect, overcoming the fragmentation of the market and promoting convergence by respecting transition deadlines, for example, were unconditional obligations. As we can see, the first years of the twenty-first century represent an important milestone on the way to the achievement of the single market, but also show insufficient progress to date in the field of financial services.

²⁸ Commission Decision 2004/9, 2004 O.J. (L 3) 34 (EC). The reader has to distinguish the Decision 2004/9/EC and the Decision 2004/6/EC. The first one refers to the “European Insurance and Occupational Pensions Committee,” and the second one refers to the “Committee of European Insurance and Occupational Pensions Supervisors.”

²⁹ *Id.* at (5) (“The Commission has proposed a Directive modifying, *inter alia*, Directive 91/675/EEC, First Council Directive 73/239/EEC of 24 July 1973 on the coordination of laws, regulations and administrative provisions relating to the taking-up and pursuit of the business of direct insurance other than life assurance (4) as amended, Directive 2002/83/EC of the European Parliament and of the Council of 5 November 2002 concerning life assurance (5), and Directive 2002/87/EC of the European Parliament and of the Council of 16 December 2002 on the supplementary supervision of credit institutions, insurance undertakings and investment firms in a financial conglomerate and amending Council Directives 73/239/EEC, 79/267/EEC, 92/49/EEC, 92/96/EEC, 93/6/EEC and 93/22/EEC, and Directives 98/78/EC and 2000/12/EC of the European Parliament and the Council (6), to delete the advisory functions of the Insurance Committee.”).

V. THE EUROPEAN INSURANCE AND OCCUPATIONAL PENSIONS COMMITTEE PURSUANT TO COMMISSION DECISION 2004/9/EC OF 5 NOVEMBER 2003

Moreover, we should remember that the European Insurance and Occupational Pensions Committee did not begin to function³⁰ until a Directive repealing the purely consultative functions of the Insurance Committee came into force. With respect to this, Directive 2005/1/EC³¹ of the European Parliament and of the Council of 9 March 2005 fulfils that mandate.

Article 5 of this latter Directive amended Directive 91/675/EEC, with regard to the powers assumed by the Insurance Committee, and renamed it the European Insurance and Occupational Pensions Committee. This more elaborate denomination for the new incarnation of the Insurance Committee had the purpose of clarifying its sphere of activity in relation to the old Insurance Committee.

A. LEGAL AUTHORITY

Reading the text of the articles of Decision 2004/9/EC, I deduce that the European Insurance and Occupational Pensions Committee has two types of legal authority. The first covered its own organization and dealt with its internal structure and procedural regime while the second dealt with its actual substantive functions, which were meant to establish, in addition to the actual attributed powers themselves, the objectives that it should pursue.

In relation to the first type of legal authority, in its Decision the Commission lays down that the Committee shall be composed of high-level representatives of Member States, and chaired by a representative of the Commission. But the Decision does not specify who these high level representatives shall be, or the method of their appointment, leaving this at the discretion of the Committee itself. On the other hand, the Decision did

³⁰ See *id.* at art. 5.

³¹ See Commission Decision 2009/79, (2), 2009 O.J. (L 25) 28 (EC) (referring to “Directive 2005/1/EC of the European Parliament and of the Council, of 9 March 2005, amending Directives 73/239/EEC, 85/611/EEC, 91/675/EEC, 92/49/EEC and 93/6/EEC of the Council and Directives 94/19/EC, 98/78/EC, 2000/12/EC, 2001/34/EC, 2002/83/EC and 2002/87/EC, in order to establish a new organisational structure for financial services committees”).

take away from the Committee the power to appoint its own secretariat, since this was incumbent on the Commission itself. As per its rules of procedure, the Decision empowered the Committee to draw up its own internal rules of procedure, but it also imposed an obligation to meet both at regular intervals and impulsively whenever the situation demanded. Furthermore, the Commission had the power to convene an emergency meeting if it considered that the situation so required.³²

With regards to its substantive functions, the Committee was authorized to advise the Commission, at the latter's request, "on policy issues relating to insurance, reinsurance and occupational pensions as well as Commission proposals in these fields," and to examine "any question relating to the application of Community provisions concerning the sectors of insurance, reinsurance and occupational pensions, and in particular Directives on insurance, reinsurance and occupational pensions." The Decision denied the Committee decision-making powers relating to specific matters concerned with, or affecting, the Community's business organizations and citizens. In effect, the Committee could not consider specific problems relating to individual insurance or reinsurance undertakings, nor to occupational pensions institutions, nor could it address labour and social law aspects such as the organization of occupational regimes, in particular compulsory membership and the results of collective bargaining agreements.³³

B. RELATED CONCEPTS

It is important to avoid confusing the different Committees operating at that time within the European Commission. In effect, and quite distinct from the European Insurance and Occupational Pensions Committee, which is the subject of this Article, at that time was the Committee of European Insurance and Occupational Pensions Supervisors, which was instituted on 5 November 2003. The confusion of the two even affected the wording of Decision 2004/9/EC itself, as evidenced by the reference to the Committee of Supervisors, when Article 3.2 mentions the European Insurance and Occupational Pensions Committee.

According to Article 2 of Decision 2004/6/EC, the functions of the Committee of European Insurance and Occupational Pensions Supervisors

³² See Commission Decision 2004/9, art. 3, 4, 2004 O.J. (L 25) 28, 30–31 (EU).

³³ See *id.* at art. 2.

are first to advise the Commission, either at the Commission's request, within a time limit which the Commission may lay down according to the urgency of the matter, or on the Committee's own initiative, in particular regarding the preparation of draft implementing measures in the fields of insurance, reinsurance, and occupational pensions. Secondly, it shall contribute to the consistent implementation of Community Directives, and to the convergence of Member States' supervisory practices throughout the Community. Finally, it shall constitute a forum for supervisory cooperation, including the exchange of information on supervised institutions.

Besides, the Article 4 of Decision 2004/6/EC established that "the Committee of European Insurance and Occupational Pensions Supervisors shall maintain close operational links with the Commission and with the Committee established by Decision 2004/9/EC"; which is to say, with the European Insurance and Occupational Pensions Committee. This meant that there were two institutions with similar titles, practically identical functions, and the power to report on the same matters.³⁴ This state of affairs was later changed with the publication of Commission Decision 2009/79/EC, broadening the powers of the Committee of Supervisors.

From a reading of the articles contained in both Decisions, we can draw the conclusion that there are no major differences in terms of their functions. It is certainly the case that Decision number 9 creates a Committee whose purpose is to advise on insurance policy and to scrutinize Community standards in this area. By contrast, Decision number 6 also addresses insurance, but from a supervisory perspective. In our view, there is no substantial difference between the two bodies because there is no demarcation of any clear division of powers between them. It was unnecessary to establish two Committees, since their functions could have been brought together in one, thereby avoiding the misunderstandings that might arise in the dealings between the two organizations.

On the other hand, it could be argued that there is a point to creating two separate Committees, if we consider that the European Committee of Supervisors establishes the basis of what would later constitute the supervisory institutions that are the subject of the present study. In effect, Decision 2004/6/EC was repealed by Commission Decision 2009/79/EC, and the latter, in turn, by the Regulation whereby a European Insurance and Occupational Pensions Authority was created. What is certain is that, if we analyze the three regulations mentioned, we

³⁴ *Id.* at art. 3.2.

see that each organization takes on the responsibilities of its predecessor, and increases its powers. This is demonstrated by the fact that the new European Authority has the previous Committees' consultative functions and, as we shall see, in a new development it is given certain powers of decision, which enable us to glimpse the likely shape of a future Financial Services Supervisory Authority.

VI. THE LAMFALUSSY PROCESS³⁵

The Lamfalussy process³⁶ began in 2001, with the intention of establishing an effective mechanism to enable European supervisory practices to begin to converge, and to ensure that Community financial services legislation would be able to adapt, rapidly and flexibly, to the evolution of the internal market. A consequence of this was the issuing of Commission Decision 2004/6/EC which, as we have already seen, established a Committee of European Insurance and Occupational Pensions Supervisors, in the guise of an "independent body for reflection, debate and advice for the Commission in the insurance, reinsurance and occupational pensions' fields."³⁷

Within this process, in 2004 when the legislative phase of the Financial Services Action Plan ("FSAP") was almost complete, the Commission decided to carry out an evaluation of the integration of European financial markets and to instigate a general consultation, based on the reports of four high level groups of experts. The Green Paper on Financial Services Policy, with which a public consultation was launched on May 3, 2005, was fundamentally centered on the application of existing measures and in cooperation, rather than in putting forward proposals for new laws. The Green Paper on Financial Services Policy (2005-2010)³⁸ set forth the general policy objectives³⁹ for financial services for the period 2005 to 2010. The purpose of this Paper was none other than to

³⁵ See generally Duncan Alford, *The Lamfalussy Process and EU Bank Regulation: Another Step on the Road to Pan-European Regulation?*, 25 ANN. REV. BANKING & FIN. L. 389, 389-416 (2006).

³⁶ It takes its name from the President of the advisory committee that set it up in March 2001, Alexandre Lamfalussy.

³⁷ See Commission Decision 2004/6, (4), 2004 O.J. (L 3) 31 (EU).

³⁸ *Commission Green Paper on Financial Services Policy 2005-2010*, COM (2005) 177 final (May 5, 2005).

³⁹ *Id.* at 3 (indicating that the Paper merely sets out "preliminary views of the Commission for its financial services policy priorities").

consolidate the progress towards an integrated, open, competitive, economically efficient European financial market, and to remove any remaining economically significant barriers to it. It sought to stimulate the development of a market in which financial services and capital could circulate freely throughout the EU at the lowest possible cost (with adequate and effective levels of prudential control, financial stability, and strong consumer protection). Further, it would apply, enforce, and carry out continuous evaluation of the existing legislative framework, rigorously implement the optimal regulatory agenda for any future initiatives, further supervisory convergence, and consolidate Europe's influence in global financial markets.

The White Paper that emerged from it was designated for integrating the financial services market as its highest priority. In the White Paper on Financial Services 2005-2010⁴⁰ of December 1, the Commission established the key objectives of its policy for the following five years, namely, consolidating progress achieved to date, completing unfinished business, enhancing supervisory cooperation and convergence, and removing the remaining barriers to integration. But more than this, in the document the following priorities were laid down: to continue to improve the efficiency of pan-European markets for long-term savings products, to establish the retail internal market, and improve the efficacy of the risk capital market.

The dynamic consolidation of financial services was based on the principle of producing better legislation by mandatory open consultation, and of impact analyses for new legislative proposals as central procedural features, as well as the ex-post evaluation of all legislative measures. Furthermore, the EC regulatory and supervisory structures were subject to review with the aim of improving their effectiveness in achieving convergence. Finally, taking into account the international context in which today's regulation on accounting practice, audit, and capital and reserves is set, the EU was of the view that it was essential for it to undertake a major role in the worldwide process of standardization and, specifically, in favor of opening up world markets for financial services. The Commission at this time proposed a dialogue between the EU and US financial markets, and to broaden the cooperation to include other countries, such as Japan, China, Russia, and India. The EU was desired to be very visibly represented in international organizations, and was to speak

⁴⁰ *Commission White Paper on Financial Services Policy 2005-2010*, COM (2005) 629 final (Dec. 1, 2005).

with a single voice on complex matters such as money laundering, the financing of terrorism, and tax fraud.

In accordance with this new approach, financial regulation was initially passed in two levels. But subsequent to the major reform introduced by Directive 2005/1/EC, the Lamfalussy process envisioned EU financial regulation as unfolding in four distinct levels or phases.

At Level 1, framework legislation setting out the core principles and defining implementing powers would be adopted by co-decision by European Parliament and the European Council,⁴¹ after a full and inclusive consultation process in line with the best regulatory practices.

At Level 2, the technical details of the legislation would be adopted after a vote of the competent regulatory Committee (the European Securities Committee, the European Banking Committee, and the European Insurance and Occupational Pensions Committee).⁴²

At Level 3, these three Committees would have an important role to contribute to consistent and convergent implementation of EU directives by securing more effective cooperation between national supervisors and the convergence of supervisory practices.

Finally, in Level 4, the Commission would enforce the timely and correct transposition of EU legislation into national law level.⁴³

VII. REVIEW OF THE LAMFALUSSY PROCESS

In line with the aforementioned Directive 2005/1/EC of the European Parliament and of the Council of 9 March 2005 amending Council Directives 73/239/EEC, 85/611/EEC, 91/675/EEC, 92/49/EEC and 93/6/EEC, and Directives 94/19/EC, 98/78/EC, 2000/12/EC, 2001/34/EC, 2002/83/EC and 2002/87/EC in order to establish a new organizational structure for financial services committees, the Commission carried out a review of the Lamfalussy process in 2007 and presented its assessment in a

⁴¹ Nowadays, that process is known as “Ordinary Legislative Procedure.”

⁴² See Commission Decision 2001/527, 2001 O.J. (L 191) 43 (EC) *amended by* Commission Decision 2004/6, 2004 O.J. (L 3) 32 (EU); Commission Decision 2004/5, 2004 O.J. (L3) 28 (EU); Commission Decision 2004/6, 2004 O.J. (L3) 30 (EU).

⁴³ See *Communication from the Commission to the Council and European Parliament*, at 1–2, COM (2007) 722 final (Nov. 20, 2007) (indicating where the Lamfalussy process is reviewed through the mandate established in Directive 2005/1/EC).

Communication of 20 November 2007, entitled “Review of the Lamfalussy process — Strengthening supervisory convergence.”

The Communication of 20 November 2007 detailed the current situation in terms of the four levels, and determined individual measures to mitigate the defects affecting each of the levels in Annex III. The measures were calculated to improve both the legislative process itself and the application of the legislation. This is why it was stated that Member States must refrain from adopting any additional national measures in those areas which, because of the legislative level of the Community regulation in question, transposition was required on the part of the Member States. The fundamental objective was to increase transparency insofar as transposition was concerned. This was based on levels 1 and 2 that we have already detailed.

The measures contained in Annex III of the Communication were also designed to improve supervisory cooperation and convergence. What was essential was the strengthening of the level 3 Committees – the European Securities Committee, the European Banking Committee, and the European Insurance and Occupational Pensions Committee. From a political perspective, the Committees were expected to deliver more results, and the national supervisors were expected to expand their missions to include a cooperation and convergence requirement at European level. The hope was that reducing the practical obstacles at European and national levels would strengthen mutual trust and the implementation of the measures. Decision-making, especially of the Committees of Regulators, would also be facilitated and carry more authority (even if non-binding) in relation to the national regulators and supervisors.⁴⁴

While reviewing the functionality of the Lamfalussy process, the European Council⁴⁵ invited the Commission to clarify the role of the Committees of Supervisors and consider all different options to strengthen the working of those Committees, without upsetting the current institutional structure or reducing the accountability of supervisors.

During its meeting of March 13 and 14, 2008, the European Council called for swift improvements to the functioning of the Committees of Supervisors.

⁴⁴ See *id.* at 6.

⁴⁵ See, e.g., Press Release 15698/07, Council of European Union, Emp’t, Soc. Policy, Health and Consumer Affairs (Dec. 4, 2007), available at http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/ecofin/97420.pdf.

On May 14, 2008, the European Council invited the Commission to revise the Commission Decisions establishing the Committees of Supervisors to ensure coherence and consistency in their mandates and tasks as well as strengthen their contributions to supervisory cooperation and convergence. The Council noted that specific tasks could be explicitly given to the Committees to foster supervisory cooperation and convergence, and their role in assessing risks to financial stability.⁴⁶

To summarize, the idea of broadening the Committees' powers was clear. The Commission itself called for the political will that was inherent in the Committees' development, and this already showed signs of the changes in responsibility and function that these institutions would undergo.

VIII. THE COMMITTEE OF EUROPEAN INSURANCE AND OCCUPATIONAL PENSIONS SUPERVISORS PURSUANT TO COMMISSION DECISION 2009/79/EC OF 23 JANUARY 2009

Article 16 of Decision 2009/79/EC repealed Decision 2004/6/EC and defined a new configuration for the Committee of Insurance and Occupational Pensions Supervisors by broadening its powers and responsibilities, starting from the premise that it was not a decision-making body, since it had no regulatory powers at Community level. All in all, its function was to carry out peer reviews, to promote best practices, and to issue non-binding guidelines, recommendations and standards in order to increase convergence across the Community, contributing to the common and uniform day-to-day implementation of Community legislation and its consistent application by the supervisory authorities.

The Committee of Insurance and Occupational Pensions Supervisors was constituted as an independent advisory group of the Commission in the insurance, reinsurance, and occupational pensions fields – although, in this latter case, the Decision made it clear that it should not address labour and social law aspects, such as the organization of occupational regimes, and in particular, issues relating to compulsory membership (affiliation) or collective agreements.

⁴⁶ See Commission Decision 2009/79, (4)–(6), 2009 O.J. (L 25) 28 (EU).

On the other hand, the Committee's mandate should cover the supervision of financial conglomerates.⁴⁷ To avoid duplication of work, to prevent any inconsistencies, to keep the Committee abreast of progress, and to give it the opportunity to exchange information, the Committee was instructed to work with the Committee of European Banking Supervisors in the supervision of financial conglomerates, to be exercised thorough the Joint Committee on Financial Conglomerates.⁴⁸

Financial systems in the Community are closely linked and events in one Member State can have a significant impact on financial institutions and markets in other Member States. The continuing emergence of financial conglomerates and the blurring of distinctions between the activities of firms in the banking, securities, and insurance sectors give rise to additional supervisory challenges at the national and Community level. In order to safeguard financial stability, a system is needed at the level of the Committee of Insurance and Occupational Pensions Supervisors, the Committee of European Banking Supervisors, and the Committee of European Securities Regulators in order to identify potential risks, across borders and across sectors, at an early stage and where necessary, to inform the Commission and the other Committees. Furthermore, it is essential that the Committee keep finance ministries and national central banks of the Member States informed. The Committee has its role to play in this respect by identifying risks in the insurance, reinsurance, and occupational pension sectors and regularly reporting on the outcome to the Commission. The Council should also be informed of these assessments.

A. FUNCTIONS OF THE COMMITTEE OF EUROPEAN INSURANCE AND OCCUPATIONAL PENSIONS SUPERVISORS

From reading the articles in the Decision, we can identify three main functions of the Committee of European Insurance and Occupational Pensions Supervisors. First, the Decision established a list of the Committee's functions in relation to multilateral cooperation between national supervisory authorities, which it developed in great detail. Second, the Committee is invested with powers of technical advice. The

⁴⁷ Council Directive 2002/87, 2003 O.J. (L 35) 1 (EU) (defining financial conglomerates as "financial groups which provide services and products in different sectors of the financial markets").

⁴⁸ See Commission Decision 2009/79, (7)–(10) 2009 O.J. (L 25), 25–26 (EU).

final function concerns the nature of the relationship between the Committee and the other supervisory Committees.

Outside of these three functions, in accordance with Article 13, the Committee was to establish an annual work program and transmit it to the European Council, the European Parliament and the Commission by the end of October each year. The Committee was to periodically and at least annually inform the Council, the European Parliament, and the Commission on the achievement of the activities set out in the work program.

1. Cooperation Between Supervisory Authorities

With respect to the first function, the review of the Lamfalussy process established that the Member States also have a key role to play in guaranteeing the full implementation of the standards and guidelines in relation to proposals designed to strengthen cooperation between home and host regulators. The action of the Commission is intended to raise awareness, and evaluate and adopt measures (delegation of functions, protocol for multilateral agreements, functioning of the principal supervisory authority, etc.).

On this basis, Article 4 of the Decision charged the Committee with one of its most important functions, which is to enhance cooperation between national supervisory authorities in the insurance, reinsurance, and occupational pensions fields and foster the convergence of Member States' supervisory practices and approaches throughout the Community. To this effect, it shall carry out the following tasks:

a) mediate or facilitate mediation between supervisory authorities in cases specified in the relevant legislation or at the request of a supervisory authority;

b) provide opinions to supervisory authorities in cases specified in the relevant legislation or at their request;

c) promote the effective bilateral and multilateral exchange of information between supervisory authorities, subject to applicable confidentiality provisions;

d) facilitate the delegation of tasks between supervisory authorities, in particular by identifying tasks can be delegated and by promoting best practices;

e) contribute to ensuring the efficient and consistent functioning of colleges of supervisors, in particular through setting guidelines for the operational functioning of colleges, monitoring the coherence of the practices of the different colleges and sharing good practices; and

f) contribute to developing high quality and common supervisory reporting standards;

g) review the practical application of the non-binding guidelines, recommendations and standards issued by the Committee.

Additionally, within this same principle of convergence, the Committee was charged with reviewing the Member States' supervisory practices and assess their convergence on an ongoing basis. The Committee was to report annually on progress achieved and identify the remaining obstacles.

The Committee was also charged with developing new practical convergence tools to promote the common supervisory approaches. This is an extremely important role, calculated to compensate for any deficiencies in Directives, since these cannot prevent the existence, on occasion, of differences between the final legislations in the different Member States.

Finally, it should be mentioned that the Decision emphasizes that the exchange of information between the supervisory authorities is fundamental to their functions. This exchange is central to the efficient supervision of insurance groups and for financial stability. While insurance legislation imposes clear legal obligations on supervisory authorities to cooperate and exchange information, the Committee was to facilitate practical day-to-day exchange of information between them, subject to relevant confidentiality provisions set out in applicable legislation.⁴⁹

2. The Committee's Typical Function: Advising

With respect to the second function, in Article 4, the Decision charges the Committee with a broad range of responsibilities for technical advice, in particular, with respect to the preparation of draft implementing measures in the fields of insurance, reinsurance, occupational pensions and financial conglomerates. In this case, the Commission has the power to lay down the time limit within which the Committee shall provide such advice.

Moreover, according to Articles 3 and 5, under the principle of convergence, the Committee shall contribute to the common and uniform implementation and consistent application of Community legislation by issuing guidelines, recommendations and standards. In pursuit of this, it is given a power of active oversight, monitoring, and assessing developments in the insurance, reinsurance, and occupational pensions sector. It is also to

⁴⁹ See Commission Decision 2009/79, (15), (18), (19), 2009 O.J. (L 25) 29 (EU).

ensure that the finance ministries and national central banks of the Member States are informed about potential or imminent problems.

The Committee shall, at least twice a year, provide to the Commission assessments of micro-prudential trends, potential risks, and vulnerabilities in the insurance, reinsurance, and occupational pensions sector.

3. Relationship Between Related Supervisors

With respect to the third function, the Decision charged the Committee, not only with coordinating with the national supervisory authorities, but also with cooperating with the various institutions that carry out a similar task to that of the Committee in matters related to the financial framework. In effect, Articles 5, 6, and 9 of the Decision state that the Committee shall cooperate closely with the Committee of European Securities Regulators, the Committee of European Banking Supervisors, and the Banking Supervision Committee of the European System of Central Banks, and contribute to the development of common supervisory practices in the field of insurance, reinsurance, and occupational pensions as well as on a cross-sectoral basis.

To this effect, it was in particular to establish sectoral and cross-sectoral training programmes to facilitate personnel exchanges and to encourage competent authorities to intensify the use of secondment schemes, joint inspection teams, and supervisory visits and other tools.

B. COMPOSITION

The Decision, in Article 7, states that the Committee shall be composed of high-level representatives from the national public authorities competent in the field of supervision of insurance, reinsurance, and occupational pensions. Each Member State shall designate a high level representative from its competent authorities to participate in the meetings of the Committee. The Decision does not define what is meant by a high level representative, which could lead to differences in interpretation on the part of the different Member States, and the consequent attendance of representatives with different levels of technical expertise, despite their all being “high level.” The Chair shall be elected from among the Committee members.

The members are enjoined not to disclose information covered by the obligation of professional secrecy. All participants in the discussions shall be obliged to comply with the applicable rules of professional

secrecy. Whenever the discussion of an item on the agenda should entail the exchange of confidential information concerning a supervised institution, participation in that discussion may be restricted to members directly involved.

The Committee, according to Article 14, shall operate by consensus of its members. If no consensus can be reached, a qualified majority shall make decisions. The votes of the representatives of the Members of the Committee shall correspond to the votes of the Member States as laid down in Articles 205(2) and (4) of the Treaty.⁵⁰ Finally, the Committee shall adopt its own rules of procedure, and organize its own operational arrangements.

IX. REGULATION (EU) NO. 1094/2010 OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL OF 24 NOVEMBER 2010, ESTABLISHING A EUROPEAN SUPERVISORY AUTHORITY (EUROPEAN INSURANCE AND OCCUPATIONAL PENSIONS AUTHORITY), AMENDING DECISION NO. 716/2009/EC AND REPEALING COMMISSION DECISION 2009/79/EC⁵¹

The financial crisis that we are presently undergoing has exposed weaknesses in cooperation, coordination, and consistency in the application of Community law, and in the mutual confidence between national supervisors.

The Commission, the Parliament, and the Council have always been aware that the Committees that have been established up to the present day have been no more than consultative bodies, with undoubted importance in relation to the quality of their technical advice, but without the power to take decisions. However, the effort made in Decision 2009/79/EC to set up the Committee as a body with a major impact in the field of insurance and occupational pensions supervision is praiseworthy.

⁵⁰ Articles 205.2 and 205.4 should be read according to the amendments introduced by the Act of Accession of 2003, which introduces amendments to Primary Law, as a result of the Accession of the Republic of Bulgaria and of Romania to the European Union. Consolidated Version of the Treaty on the European Union, Dec. 29, 2006, 2006 O.J. (C 321) 327.

⁵¹ Commission Regulation 1092/2010, 2010 O.J. (L 331) 48–83.

On 25 February 2009, a group of experts, under the chairmanship of J. de Larosière, published a report⁵² at the behest of the Commission. The report concluded that the supervisory framework needed to be strengthened, and recommended the creation of a European System of Financial Supervisors, consisting of three European Supervisory Authorities: one in the insurance and occupational pensions sector, one in the banking sector, and the third in the securities sector, as well as a European Systemic Risk Board.

The European Council, in its conclusions dated 19 June 2009, recommended the creation of a European System of Financial Supervisors, consisting of three new European Supervisory Authorities. This system should focus on improving the quality and cohesiveness of national supervision, strengthening control over transnational business groups, and establishing a single EU rule book applicable to all financial institutions in the single market. The European Council emphasized that the European Supervisory Authorities should also have supervisory powers for credit ratings agencies. The Council invited the Commission to present concrete proposals as to the manner in which the European System of Financial Supervisors⁵³ would be able to take firm action in critical situations, making the point that the decisions adopted by the European Supervisory Authorities should not have any effect on the budgetary responsibilities of the individual Member States.

The European Supervisory Authorities are intended to replace the Committee of European Banking Supervisors established by Commission Decision 2009/78/EC, the Committee of European Insurance and Occupational Pensions Supervisors established by Commission Decision 2009/79/EC, and the Committee of European Securities Regulators established by Commission Decision 2009/77/EC, and assume all the tasks and powers of those Committees.⁵⁴

⁵² THE DE LAROSIÈRE GROUP, THE HIGH-LEVEL GROUP ON FINANCIAL SUPERVISION IN THE EU (Feb. 25, 2009).

⁵³ See A.J. Tapia Hermida, *La Nueva Estructura Centralizada de Supervisión de los Mercados Financieros en la Unión Europea: Las Propuestas Regulatorias de la Comisión 23 de Septiembre de 2009 para la Creación del Consejo Europeo de Riesgo Sistémico y del Sistema Europeo de Supervisores Financieros*, 116 REVISTA DE DERECHO BANCARIO Y BURSÁTIL 209, 296–97 (2009).

⁵⁴ See Commission Regulation 1094/2010, 2010 O.J. (L 331) 58 (EU). (“The Authority (EIOPA) shall form part of a European System of Financial Supervision

A. UNDERLYING LEGAL AUTHORITY

At the outset, it is necessary to consider the legislative approval process under which this new EIOPA is established. Article 95 of the EC Treaty⁵⁵ was chosen as the underpinning of its creation. The purpose of this precept is to facilitate the actions of the Council, the Commission, and the Parliament, within their respective competences, with the objective of

(ESFS). The main objective of the ESFS shall be to ensure that the rules applicable to the financial sector are adequately implemented to preserve financial stability and to ensure confidence in the financial system as a whole and sufficient protection for the customers of financial services. The ESFS shall comprise the following: the European Systemic Risk Board (ESRB) for the purposes of the tasks as specified in Commission Regulation (EU) 1092/2010 and this Regulation; the Commission Authority (EIOPA); the European Supervisory Authority (European Banking Authority) established by Commission Regulation (EU) 1093/2010 and the European Parliament and of the Council; the European Supervisory Authority (European Securities and Markets Authority) established by Regulation (EU) 1095/2010 of the European Parliament and of the Council; the Joint Committee of the European Supervisory Authorities (Joint Committee) for the purposes of carrying out the tasks as specified in Articles 54 to 57 of this Regulation, of Commission Regulation (EU) 1093/2010 and of Regulation (EU) No 1095/2010; the competent or supervisory authorities in the Member States as specified in the Union acts referred to in Article 1 of this Regulation, of Regulation (EU) No 1093/2010 and of Regulation (EU) No 1095/2010. The Authority shall cooperate regularly and closely with the ESRB as well as with the European Supervisory Authority (European Banking Authority) and the European Supervisory Authority (European Securities and Markets Authority) through the Joint Committee, ensuring cross-sectoral consistency of work and reaching joint positions in the area of supervision of financial conglomerates and on other cross-sectoral issues. In accordance with the principle of sincere cooperation under Article 4 of the Treaty on European Union, the parties to the ESFS shall cooperate with trust and full mutual respect, in particular in ensuring the flow of appropriate and reliable information between them. Those supervisory authorities that are party to the ESFS shall be obliged to supervise financial institutions operating in the Union in accordance with the acts referred to in Article 1”).

⁵⁵ Today it is known as Article 114 in the consolidated versions of the Treaty on European Union and the Treaty on the Functioning of the European Union, as well as their Protocols and Annexes, resulting from the amendments introduced by the Treaty of Lisbon, signed on 13 December 2007 in Lisbon, that took effect on 1 December 2009. Commission Regulation 1094/2010, 2010 O.J. (C 83) 94 (EU).

assimilating the different national systems of legislation.⁵⁶ The new Authority is established in accordance with the aforesaid, and by means of co-decision.

However, the most important question is if the European Commission, Council, and Parliament have enough powers to create the EIOPA. As an introduction, the Commission mentions in Legal Reason 16 of the Proposal for a Regulation that the Court of Justice of the European Communities, in its Judgment of 2 May 2006 in case C-217/04⁵⁷ (*United Kingdom of Great Britain and Northern Ireland v. European Parliament and Council of the European Union*), acknowledges that Article 95 of the EC Treaty, relating to the adoption of measures for the assimilation of laws with a view to the establishment and functioning of the internal market, constitutes a sufficient legal basis for the creation of “a Community body responsible for contributing to the implementation of a process of harmonisation.” Therefore, the purpose and tasks of the Authority – assisting competent national supervisory authorities in the consistent interpretation and application of Community rules and contributing to financial stability necessary for financial integration – are closely linked to the objectives of the Community *acquis*⁵⁸ concerning the internal market for financial services. The European Parliament and the European Council adopted this legal proof in Legal Reason 16 of the Regulation.

⁵⁶ See T.C. HARTLEY, *THE FOUNDATIONS OF EUROPEAN LAW COMMUNITY LAW* 114–18 (5th ed. 2003).

⁵⁷ Case C-217/04, *United Kingdom of Great Britain and Northern Ireland v. European Parliament and Council of the European Union*, 2006 O.J. (C 143) 8 (EU).

⁵⁸ The Community *acquis* is the body of common rights and obligations which bind all the Member States together within the European Union. It is constantly evolving and comprises: the content, principles and political objectives of the Treaties; the legislation adopted in application of the treaties and the case law of the Court of Justice; the declarations and resolutions adopted by the Union; measures relating to the common foreign and security policy; measures relating to justice and home affairs; international agreements concluded by the Community and those concluded by the Member States between themselves in the field of the Unions’ activities. Applicant countries have to accept the Community *acquis* before they can join the Union. Derivations from the *acquis* are granted only in exceptional circumstances and are limited in scope. To integrate into the European Union, applicant countries will have to transpose the *acquis* into their national legislation and implement it from the moment of their accession.

The same precept introduces extremely comprehensive authorization for assimilating the legal, regulatory and administrative regulations of the Member States,⁵⁹ with the exception of certain matters such as tax regulations, those covering the free movement of people, and those affecting employees. This authorization has served, except where specific prohibitions or limitations are in force, as one of the most important mechanisms in the extension of Community law. In addition to this, the development has also been based on the jurisprudential doctrine of *direct effect*,⁶⁰ whereby, except when exercising competences conceded under the Treaty, the European Union is empowered to go beyond the explicit competences.

This mechanism, which is also known as the *principle of subsidiarity*, implies overriding and going beyond the rigid concept of competence by direct attribution, and achieving maximum applicability in all those areas that do not fall either within the domain of national sovereignty, or within the exclusive competence of the Community.⁶¹

Through in-depth analysis of that question, then we must ask ourselves if there is a sufficient basis of statutory approval to create the EIOPA according to the aforementioned Article 95. In effect, the Judgment of 2 May 2006, attempted to resolve the question of whether the creation of the European Network and Information Security Agency

⁵⁹ See E. LINDE PANIAGUA, *POLÍTICAS DE LA UNIÓN EUROPEA* 51, 52 (3rd ed., 2006).

⁶⁰ See Case 22/70, *Comm'n v. Council*, 1971 E.C.R. 263. The direct effect of European law has been enshrined by the Court of Justice in the judgment of *Van Gend en Loos* of 5 February 1963. See Case 26/62, *Van 198en den Loos v. Nederlandse Adminstratie der Belastingen*, 1963 E.C.R. 1. In this judgment, the Court states that European law not only engenders obligations for Member States, but also rights for individuals. Individuals may therefore take advantage of these rights and directly invoke European acts before national and European courts. However, it is not necessary for the Member State to adopt the European act concerned into its internal legal system. There are two aspects to direct effect: a vertical aspect and a horizontal aspect. Vertical direct effect is of consequence in relations between individuals and the State. This means that individuals can invoke a European provision in relation to the State. Horizontal direct effect is consequential in relations between individuals. This means that an individual can invoke a European provision in relation to another individual.

⁶¹ See MARTIN A. MANGAS & LINAN D.J. NOUGUERAS, *Instituciones y Derecho de la Unión Europea* 326–30 (1996).

(“ENISA”)⁶² contravenes the EC Treaty, or if Article 95 possesses sufficient legislative power to establish such a body. According to that judicial decision, ENISA is a body that does not have the broad powers similar to those conferred by the Regulation that created EIOPA. Instead, the legal powers of ENISA are very similar to those of the Committee of European Insurance and Occupational Pensions Supervisors, which was abolished by the new Regulation. ENISA’s functions only extend to providing information and advice, cooperation, and assistance. In this regard, the European Parliament Legislative Resolution of 22 September 2010, in which the first or simple reading of the Proposal for a Regulation⁶³ for setting up the Authority that is the subject of the present study is published, does not elaborate on this question, but rather avoids alluding to the justification on which the creation of the Authority is based. It would seem that, in light of this frame of mind, perhaps the Court of Justice of the European Communities should rule on the issue.

B. FUNCTIONS

The Regulation is designed to overcome the disadvantages of the old Committee of Supervisors. The anomalous situation, in our view, in which the old Committee found itself, due to being a body with considerable technical potential, but with purely consultative functions, is resolved by the creation of the new Authority. In this way, then, it is entrusted, in areas defined by Community law, with the elaboration of draft regulatory technical standards, which do not involve policy choices. The Commission should endorse those draft regulatory technical standards in accordance with Community law in order to give them binding legal force. At the same time, the process of drawing up technical standards does not prejudice the Commission’s powers to adopt, on its own initiative, measures whose application is in accordance with the comitology⁶⁴

⁶² Regulation of the European Parliament 460/2004, 2004 O.J. (L 77) 1 (EU).

⁶³ *Proposal for a Regulation of the European Parliament and of the Council Establishing a European Insurance and the Occupational Pensions Authority*, COM (2009) 502 final (Sept. 22, 2010), available at <http://www.europarl.europa.eu/sides/getDoc.do?type=TA&language=EN&reference=P7-TA-2010-0334#BKMD-18>.

⁶⁴ Council Decision 1999/486, 1999 O.J. (D 0486) 2 (EC). In accordance with the Treaty on the Functioning of the European Union (TFEU), Member States implement European law by adopting measures for implementing legal acts into their national legislations. In accordance with the principles of subsidiarity and

procedures at level two of the Lamfalussy structure, that are laid down in the relevant Community legislation.

The new Authority is set up to be a body with legal personality, without usurping the Commission's powers, and being accountable to the

proximity, decisions shall be taken as close to the citizens as possible. Implementing powers may also be attributed to the Commission so that legislation is implemented uniformly in the Member States, or to the Council for implementing acts related to the Common Foreign and Security Policy. Consolidated Version of the Treaty on the European Union, Oct. 26, 2012 O.J. (C 326) 58–59. In exercising its implementing powers, the Commission is assisted by representatives of the Member States through committees, in accordance with the “comitology” procedure.

The committees are forums for discussion consisting of representatives from Member States and are chaired by the Commission. They enable the Commission to establish dialogue with national administrations before adopting implementing measures. The Commission ensures that measures reflect as far as possible the situation in each of the countries concerned.

Relations between the Commission and the committees are based on models set out in the Council “Comitology Decision.” This decision has been amended several times. In 1999, it accorded the European Parliament a “right to scrutiny” in implementing legislative acts adopted by co-decision. It also increased the transparency of the system by making committee documents more accessible to the Parliament and the public and by requiring the documents to be registered in a public register.

Council Decision 2006/512, 2006 O.J. (L 200) 11 (EU). The “Comitology Decision” was amended again in 2006. It introduced a new way of exercising implementing powers: the regulatory procedure with scrutiny.

Consolidated Version of the Treaty on the European Union, Oct. 26, 2012 O.J. (C 326) 58–59. The Treaty of Lisbon provides that the relationship between the Commission and its committees is henceforth organized on the basis of a regulation adopted by the European Parliament under the ordinary legislative procedure. Until such a regulation is adopted, the Council “Comitology Decision” adopted in 2006 is to apply. Committees may be formed in accordance with the following typology: advisory committees who give their opinions to the Commission, which must try to take account of them; management committees: they intervene when implementing measures relate to the management of programs and when they have budgetary implications; and regulatory committees: they are responsible when the implementing measures relate to legislation applicable in the whole of the European Union (EU). Regulatory committees with scrutiny must allow the Council and the European Parliament to carry out a check prior to the adoption of measures of general scope designed to amend non-essential elements of a basic instrument adopted by co-decision.

European Council and to the European Parliament.⁶⁵ Ensuring the correct and full application of Community law is a core prerequisite for the integrity, transparency, efficiency, and orderly functioning of financial markets, the stability of the financial system, and for neutral conditions of competition for financial institutions in the Community, including protection for the consumer as the end-user.

1. Binding Decisions

Article 17 of the Regulation (EU) No. 1094/2010, establishes a mechanism, which allows the Authority to deal with cases of incorrect or insufficient application of Community law. For this purpose, a three-stage mechanism is created.

In the first stage, the Authority is empowered to investigate alleged incorrect or insufficient application of Community law obligations by national authorities in their supervisory practice, concluded by a recommendation, in which the action necessary to comply with Union law is set out. The national authority has the obligation to inform the Authority of the steps it has taken, or intends to take, as a result of the recommendation.

The second stage begins when the national authority fails to abide by the recommendation and it is necessary to remedy in a timely manner such non-compliance in order to maintain or restore neutral conditions of competition in the market or ensure the orderly functioning and integrity of the financial system. The Authority may issue an individual decision addressed to a financial institution requiring the necessary action to comply with its obligations under Union law including the cessation of any practice. All of this is without prejudice to the powers of the Commission under Article 258 TFEU.⁶⁶

⁶⁵ This responsibility clause is introduced by Article 1.3 of European Parliament Legislative Resolution of 22 September 2010, in which the first or simple reading of the Proposal for a Regulation is published. *Proposal for a Regulation of the European Parliament and of the Council Establishing a European Insurance and the Occupational Pensions Authority*, COM (2009) 502 final (Sept. 22, 2010), available at <http://www.europarl.europa.eu/sides/getDoc.do?type=TA&language=EN&reference=P7-TA-2010-0334#BKMD-18>.

⁶⁶ This of course according to the consolidated versions of the Treaty on European Union and the Treaty on the Functioning of the European Union, and their Protocols and Annexes, resulting from the amendments introduced by the

Finally, the third stage begins when there are adverse developments which may seriously jeopardize the orderly functioning and integrity of financial markets or the stability of the whole or part of the financial system in the Union. The Authority may adopt individual decisions requiring competent authorities to take the necessary action, and requiring financial institutions to take the necessary action to comply with their obligations under Union law including the cessation of any practice.

2. The Conciliation and Arbitration Function

The Regulation also, in Article 19, endows the Authority with the function of carrying out arbitration, in order to ensure effective supervision, and a balanced consideration of the positions held by the national supervisory authorities of the different Member States. The procedure is divided into two phases. In the first, a conciliation phase should be provided for during which the national supervisory authorities may reach an agreement. At that stage, the Authority shall act as a mediator. If the authorities fail to reach an agreement, then the second phase is initiated. In the second, the Authority may take a decision requiring them to take specific action or to refrain from action in order to settle the matter, in accordance with Community law. This Decision is binding on the competent authorities in question in order to ensure compliance with Union law. The decisions adopted shall prevail over any previous decision adopted by the competent authorities on the same matter.⁶⁷

On the basis of this last paragraph, the Authority is to assess whether it is competent to make a ruling on the resolution of the particular case. If the Authority considers that it is competent to resolve the disagreement it will make a ruling. The ruling is binding since, if the supervisory authority does not conform to this resolution, then the Authority has the power to adopt an individual decision, addressed to the

Treaty of Lisbon signed on 13 December 2007 in Lisbon, that took effect on 1 December 2009. 2010 O.J. (C 38) 13.

⁶⁷ Regulation introduced in Art. 11.4.2 of European Parliament Legislative Resolution of 22 September 2010, in which is published the first or simple reading of the Proposal for a Regulation. *Proposal for a Regulation of the European Parliament and of the Council Establishing a European Insurance and the Occupational Pensions Authority*, COM (2009) 502 final (Sept. 22, 2010), available at <http://www.europarl.europa.eu/sides/getDoc.do?type=TA&language=EN&reference=P7-TA-2010-0334#BKMD-18>

financial entity, urging it to take the necessary action to comply with its obligations under Community law including the cessation of any practice.

Finally, from a reading of Article 19, there are two limitations on this power. In the first place, where there exists in Community law a remedy for the conflict, or a mechanism for resolving the type of conflict that falls outside the Authority's competence, it will refrain from settling the case and point out to the parties the proper place for the resolution of the disagreement. The second limitation arises when the Commission holds the power of resolution over the conflict.

3. Delegation of Tasks and Responsibilities

The Regulation also authorizes the delegation of tasks and responsibilities in order to reduce the duplication of supervisory tasks, to foster cooperation and thereby streamline the supervisory process, and to reduce the burden imposed on financial institutions. Delegation of tasks means that tasks are carried out by a supervisory authority other than the responsible authority, while the responsibility for supervisory decisions remains with the delegating authority. Through the delegation of responsibilities, a national supervisory authority, the authority delegated to, should be able to decide upon a certain supervisory matter in the name and stead of another national supervisory authority. On this basis, responsibility may be delegated to the Authority itself or to other authorities.

Delegations should be governed by the principle of allocating supervisory competence to a supervisor, which is best technically qualified to take action. In this respect, the Authority must be informed in order to issue a prior notice about it, should this in its view be necessary.

4. Regulatory and Implementing Technical Standards

The Authority is empowered to adopt regulatory technical standards and implementing technical standards under the provisions of Articles 10 and 15 of the Regulation.

Regulatory technical standards are designed to address technical issues, and shall not imply strategic decisions or policy choices and their content shall be delimited by the legislative acts on which they are based. Before submitting them to the Commission, the Authority shall conduct open public consultations on draft regulatory technical standards, and analyse the potential related costs and benefits, unless such consultations and analyses are disproportionate in relation to the scope and impact of the

draft regulatory technical standards concerned or in relation to the particular urgency of the matter.

It is important to note that when the Authority does not submit a draft regulatory technical standard to the Commission within the time limits, then the Commission may adopt a regulatory technical standard by means of a delegated act without a draft from the Authority.

As regards the second type, implementing technical standards shall be technical, shall not imply strategic decisions or policy choices, because those subjects are enacted by the European Council or the Commission, and their content shall be to determine the conditions of application of those acts. The Authority shall submit its draft implementing technical standards to the Commission for endorsement. The approval procedure is the same as that for the approval of regulatory technical standards.

5. The Advisory Function

As we have seen thus far, the Regulation places emphasis on the creation of an Authority with powers of decision. But, its antecedents as a consultative body are not abolished and must be kept in mind; rather, those powers are broadened. In effect, with respect to the field of insurance and occupational pensions, the Authority functions as a consultative body, not only as advisor to the Commission, but now also to the European Parliament, and to the European Council.

Besides, and with the objective of ensuring full effectiveness of the functioning of the European Systemic Risk Board (“ESRB”)⁶⁸ and the

⁶⁸ The ESRB is responsible for the macro-prudential oversight of the financial system in the EU. One of its main objectives is to prevent and mitigate systemic risks which might prejudice the financial stability of the EU. In this regard, the ESRB must in particular: determine and collect the information necessary for its action; identify systemic risks and prioritize them; issue warnings and make them public if necessary; recommend measures to be taken once the risks have been identified. The ESRB is composed of: a General Board to ensure the performance of tasks; a Steering Committee which contributes to the decision-making process; a Secretariat responsible for day-to-day business; an Advisory Scientific Committee and an Advisory Technical Committee to provide advice and assistance. The President of the European Central Bank (ECB) shall chair the ESRB for a term of five years. The Chair will perform his duties assisted by two Vice-Chairs, the first of which shall be elected by and from the General Council of the ECB, while the second shall be the Chair of the Joint Committee. Members of the ESRB shall have an obligation to comply with the principles of impartiality and professional secrecy

follow-up to its warnings and recommendations, the Authority must provide it with all relevant information. Upon receipt of warnings or recommendations addressed by the European Systemic Risk Board to the Authority or a national supervisory authority, the Authority should ensure follow-up.

C. INTERNAL ORGANIZATION

Chapter III of the Regulation is entitled “Organisation,” and contains four sections describing the bodies that constitute EIOPA.

Section 1 authorizes the **Board of Supervisors**, presided over by the Chairperson, who is non-voting, and consisting of the heads of the competent national public authorities of each Member State. The Board’s function is to give guidance to the work of the Authority and to adopt the opinions, recommendations and decisions, and to issue the advice referred to in Chapter II, concerning the Authority’s tasks and responsibilities. The Board also adopts the Authority’s multi-annual work programme and exercises disciplinary authority over the Chairperson and Executive Director, including the power to remove them from office if necessary.

Section 2 creates the **Management Board**, which is presided over by the Authority’s Chairperson. The Management Board’s role is to ensure that the Authority carries out its mission, to propose an annual and multi-annual work programme, to exercise its budgetary powers in accordance with the Regulation, and to adopt the Authority’s staff policy plan.

Section 3 designates the **Chairperson**, who may be appointed by the Board of Supervisors, and who may be removed from office only by the Parliament, following a decision of the Board. The Chairperson’s term of

when performing their duties, including after their duties have ceased. Meetings of the General Board shall take place four times a year, preceded by meetings of the Steering Committee. The Chair of the ESRB may convene extraordinary meetings. The ESRB may also seek the advice of the private sector when necessary. Finally, The ESRB may issue warnings and make recommendations concerning remedial action to be adopted, or even legislative initiatives. Such recommendations may be addressed: to the EU; to one or several Member States; to one or several European supervisory authorities; to one or several national supervisory authorities. Recommendations relating to measures to be adopted shall be issued according to a color code which varies according to the level of risk. If the ESRB observes that its recommendations have not been followed, it shall, confidentially, inform the addressees, the Council and, where relevant, the European Supervisory Authority concerned.

office is five years and may be extended once. The Chairperson shall neither seek nor take instructions from Union institutions or bodies, from any government of a Member State, or from any other public or private body.

Section 4 creates the post of the **Executive Director**, who is appointed by the Board of Supervisors, on the basis of merit, skills, knowledge of financial institutions and markets, and experience relevant to financial supervision and regulation and managerial experience, following an open selection procedure. The Executive Director is in charge of the management of the Authority and prepares the work of the Management Board. The Executive Director is also responsible for implementing the annual work programme of the Authority, and shall take the necessary measures, notably the adoption of internal administrative instructions and the publication of notices, to ensure the functioning of the Authority. Finally, each year the Executive Director shall prepare a draft report with a section on the regulatory and supervisory activities of the Authority and a section on financial and administrative matters.

D. BODIES SET UP BY THE REGULATION

Chapter IV, dealing with *Joint Bodies of the European Supervisory Authorities*, establishes in its Section 1 the **Joint Committee of European Supervisory Authorities** and in its Section 2 the **Board of Appeal**.

The purpose of the Joint Committee is to serve as a forum in which the Authority shall cooperate regularly and closely and ensure cross-sectoral consistency with the European Banking Authority and the European Securities and Markets Authority. It is composed of the Chairperson of the Authority and the Chairpersons of the Authorities aforementioned. Within the Committee there shall be a Sub-Committee on financial conglomerates and further Sub-Committees as may be deemed necessary.

The Board of Appeal shall be a joint body of the European Banking Authority, the European Insurance and Occupational Pensions Authority and the European Securities and Markets Authority. It shall be composed of six members and six alternates with a proven record of relevant knowledge and experience, excluding current staff of the competent authorities or other national or Community institutions involved in the activities of the Authority. Any natural or legal person, including competent authorities, may appeal a decision of the Authority. Such an

appeal shall not have suspensive⁶⁹ effect. Finally, decisions taken by the Board of Appeal may be contested before the Court of Justice of the European Union, in accordance with Article 263 TFEU.

X. CONCLUSION

The history of the succession Committees up to the present day, namely those concerned with the whole field of financial services is commendable for the attempts to achieve convergence between the different national standards. In effect, in the context of the multiplicity of standards and of the fragmented nature of the market within the Community, actually being able to find the point of inflection, where those regulations can coincide with a view to constructing a unified market, is no mean feat. In our opinion, developing the Committees for the purpose of promoting their technical advice was the source of the great profusion of working materials from which it has been possible to construct a common supervisory and regulatory body.

Along with all this material, the Lamfalussy process and its review have led to the amendment of a broad spectrum of directives aimed at unifying supervisory criteria as the *conditio sine qua non* for the attainment of this common market. The creation of a single supra-national Authority can be regarded as the high point of an entire process of unification of principles of finance that provides this body with the power to issue resolutions without having any destabilizing effect, both in Community and in national markets. Certainly, the different intra-community markets, in spite of their interconnections, and taking account of their particular individual nature and characteristics, cannot allow themselves to be affected by the decision of a supra-national body that upsets a given market and distorts the ends it is designed to serve. This is why the work of legislative convergence is a ceaseless task, and involves constant assessment of its consequences.

It is also the case that the Lamfalussy process constitutes a major challenge in supra-Community terms. The increasing globalization that we are experiencing today, makes easier the movement and investment of foreign capital, both to create new enterprises and to develop existing ones. This is why one of the objectives of the process has been to project to the outside world the image of a strong and solid Community market, which,

⁶⁹ It means that the Decisions enacted by the Authority can be implemented, and the appeals cannot stop the Decision's effects.

thanks to this appearance, is able to attract investors who are willing to participate in a business environment that is secure, both from the point of view of standards and of economic prospects. As a result, the regulation and supervision of insurance and of the other financial services needs to be developed in such a way as to simultaneously promote mutual confidence between the different supervisors, with a view to avoiding having investors perceive distortions or tensions concerned with legislation. In this respect, the creation of the Committee of Supervisors by the Decision of 23 January 2009 promoted the move towards convergence of the different national supervisors. That was in our view a very successful move, in that the Committee embodied the supra-national ethos that was needed to permeate supervisory practice in the nations. As we can see, that drawing together has not yet been achieved as fully as would be desired.

The reluctance, on the part of national authorities to relinquish competences in matters of financial market governance has been a constant factor, in spite of the aspiration towards integration. The European Council included in its conclusions of 19 June 2009 reference to the standstill in the financial market. The Council was of the view that it would be helpful to take a further step forward in this matter and to set up a supra-national supervisory body that would at least draw together the functions of the national supervisors, even if this were initially in a somewhat tentative manner.

The new European Insurance and Occupational Pensions Authority is constituted as a joint body, because of the disparity of the tasks attributed to it by the Proposal for a Regulation. The advisory function, the oversight of the incorrect or insufficient application of Community law, the production of proposals, and the delegation of functions, all lead us to suspect that in the future this Authority will be the sole supervisory body operating in all Member States. This is also likely true for the similar arrangements governing banking supervision and securities regulation. For sure, it seems likely that we are progressing towards a new conception as regards the supervision and regulation of insurance in our country, or perhaps what we are witnessing is another step towards Community-wide integration.

FORTUITY VICTIMS AND THE COMPENSATION GAP: RE-ENVISIONING LIABILITY INSURANCE COVERAGE FOR INTENTIONAL AND CRIMINAL CONDUCT

ERIK S. KNUTSEN^{†1}

Insurance is based on the notion that only uncertain, or fortuitous, losses are insurable. There are systemic problems, however, with the consistency in which fortuity clauses are applied in the liability insurance context. Differing interpretive approaches and litigation distortions include the use of at least three interpretive perspectives and two substantive requirements to interpret the intentional act fortuity clause, and four interpretive perspectives to interpret the criminal act fortuity clause. These problems stem from the tension between the two purposes of liability insurance (wealth protection and victim compensation) coupled with a move from explanatory rhetoric about fortuity to explanatory rhetoric about morality.

This Article outlines the importance of balancing that tension and examines the problematic effects of these two ubiquitous fortuity clauses that remove coverage for policyholders and simultaneously deny access to compensatory funds for injured victims. The Article argues that intentional and criminal act fortuity clauses need to be more consistently interpreted to avoid a host of inefficient distortion effects that otherwise result from the introduction of moral concerns, and it concludes by offering possible solutions for redress for those accident victims that would still be left, though more predictably, in the liability insurance compensation gap.

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I. INTRODUCTION

It surprises many that an accident victim who is hurt as a result of a wrongdoer's intentional or criminal actions often receives no compensation from a tort lawsuit. In fact, tort lawsuits are rarely brought for these kinds of injuries. The reason is because the wrongdoer's liability insurance policy typically excludes insurance coverage for losses arising from the wrongdoer policyholder's intentional or criminal actions. There is thus no money available for the victim's compensation. These are often the most morally disturbing kinds of injuries because, in most instances, the wrongdoer meant to harm the victim. It was no "accident." So why does liability insurance pay an injured accident victim when the policyholder causes an accident but not when the policyholder acts intentionally or criminally? More importantly, what if the policyholder acted intentionally or criminally and still caused an "accident?"

What if the policyholder did not mean to harm the victim? This can occur in a variety of ways. A policyholder could be playing a prank to scare a friend. The prank gets out of hand and the friend is injured. But the policyholder never means to harm the friend. Did the policyholder act "intentionally" and therefore there should be no liability insurance coverage available to him if the friend sues him for compensation? What if the policyholder's actions violate a criminal law and the policyholder is charged with a crime arising out of the prank behavior? Should there be no liability insurance coverage then? And what is the injured friend to do for compensation, without the policyholder's financial safety net of liability insurance to access?

This Article examines the problematic effects of two ubiquitous fortuity clauses in liability insurance: a clause which removes coverage for intentionally caused losses and one which removes coverage for losses arising from a policyholder's criminal acts. A fortuity clause is insurance policy language designed to remove coverage for non-fortuitous risks. The fortuity clause controls access to insurance coverage for a liability insurance policyholder while simultaneously controlling access to compensatory funds for the injured accident victim who sues the wrongdoer policyholder.

Intentional and criminal act fortuity clauses are interpreted in a highly inconsistent fashion by courts and litigators, making insurance cases hinging on the clauses costly and unpredictable to litigate. Litigants have also devised creative but costly litigation distortions as workarounds for avoiding the operation of these clauses. This, in turn, has resulted in a large group of injured accident victims who face a compensation gap as a

result of courts' and litigants' inconsistent fortuity clause interpretation. The population of accident victims within the compensation gap is constantly expanding and contracting with the whims of varying fortuity clause interpretations. These accident victims are "fortuity victims." This makes finding a solution to this compensation gap doubly problematic for this group of injured accident victims because it is difficult to categorize, at any one time, which victims will be left uncompensated. While liability insurance does not, and cannot, provide coverage for every loss, there is something slippery about the fact that identically-worded fortuity clauses are interpreted to have different effects in different cases, despite remarkably similar factual circumstances in those cases.

Interpreting fortuity clauses in the liability insurance context is unpredictably problematic because the interpretive exercise is affected by the tension between two co-existing purposes of liability insurance: wealth protection and accident compensation. These purposes often cancel each other out, leaving the injured accident victim without compensation – a serious collateral effect. At the same time, because these fortuity clauses target intentional and criminal conduct, there is incentive for improper and misleading introduction of moral concerns into the interpretation. The fortuity clause can morph into a morality clause, with a host of inefficient distortion effects. To avoid these problems, there should be a more consistent interpretive solution which firmly grounds the intentional and criminal act fortuity clauses in fortuity concepts, not morality concepts. This would go a long way to bettering the accident compensation system as a whole by removing the unpredictability about which fortuity victims are left in the compensation gap. Once that occurs, there can then be a more efficient accounting as to where certain societal losses will ultimately lie – with insurers, wrongdoers, or society's social safety net.

Part I of this Article explains how fortuity is fundamental to the insurance relationship. Insurance can only insure against uncertain risks. Part II explains how liability insurance operates within the tort system and introduces the tension between liability insurance's two often-competing purposes: a wealth protection vehicle for the policyholder and a vital and expected component of society's accident compensation web. In Part III, the Article focuses on two common liability insurance fortuity clauses, the intentional and criminal act fortuity clauses. The problems created by courts' and litigants' current interpretation of these fortuity clauses is dealt with in Part IV. Part V explains the causes of these problems, tracing how the historically moral nature of the clauses affects their interpretation in today's modern insurance world, which is focused on risk management, not morality. Part VI introduces an interpretive solution for the intentional and

criminal act fortuity clauses. Part VII addresses some possibilities for redress for those accident victims still left in the liability insurance compensation gap after the solution is applied. Part VIII concludes with a reminder that better predictability and consistency in insurance coverage results can be maintained if fortuity clauses remain grounded in fortuity, not morality.

II. INSURANCE AND FORTUITY

A standard tenet of insurance is that it is designed to protect a policyholder against losses that are fortuitous.² It is typically not economically sensible for insurers to offer protection for losses that are certain to happen.³ The insurance arrangement between insurer and policyholder depends on the insurer shouldering some potential risk that a future covered event may or may not occur. The insurer profits from the superior ability to better estimate the likelihood of a future payout-triggering occurrence and balance that risk with the amount of insurance premium charged to the policyholder who wishes her risk to be underwritten by the insurer. The premium paid is usually a fraction of the actual cost of a future expected loss. By pooling together multiple policyholders who wish similar risks underwritten, the insurer is able to ride the waves of random (or fortuitous) future payouts and, owing to the law of large numbers, profit from the fact that not everyone will experience a payout-triggering loss at once. The insurer is thus taking on two risks: (1)

² JEFFREY W. STEMPEL, *STEMPEL ON INSURANCE CONTRACTS* 37–68 (3d ed. 2006); Kenneth S. Abraham, *Peril and Fortuity in Property and Liability Insurance*, 36 *TORT & INS. L.J.* 777, 777 (2001); James A. Fischer, *The Exclusion from Insurance Coverage of Losses Caused by the Intentional Acts of the Insured: A Policy in Search of a Justification*, 30 *SANTA CLARA L. REV.* 95, 96 (1990); George L. Priest, *Insurability and Punitive Damages*, 40 *ALA. L. REV.* 1009, 1020–25 (1989); *see also* *Aetna Cas. & Sur. Co. v. Dow Chem. Co.*, 10 F. Supp. 2d 771, 789 (E.D. Mich. 1998); *Gen. Housewares Corp. v. Nat'l Sur. Corp.*, 741 N.E.2d 408, 413 (Ind. Ct. App. 2000); *United Capitol Ins. Co. v. Hoodco, Inc.*, 974 S.W.2d 572, 576 (Mo. Ct. App. 1998); *Scottsdale Ins. Co. v. Travis*, 68 S.W.3d 72, 75 (Tex. Ct. App. 2001); *Aluminum Co. of Am. v. Aetna Cas. & Sur. Co.*, 998 P.2d 856, 878–79 (Wash. 2000).

³ Indeed, some states have statutory prohibitions against insurance coverage for willful acts. *See* CAL. INS. CODE § 533 (West 2013) (“An insurer is not liable for a loss caused by the willful act of the insured; but he [the insurer] is not exonerated by the negligence of the insured, or of the insured’s agents or others.”).

the risk of a future event occurring, which would trigger payout to a policyholder, and (2) the risk that not every policyholder in the risk pool will require a payout at once.

The insurer's risk shouldering in exchange for a policyholder's premium breaks down as a commercially sensible arrangement if a policyholder attempts to have an insurer underwrite a risk that the policyholder knows he is certain to realize. In that case, there is no risk transfer at all. In exchange for a small fraction of the cost of the loss, the policyholder would be made whole because the insurer makes up the difference. No insurer could profit from that arrangement. To that end, insurance is based on the notion that insurable risks must be uncertain, or fortuitous, ones.

III. WHAT IS LIABILITY INSURANCE?

Most liability insurance policies marketed today provide a policyholder with coverage for a wide variety of loss-causing behavior. Standard liability insurance policies include homeowners' policies which protect the policyholder from liability for a broad spectrum of potential losses, commercial liability policies which provide protection against liability resulting from business operations, and automobile liability policies which protect drivers from legal liability for accidents that result from use of their vehicle. Liability insurance can be understood as a kind of "tort" insurance, or "behavior" insurance.⁴ If the policyholder does something (like a tort) that results in her being sued by another third party for losses she caused, liability insurance steps in to do two things. First, it provides for a legal defense for the policyholder. Second, if, as a result of the lawsuit, the policyholder is found legally liable to pay for the loss to a third party, the liability insurance policy provides funds to compensate that wronged third party, up to the financial limits of the policy. Liability insurance provides policyholders protection against paying for both property and personal injury damages to a third party. The focus in this Article is on personal injury cases where the policyholder has injured a third party victim. However, the same issues arise when policyholders become legally liable to pay for third party property damages. The compensatory gap issues are, however, markedly different (and arguably less compelling) in property loss instances. The injury is then not one of

⁴ Erik S. Knutsen, *Confusion About Causation in Insurance: Solutions for Catastrophic Losses*, 61 ALA. L. REV. 957, 963 (2010).

loss of life and limb, but of property. Society's web of accident compensation sources does not really attempt to address property losses in a holistic fashion.

A key notion for this Article is that, although the liability insurance policy is marketed and drafted by the insurer to protect the policyholder from legal liability to a third party, the financial payout from the liability insurance policy ultimately goes to the third party victim who suffered the loss at the hands of the policyholder. If John's negligence results in him injuring Mary and thus he is liable to pay for Mary's injury, John's liability insurer pays Mary compensation for her injury. This mechanism creates a tension as to the purpose of liability insurance itself. Is liability insurance to be merely a wealth protection mechanism for the insured policyholder, so that, in the event he is sued for some loss-causing behavior, he does not have to call upon his own assets (if any) to pay for the loss? Or is liability insurance instead to be the largest player in the broader societal web of accident compensation in that it often acts as the sole source of reparation for an injured victim?⁵ This tension becomes relevant when courts attempt to discern whether or not a policyholder has coverage under an insurance policy, because the effect of that decision is ultimately felt not only by the policyholder (and sometimes not at all, if the policyholder is impecunious), but by the wronged accident victim seeking redress. It is most stark when the victim suffers personal injuries and often has nowhere satisfactory to turn to for much-needed compensation.

The coverage provided by liability insurance policies is typically very broad.⁶ For example, the coverage clause in a liability insurance policy usually provides coverage for all damages or injury for which the policyholder becomes "legally obligated to pay." This breadth of coverage makes sense because there are a myriad of combinations of human behavior that could lead up to a policyholder's legal liability to pay for a third party's loss. To that end, because liability insurance provides such broad-spectrum coverage, insurers must rely on wording within the insurance policy to delineate what categories of behaviors or losses are not covered. Of course, insurers wish to exclude losses that result from non-

⁵ See generally Tom Baker, *Liability Insurance as Tort Regulation: Six Ways that Liability Insurance Shapes Tort Law in Action*, 12 CONN. INS. L.J. 1 (2005).

⁶ See, e.g., *Klepper v. ACE American Ins. Co.*, 999 N.E.2d 86, 91 (Ind. Ct. App. 2013) ("[We] will pay those sums that the insured becomes legally obligated to pay as damages because of bodily injury or property damage to which this insurance applies." (internal quotation marks omitted)).

fortuitous events because these events frustrate the fundamental nature of the insurance arrangement.⁷

IV. FORTUITY CLAUSES

Two categories of losses that are commonly excluded from standard liability insurance coverage are losses resulting from the intentional acts or from the criminal acts of the policyholder. These losses can be excluded using variously worded insurance clauses. These “fortuity clauses”⁸ are ultimately aimed at targeting behavior that undermines the risk-sharing relationship between insurer and policyholder. A fortuity clause delineates those certain categories of behavior that produce non-fortuitous, and thus uninsurable, losses. The fortuity clause most prevalent in liability insurance policies is an “intentional act” fortuity clause, which excludes from coverage those losses “either expected or intended from the standpoint of the insured.”⁹ Alternatively, the intentional act fortuity clause could be worded as to remove coverage for losses resulting from a policyholder’s intentional acts.¹⁰ Occasionally, the removal of coverage for intentional acts could be through reference to a definition contained in the liability policy’s coverage clause. Some liability policies provide coverage for legal liability resulting from an “occurrence,” which is then typically defined as an “accident.”¹¹ The policy then excludes intentionally caused

⁷ See, e.g., *Bailey v. Lincoln Gen. Ins. Co.*, 255 P.3d 1039, 1047 (Colo. 2011) (finding intentional act exclusions necessary for insurers in setting rates and providing coverage and that the purpose of insurance is violated should policyholder be allowed to intentionally control losses).

⁸ See generally Erik S. Knutsen, *Fortuity Clauses in Liability Insurance: Solving Coverage Dilemmas for Intentional and Criminal Conduct*, 37 *QUEEN’S L.J.* 73 (2011).

⁹ See, e.g., *Capano Mgmt. Co. v. Transcon. Ins. Co.*, 78 F. Supp. 2d 320, 323 (D. Del. 1999) (noting that the “expected or intended” element of the exclusion is at issue); see also *Hirst v. Thieneman*, 2004-0750, p. 12 (La. App. 4 Cir. 5/18/05); 905 So. 2d 343, 351 (noting that the “expected or intended” exclusion is commonly referred to as the “intentional act” exclusion).

¹⁰ See, e.g., *Thomas v. Benchmark Ins. Co.*, 140 P.3d 438, 442 (Kan. Ct. App. 2006) (holding that an automobile liability policy excludes “damage or injury ‘caused intentionally’”); see also *Montgomery Mut. Ins. Co. v. Dyer*, 170 F. Supp. 2d 618, 621 (W.D. Va. 2001) (holding coverage is excluded if insured acted “with the intent to cause a loss”).

¹¹ See, e.g., *State Farm Fire & Cas. Co. v. Doe*, 946 P.2d 1333, 1335 (Idaho 1997) (holding that a homeowner’s liability policy provided coverage for “personal

losses. In this fashion, insurers fold an exclusion into the definition of words used in a coverage clause: “occurrence” or “accident.”

The second common fortuity clause is a “criminal act” fortuity clause which removes coverage for losses resulting from a policyholder’s criminal act,¹² “violation of a penal statute or ordinance,” or some criminal conduct.¹³

At first blush, losses resulting from criminal and intentional acts of the policyholder may appear to be among the most fortuity-frustrating kinds of behavior that an insurer would want to avoid insuring. A death resulting from a premeditated murder or a burned factory resulting from a premeditated arson hardly appear to be fortuitous events. Surely the policyholder has control over whether the loss transpires or not. But what about losses arising when the policyholder is criminally negligent while causing a loss such that she attracts a criminal charge for substandard behavior, like negligently handling a firearm and an accidental discharge harms a third party?¹⁴ Are those losses really “criminal” and thus non-fortuitous and uninsurable? Or what about losses arising from a prank

injury” caused by an “occurrence” (which is then defined as an “accident”) but finding an exclusion if policyholder acted with “intent to cause personal injury”); *see also* *Voorhees v. Preferred Mut. Ins. Co.*, 607 A.2d 1255, 1262–63 (N.J. 1992) (finding that homeowners’ liability policy covered legal liability arising from an occurrence (which is defined as an “accident”) and finding that coverage excluded that of “insureds whose conduct is intentionally-wrongful”).

¹² *Cf.* *Wilshire Ins. Co. v. S.A.*, 227 P.3d 504, 506 (Ariz. Ct. App. 2010); *SECURA Supreme Ins. Co. v. M.S.M.*, 755 N.W.2d 320, 325 (Minn. Ct. App. 2008).

¹³ *See, e.g.*, *Wilderman v. Powers*, 956 A.2d 613, 616 (Conn. App. Ct. 2008) (finding no coverage when occurrence is the result of a “violation of a penal law or ordinance”); *State Farm Fire & Cas. Co. v. Condon*, 839 N.E.2d 464, 469 (Ohio Ct. App. 2005) (finding no coverage when occurrence is the result of a “willful violation of a penal statute.”); *Am. Family Mut. Ins. Co. v. Zavala*, 302 F. Supp. 2d 1108, 1124 (D. Ariz. 2003) (finding no coverage when an occurrence is the result of a “violation of any criminal law for which any insured is convicted[.]”).

¹⁴ *See, e.g.*, *Allstate Ins. Co. v. Berube*, 854 A.2d 53, 54–55 (Conn. App. Ct. 2004) (taking a loaded, sawed-off rifle to bed with his wife and two-month-old daughter and unintentionally shooting his wife); *Auto Club Group Ins. Co. v. Booth*, 797 N.W.2d 695, 696–97 (Mich. App. 2010) (injuring another teen where firearm accidentally discharged); *Eichmanis v. Wawanesa Mut. Ins. Co.* (2007), 278 D.L.R. 4th 15, para. 9 (Can. Ont. C.A.) (playing with a firearm when it accidentally discharges, teen injures another teen).

where a policyholder intends to scare a third party and that third party gets injured? Does the “intentional act” fortuity clause oust coverage when the policyholder subjectively acts with intent to cause a loss, or is an objective or some hybrid standard to be used? For example, if a college student’s friends pile toilet paper on the sleeping student and then light the paper on fire as a prank, but the student is injured, are those losses really “intentional” or “expected” and thus non-fortuitous and uninsurable?¹⁵

V. PROBLEMS: UNPREDICTABILITY AND COMPENSATION GAPS

The examples above highlight the two major problems with the ways the intentional and criminal act fortuity clauses are interpreted by courts, insurers, and policyholders attempting to solve insurance coverage disputes. The first problem is that past courts’ interpretations of the clauses have often led to unpredictable and inconsistent results. There are opposite case outcomes for similar cases featuring similarly worded fortuity clauses. For example, some courts have held that a policyholder’s act of self-defense which injures a third party is not covered behavior by a liability policy because the policyholder has intended to injure the victim.¹⁶ Other courts, however, have held that self-defense bars the application of an intentional acts fortuity clause.¹⁷ Some of these courts have also determined that coverage will be ousted for “unreasonable acts” of self-defense.¹⁸

¹⁵ See generally *Godonoaga v. Khatambakhsh* (2000), 188 D.L.R. 4th 706 (Can. Ont. C.A.) (concluding that fortuity clause did not exclude coverage for parents’ negligent actions in allowing children to commit intentional assault).

¹⁶ See, e.g., *L.A. Checker Cab Co-op., Inc. v. First Specialty Ins. Co.*, 112 Cal. Rptr. 3d 335, 337–38 (2010) (finding loss to be intentional, and thus excluded, where cab driver believed he had to defend himself and as such he shot passenger who provoked him).

¹⁷ See, e.g., *Vermont Mut. Ins. Co. v. Singleton*, 446 S.E.2d 417, 420–21 (S.C. 1994) (finding no intent to injure when policyholder defended himself in fist fight because he was only trying to protect himself); see also *Farmers & Mechanics Mut. Ins. Co. of W. Va. v. Cook*, 557 S.E.2d 801, 810 (W. Va. 2001) (finding loss resulting from self-defense “not expected or intended by the policyholder”).

¹⁸ See, e.g., *Auto Owners Ins. Co. v. Harrington*, 538 N.W.2d 106, 110 (Mich. Ct. App. 1995) (denying coverage where policyholder shot a man who acted in an aggressively frightening manner and who climbed the policyholder’s wall and finding policyholder did not act reasonably as the aggressor was unarmed and police were not called).

Unpredictability is harmful for the insurer, the policyholder, and the wronged accident victim. If no one can tell, up front, when a fortuity clause in a liability insurance policy will or will not oust coverage for a loss, litigation can become protracted and expensive as each party attempts to stress a different interpretation of the same clause. Insurers are thus often unable to predict both their financial exposure on an individual basis for these types of losses and additionally their exposure over a large risk pool. Policyholders are often unable to predict what types of behavior will remove coverage for a loss, thus making it difficult for them to adjust their actions so they remain covered for potential legal liability. Wronged accident victims are unable to predictably expect compensation because the question is too often driven by an insurance lawsuit about the policyholder's liability insurance coverage. This has resulted in increased litigation costs for all parties involved and has prompted inefficient litigation workarounds that attempt to circumvent the unpredictable application of these clauses.

The second problem with interpreting fortuity clauses is that many courts are ignoring the fact that the wronged accident victim's expected compensation hangs in the balance in virtually every decision about fortuity clauses and insurance coverage. When these clauses are triggered and payment is denied to a policyholder, and thus to an injured victim, the compensatory gap left is not routinely addressed anywhere else in the patchwork web of sources comprising the accident compensation system.¹⁹ Those accident costs do not disappear simply because a policyholder is denied coverage. They must be absorbed elsewhere, and often in very inefficient ways. Therefore, any denial of liability insurance coverage needs to be done in a principled and measured fashion, carefully weighed against its effect on the wronged accident victim who likely will have few avenues to turn to for financial assistance. To that end, it becomes important to develop a better way to deal with fortuity clauses which produces predictable and fair results for policyholders, insurers, and accident victims.

¹⁹ See Ellen S. Pryor, *Part of the Whole: Tort Law's Compensatory Failures Through a Wider Lens*, 27 REV. LITIG. 307, 317–18 (2008); see also Erik S. Knutsen, *Five Things Wrong with Personal Injury Litigation (And What to Do About It!)*, 40 ADVOCATES Q. 492, 495–96 (2013).

A. UNPREDICTABILITY

Unpredictability breeds litigation. Many litigants disputing fortuity clause interpretations – insurers and policyholders alike – are incentivized to remain in litigation up to the appeals stage because of the possibility that they will obtain an interpretive finding favorable to them. This costly unpredictability is exacerbated in the fortuity clause context in two ways: interpretive unpredictability and litigation distortion from costly workarounds.

1. Interpretive Unpredictability

a. *Intentional Act Fortuity Clause*

Courts attempting to apply the intentional act fortuity clause to make coverage determinations have devised three very different ways of interpreting this clause, each with differing coverage results. This has occurred despite a major rewording of the standard clause in most commercial general liability policies in an attempt to address this very problem. Once worded as an “intentional acts” exclusion, the CGL fortuity clause now ousts coverage for losses “expected or intended” from the standpoint of the policyholder.²⁰

Some courts interpreting the intentional act fortuity clause utilize an objective interpretive perspective. This perspective removes liability insurance coverage if a reasonable policyholder should have known that damage or injury would result from her conduct.²¹ This perspective is problematic because it ousts coverage for behavior that some policyholders clearly expect would not lead to damage or injury (or they probably would

²⁰ See, e.g., Stempel, *supra* note 2, at 73; see also *infra* p. 14.

²¹ See, e.g., *Blue Ridge Ins. Co. v. Puig*, 64 F. Supp. 2d 514, 518–19 (D. Md. 1999) (finding no coverage because, even if policyholder subjectively did not intend injury when he kicked in a washroom stall door to deliver a “wake-up call” to the occupant, it was “reasonably expected” that door would hit and injure occupant); *Scott v. Allstate Indem. Co.*, 417 F. Supp. 2d 929, 936 (N.D. Ohio 2006) (finding no coverage where policyholder held a match to a wet substance to see if it is flammable because it should be reasonably expected that fire would result); *Auto-Owners Ins. Co. v. Moore*, No. 266721, 2006 WL 891078, at *1, *2–*3 (Mich. Ct. App. Apr. 6, 2006) (finding no coverage when child lit a lighter near gasoline-soaked pants, even though intent was to light a fire near leg, because fire was natural, foreseeable, and anticipated consequence of actions).

not have behaved that way in the first place). A policyholder cannot adjust *ex ante* her behavior to avoid losing insurance coverage if she cannot reliably predict what behavior leads to coverage loss. In operation, the clause therefore removes coverage for some behavior that is risky and fortuitous but not subjectively intentional. Because liability insurance is supposed to provide coverage for fortuitous behavior, this is an incongruous result.²²

Some courts appear to apply a middle-ground hybrid interpretive perspective, where coverage is ousted when the policyholder intended some injury, but the resulting loss was greater than expected.²³ This perspective exhibits the same problem as the objective interpretive perspective but on a sliding scale. Once the policyholder's conduct is judged by objective reasonable standards, some fortuitous conduct will not be covered. Under the objective and hybrid perspectives, policyholder behavior will be over-deterred because coverage is dependent not on the policyholder's subjective and controllable intent, but on an objective, third party view of what conduct is reasonable. When that view differs from the policyholder's (which it does in nearly all of these cases, or a policyholder probably would not have behaved a certain way), a policyholder lacks predictable coverage information to assist in determining how to behave so as to remain within liability coverage protection. Furthermore, litigants in insurance coverage disputes will differ as to what types of conduct appear "reasonable" or not. This fuels the litigation.

Finally, some courts use a subjective interpretive perspective to hold that coverage is not ousted unless the policyholder actually expected or intended the loss.²⁴ This perspective offers the most predictable

²² ROBERT H. JERRY & DOUGLAS R. RICHMOND, UNDERSTANDING INSURANCE LAW 460 (4th ed. 2007).

²³ See, e.g., *Canterberry v. Chamblee*, 41, 940, p. 6 (La. App. 2d Cir. 2/27/07); 953 So. 2d 900, 904 (finding no coverage where boy intended to fight even though he did not intend to break victim's nose); *Hatmaker v. Liberty Mut. Fire Ins. Co.*, 308 F. Supp. 2d 1308, 1315 (M.D. Fla. 2004) (finding no coverage where policyholder threw victim to ground and punched him in head, even though policyholder did not intend to cause any injuries); *Harleysville Ins. Cos. v. Garitta*, 785 A.2d 913, 923 (N.J. 2001) (finding no coverage where the policyholder stabbed victim twice and pled guilty to third-degree murder even though policyholder had not intended to cause death).

²⁴ See, e.g., *Bituminous Cas. Corp. v. Kenway Contracting, Inc.*, 240 S.W.3d 633, 640 (Ky. 2007) (finding coverage where policyholder conducted a demolition and tore down entire residential structure instead of the intended carport because

approach to the intentional act fortuity clause because it is the only approach that removes coverage when a policyholder's behavior results in a non-fortuitous loss. A policyholder knows where she stands vis-à-vis coverage: if she intends the loss, coverage will not attach.

To complicate matters further, courts split further as to what must be intended by the policyholder: the intentional action alone²⁵ or both the intentional action and the resultant injury.²⁶ For example, even though a child may have intended to light a fire as a prank, if no damage was intended, liability for the resulting fire loss would be covered under the latter approach.²⁷ The problem with determining coverage based on the policyholder's actions is that most actions have some intentional component to them. These cases, therefore, tend to hyper-examine the conduct leading up to a loss to determine what intentional actions comprised the behavior. Proving intent is also fraught with difficulty because coverage often turns on circumstantial evidence or the credibility of the policyholder's testimony. This makes determining which of the

he did not subjectively intend damage to the entire residential structure); *Clayburn v. Nationwide Mut. Fire Ins. Co.*, 871 N.Y.S.2d 487, 488–89 (N.Y. App. Div. 2009) (finding that a policyholder who put victim in bear hug and fell through plate glass window was still covered because injuries were not subjectively intended); *Allstate Ins. Co. v. Sanders*, 495 F. Supp. 2d 1104, 1109 (D. Nev. 2007) (finding that intentional act fortuity clause did not bar coverage despite policyholder throwing a metal sign at someone during horseplay because policyholder did not subjectively intend to hit or injure victim).

²⁵ See, e.g., *Fontenot v. Duplechine*, 2004-424, pp. 6–7 (La. App. 3 Cir. 12/8/04); 891 So. 2d 41, 46–47 (finding no coverage when student struck classmate on the head with desktop, regardless of student's intent to injure); *Metro. Prop. & Cas. Ins. Co. v. Buckner*, 302 S.W.3d 288, 297 (Tenn. Ct. App. 2009) (finding no coverage where teens fired rifles at tractor-trailers on interstate, killing and injuring people, even though their intent was to damage trucks; their intent to discharge rifles was not enough to oust coverage).

²⁶ See, e.g., *State Farm Fire & Cas. Co. v. Weaver*, 585 F. Supp. 2d 722, 729 (D.S.C. 2008) (explaining that both the act that caused the loss and the results thereof must be intentional); *Lincoln Logan Mut. Ins. Co. v. Fornshell*, 722 N.E.2d 239, 242–43 (Ill. App. Ct. 1999) (explaining that both the act and the harm must be intended).

²⁷ See, e.g., *Vermont Mut. Ins. Co. v. Singleton*, 446 S.E.2d 417, 421 (S.C. 1994) (finding coverage where a teen, acting in self-defense, struck another teen but did not intend to cause extensive eye injuries); *Miller v. Fidelity-Phoenix Ins. Co.*, 231 S.E.2d 701, 75 (S.C. 1977) (coverage for ten-year-old boy who set fire to fire trucks was granted because he did not intend for the fire to burn down a home).

policyholder's actions trigger a fortuity clause a question with an answer that is somewhat of a moving target.

b. *Criminal Act Fortuity Clause*

Courts attempting to apply the criminal act fortuity clause to make coverage determinations have devised two different ways of interpreting this clause, with correspondingly different coverage results. Some courts have held that any policyholder's criminal act causally related to the loss ousts liability insurance coverage, regardless of the policyholder's intent to cause the loss.²⁸ Still others have held that a policyholder committing a crime at the time of the loss will lose liability coverage, regardless as to whether the crime itself is causally involved in bringing about the loss²⁹ or whether there was even a criminal charge or conviction.³⁰ Other courts have held that, in order to oust coverage, a policyholder must have intended the loss brought about by the criminal act.³¹ This subjective approach best matches the criminal act fortuity clause's purpose as a clause targeted at removing coverage for non-fortuitous behavior. Otherwise, the clause risks being used as an unpredictable morality clause, as described more fully below.

²⁸ See, e.g., *Progressive N. Ins. Co. v. McDonough*, 608 F.3d 388, 391–92 (8th Cir. 2010) (explaining that the criminal act fortuity clause does not require subjective intent to commit the crime); *SECURA Supreme Ins. Co. v. M.S.M.*, 755 N.W.2d 320, 325 (Minn. Ct. App. 2008) (explaining that no subjective intent is required to trigger criminal act fortuity clause where mentally ill boy stabbed his neighbor with a knife).

²⁹ See, e.g., *Progressive Cas. Ins. Co. v. K.S.*, 731 F. Supp. 2d 829, 836 (S.D. Ind. 2010) (denying coverage where a boy “moonied” an oncoming vehicle, distracting the driver and causing her to flip the car, as “moonieing” is considered a crime).

³⁰ See, e.g., *Allstate Ins. Co. v. Berube*, 854 A.2d 53, 56 (Conn. App. Ct. 2004) (explaining that a policyholder who got into bed with a rifle and accidentally shot his wife could theoretically be charged with a crime because he risked injury of shooting the child who was also in bed with him).

³¹ See, e.g., *Allstate Ins. Co. v. Raynor*, 21 P.3d 707, 712 (Wash. 2001) (explaining that the criminal act fortuity clause does not apply to all acts technically classified as crimes but only to serious criminal conduct done with malicious intent).

c. *Insurance Policy Interpretation Differences*

State-by-state and even court-by-court differences in the basic insurance policy doctrinal tools employed to interpret fortuity clauses result in additional inconsistency in interpreting even identically-worded fortuity clauses. As insurance policies are contracts of adhesion, special policyholder-friendly rules have developed over time to assist in fairly applying meaning to insurance policy language.³² Many states employ a varied panoply of interpretive tools to help discern the meaning of insurance policy language. Some states utilize the reasonable expectations doctrine to varying degrees.³³ That doctrine holds that the reasonable expectations of the policyholder have some interpretive value in discerning the meaning of insurance policy language. Other states are far stricter constructionists of insurance policy language, and reasonable expectations do not come into play in their analyses. Some states also more regularly employ the doctrine of *contra proferentem* to construe ambiguous wording against the insurer drafter.

In some instances, state statutes³⁴ or state public policy³⁵ hold that liability insurance policies do not cover losses arising from a policyholders'

³² For a discussion of how special policyholder-friendly rules have developed over time, see, e.g., Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation*, 95 MICH. L. REV. 531 (1996); Michelle E. Boardman, *Contra Proferentem: The Allure of Ambiguous Boilerplate*, 104 MICH. L. REV. 1105 (2006); James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context*, 24 ARIZ. ST. L.J. 995 (1992); Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961 (1970); Peter Nash Swisher, *Judicial Interpretations of Insurance Contract Disputes: Toward a Realistic Middle Ground Approach*, 57 OHIO ST. L.J. 543 (1996); Peter Nash Swisher, *Judicial Rationales in Insurance Law: Dusting Off the Formal for the Function*, 52 OHIO ST. L.J. 1037 (1991).

³³ See generally, e.g., Kenneth S. Abraham, *Judge-Made Law and Judge-Made Insurance: Honoring the Reasonable Expectations of the Insured*, 67 VA. L. REV. 1151 (1981); Jeffrey E. Thomas, *An Interdisciplinary Critique of the Reasonable Expectations Doctrine*, 5 CONN. INS. L. J. 295 (1998); Swisher, *Judicial Interpretations*, *supra* note 32; Swisher, *Judicial Rationales*, *supra* note 32.

³⁴ See, e.g., CAL. INS. CODE § 533 (West 2013) ("An insurer is not liable for a loss caused by the wilful act of the insured; but he is not exonerated by the negligence of the insured, or of the insured's agents or others").

³⁵ See, e.g., *Swan Consultants, Inc. v. Travelers Prop. Cas. Co.*, 360 F. Supp. 2d 582, 591 (S.D.N.Y. 2005) (finding that New York public policy prohibits

own willful acts, even if there is no express fortuity clause in the policy itself. When courts construe fortuity clauses, these additional principles can confusingly overlap with the insurance policy interpretation exercise.

These differences in interpretive approaches have a costly litigation spillover effect because litigants often cannot predict how their own courts would interpret a clause. Indeed, while some courts take a literalist view about the applicability of the intentional and criminal act fortuity clauses, others are far more contextual and hold that these clauses may mean different things depending on the context and policyholder behavior being examined.

2. Litigation Distortions

There are obvious consistency problems with courts using three interpretive perspectives and two substantive requirements to interpret the intentional act fortuity clause and, at the same time, using four interpretive perspectives to interpret the criminal act fortuity clause. These problems are compounded by the workarounds invented by litigation counsel intended to circumvent some of the challenges with these fortuity clauses. The litigation workarounds produce further costly and unpredictable litigation distortions.

First, the practice of over or under-pleading a policyholder's conduct to attract or repel coverage at the pleadings stage of an action

insurance indemnification for intentionally-caused injuries); *Capitol Indem. Corp. v. Evolution, Inc.*, 293 F. Supp. 2d 1067, 1075 (D.N.D. 2003) (explaining that all insurance policy provisions that allow coverage for intentionally caused injuries are void by public policy); *State Farm Mut. Auto. Ins. Co. v. Montagna*, 874 A.2d 406, 408–09 (Me. 2005) (explaining that policies will not be interpreted to require an insurer to defend or indemnify an insured for the insured's own criminal acts); *Farmland Mut. Ins. Co. v. Scruggs*, 886 So.2d 714, 720 (Miss. 2004); *Merrimack Mut. Fire Ins. Co. v. Coppola*, 690 A.2d 1059, 1065 (N.J. Super. Ct. App. Div. 1997) (explaining that the reasonable insurance contract between the parties excludes all intentional acts); *Gearing v. Nationwide Ins. Co.*, 665 N.E.2d 1115, 1120 (Ohio 1996); *Minn. Fire & Cas. Co. v. Greenfield*, 855 A.2d 854, 866 (Pa. 2004) (explaining that public policy supports providing coverage for acts that were not intentional); *American Family Mut. Ins. Grp. v. Kostaneski*, 688 N.W.2d 410, 415 (S.D. 2004) (explaining that South Dakota public policy precludes extending coverage to an individual who intentionally harms others.); *Decorative Ctr. of Houston v. Emp'rs Cas. Co.*, 833 S.W.2d 257, 260 (Tex. Ct. App. 1992) (explaining that an insured cannot insure against his own intentional misconduct).

actually twists the litigation story in inefficient ways.³⁶ Policyholders are incentivized to under-plead their case as one involving negligent, not intentional or criminal, conduct in order to ensure that there will be liability insurance coverage for the loss. At the same time, insurers are incentivized to over-plead that the policyholder's behavior is particularly intentional or criminal, and anti-social and dangerous, in an attempt to avoid covering a particular loss. In doing so, litigation counsel may strain and stretch the facts to a near-unsupportable point in order to craft the litigation story away from or towards intentional or criminal conduct. This leads to inefficiencies in the fact-finding discovery process as parties spend expensive time attempting to mold the nature of the policyholder's conduct not because they actually want the truth but because they want it to either be, or not be, a certain category of behavior important only for insurance coverage purposes.

Second, creative lawyers for injured accident victims have attempted to get around the operation of a fortuity clause by focusing instead on viable alternative litigation targets through doctrinal innovations such as vicarious liability or claims for negligent supervision.³⁷ If a policyholder's intentional or criminal behavior may trigger a fortuity clause and thereby leave an accident victim without compensation, the victim's lawyer could instead target another category of policyholder who may have some secondary responsibility for the victim's injury and who may be covered by liability insurance. A common example is the use of vicarious liability to access insurance coverage from another policyholder's liability policy. Often, these are institutional policyholders with supervisory responsibilities over the policyholder who more directly caused the victim harm. For example, a victim of a sexual assault would typically sue the perpetrator but, to seek liability insurance coverage, may also sue the perpetrator's employer in negligence for failing to supervise the

³⁶ Tom Baker, *Liability Insurance at the Tort-Crime Boundary*, in *FAULT LINES: TORT LAW AS CULTURAL PRACTICE* 66, 69 (David M. Engel & Michael McCann eds., 2009); Ellen S. Pryor, *The Stories We Tell: Intentional Harms and the Quest for Insurance Funding*, 75 *TEX. L. REV.* 1721, 1723 (1997); Rick Swedloff, *Uncompensated Torts*, 28 *GA. ST. U. L. REV.* 721, 742–44 (2012); Jennifer Wiggins, *Domestic Violence Torts*, 75 *S. CAL. L. REV.* 121, 123–29 (2001).

³⁷ Swedloff, *supra* note 36, at 742; Wiggins, *supra* note 36, at 164.

employee.³⁸ Also, parents and supervisory adults can be sued for negligently supervising children in their care when children injure others through intentional or criminal conduct. When third parties like supervisory or vicariously liable institutions or parents are injected into the litigation fray for coverage-seeking purposes only, this can often add unnecessary delay, complication, and expense to a lawsuit. However, accident victims are often forced to bring in these additional parties to ensure access to at least some compensation through liability insurance.

Third, fortuity clauses affect settlement dynamics in significant ways. In order to preserve insurance coverage, both policyholders and accident victims have greater incentives to settle a case rather than litigate. For example, an accident victim may be involved in litigation exhibiting multiple causes of action. Such a victim may be incentivized to avoid a judgment on the merits regarding any policyholder intentional or criminal conduct that might thereby trigger a fortuity clause and thus exclude liability insurance coverage. A policyholder is incentivized to settle to preserve personal assets (although the control of the litigation is often through the insurer's appointed counsel, the policyholder is obliged to cooperate in the litigation). The policyholder would want to neither admit nor deny liability regarding an intentional or criminal act in order to maintain coverage.

Finally, fortuity clause interpretation can fall into common doctrinal pitfalls about insurance causation, creating further unpredictability as courts and litigants take different interpretive positions about the same fortuity clauses. To trigger a fortuity clause, the policyholder's behavior should be causative of the loss. The "expected or intended" intentional act fortuity clause specifically assumes this in its wording. Other intentional act fortuity clauses oust coverage for loss or damage "resulting from," "arising out of," or "caused by" an intentional act of the policyholder. Criminal act fortuity clauses also use that similar linguistic construction where coverage is ousted if the loss or damage is "resulting from," "arising out of," or "caused by" a criminal act of the policyholder.

If the loss is caused by some other behavior but the policyholder's intentional or criminal actions occurs somewhere in the factual matrix, coverage should not be removed. Insurance causation issues in liability

³⁸ See, e.g., Jeffrey P. Klenk, *Emerging Coverage Issues in Employment Practices Liability Insurance: The Industry Perspective on Recent Developments*, 21 W. NEW ENG. L. REV. 323, 323–27 (1999).

insurance can get misleadingly confused with tort principles of causation.³⁹ This can prompt courts to produce inconsistent coverage decisions about fortuity clauses. The question should not be “the policyholder acted intentionally or criminally and the loss occurred.” The question should instead be “was the policyholder’s intentional or criminal action one that brought about the loss.” However, it is very tempting for courts and litigants to wade into concepts of causal fault and blameworthiness, particularly because the conduct being considered is intentional or criminal and courts are used to sorting those questions using fault-based and crime-based language. Insurer litigants may be incentivized to bend insurance causation principles with criminal and fault-based causation concepts to get a coverage denial. This merely detracts from the very specific insurance policy interpretation issue about whether the fortuity clause applies or not, given the role of certain behavior in bringing about a certain loss.

Differing interpretive approaches and litigation distortions are the two major sources of unpredictability leading to the problematic nature of these fortuity clauses. While the interpretive unpredictability is inherent in the design and wording of the clause itself and the applicable legal rules around interpreting policy language, the litigation distortions have expanded in nature over time. Greater certainty in dealing with fortuity clauses would go a long way to saving money for insurers setting insurance premiums and funding coverage litigation. It would also save policyholders money as there would be less coverage litigation about the ambiguous nature of fortuity clauses. The by-product of this is that accident victims’ compensatory needs hang in the balance. They may have to wait until the coverage questions are sorted out. They may also, often unpredictably, lose out on compensation one might expect would be a sensible commercial result if a particular loss triggers a particular liability insurance policy.

B. THE COMPENSATORY GAP

Victims of intentional act torts and crimes, or “fortuity victims,” are often seriously injured and have dire compensatory needs.⁴⁰ These are the victims of assaults, attempted murders, and sexual assaults. The compensatory gap left by the varying and unpredictable approaches to

³⁹ Knutsen, *supra* note 4, at 968–70.

⁴⁰ Swedloff, *supra* note 36, at 739, 741–44 (detailing the compelling need for compensation for this particular subset of accident victims).

fortuity clauses expands and contracts because of the unpredictability involved in interpreting the clauses. Streamline the interpretive process and one could better control which types of victims would be facing a compensatory gap, all with an eye to designing a system to sensibly address such gaps.⁴¹ As a result, much fortuity clause insurance coverage litigation would also drop away. Many fortuity victims find themselves in that compensation gap because they were unlucky enough to be injured by a policyholder whose coverage was later denied by an insurer or court interpreting a fortuity clause in one way or another. The problem is that other victims in similar circumstances may not meet the same fate, depending on a given insurer or court's approach to interpreting the fortuity clause at issue. This is a very costly and profound problem because it is difficult to recognize and define solutions for a constantly fluctuating group of people with real compensatory needs in society. It is also difficult for insurers trying to set risk-based premiums for risk pools when the potential payout mutates. It is difficult for policyholders trying to evaluate liability insurance coverage purchases. A good start to addressing these problems caused by this mutating compensatory gap is to ensure that fortuity clauses are interpreted in predictable fashions so that one can discern who is in the gap and how big it really is.

If liability insurance proceeds are denied fortuity victims as a result of the operation of a fortuity clause, where do those injury costs go? There are few other avenues of recourse left. The policyholder is likely unable to provide compensatory assistance in a personal fashion.⁴² Very few people carry first party disability insurance.⁴³ Most may carry health insurance for the out-of-pocket expenses from physical injuries. There may be recourse for the fortuity victim through government-run victims' compensation funds, but these are often limited in nature.⁴⁴ Most fortuity victims,

⁴¹ Swedloff, *supra* note 36, at 724–27 (generating solutions for serious gaps in intentional tort victims' ability to recover damages in the face of fortuity clauses); Wriggins, *supra* note 36, at 152–57 (exploring solutions for victims of domestic violence torts who are presently not compensated because of the operation of fortuity clauses in their attackers' liability insurance policies).

⁴² Stephen Giles, *The Judgment-Proof Society*, 63 WASH. & LEE L. REV. 603, 606 (2006) (detailing how most tortfeasors in lawsuits would be unable to satisfy a tort judgment from their personal assets).

⁴³ See, e.g., Jerry & Richmond, *supra* note 22, at 482–83.

⁴⁴ Swedloff, *supra* note 36, at 726 (noting the limited nature of government-run criminal injuries compensation schemes).

however, are left to “lump it.”⁴⁵ That means that the social cost of absorbing their injury-related expenses is off-loaded from the at-fault tortfeasor to employer workplace accommodations and to primarily state-funded programs for the needy: Medicare, Medicaid, welfare, and other state disability programs.⁴⁶ The fact remains that the current web of modern accident compensation relies heavily on privately available liability insurance. There are just not sufficient mechanisms to provide effective compensation for fortuity victims who unpredictably fall through the cracks solely because they cannot access a policyholder’s liability insurance due to some conduct on the part of the policyholder, which itself is fortuitous when viewed from some interpretive perspectives. So, having a smaller and more predictably identifiable group of uncompensated fortuity victims would take the burden off of the other, inadequate socialized compensation mechanisms. This would shift some of the burden to insurers who may have taken a premium for underwriting a risk that will never materialize simply because of a fluxious interpretation of a fortuity clause in the wake of actual fortuitous behavior on the part of the policyholder. What it would leave would be those whose losses are the result of truly non-fortuitous circumstances, which best suits the true purpose of liability insurance in the first place.

VI. THE CAUSE OF THE PROBLEMS

The reason that there are palpable and systemic inconsistencies with how these fortuity clauses are applied in a liability insurance context stems from two linked, dynamic notions: the tensions between the two purposes of liability insurance (wealth protection and victim compensation) coupled with a move from explanatory rhetoric about fortuity to explanatory rhetoric about morality.

⁴⁵ See, e.g., Richard E. Miller & Austin Sarat, *Grievances, Claims and Disputes: Assessing the Adversary Culture*, 15 LAW & SOC’Y REV. 525, 547 (1981) (describing the strategy of not pursuing a claim and writing it off to “experience”).

⁴⁶ Pryor, *supra* note 19, at 309–10 (demonstrating how the cost of tort law’s occasional failure to compensate accident victims is borne elsewhere in society, in an inefficient manner).

A. THE TENSION BETWEEN WEALTH PROTECTION AND ACCIDENT
COMPENSATION

The tension between two perceived purposes for liability insurance is at the root of the uncertainty in interpreting fortuity clauses. Solving this tension – or at least recognizing it and balancing it appropriately in context – would go a long way toward streamlining the interpretive process, keeping litigation costs down, and reducing the mutating compensation gap.

Liability insurance is different than other types of insurance in that it is third party insurance. That difference is at the heart of the tension between the two purposes for this kind of insurance. Unlike property, life, and long-term disability insurance (all of which are first party insurance products), the proceeds of any triggered liability insurance go to pay some injured third party for a loss resulting from the policyholder's behavior. Private market liability insurance comprises the largest and most prevalent compensatory source for injured accident victims.⁴⁷ Liability insurance is the backbone of the tort system. Tort suits would not be brought if not for available liability insurance.⁴⁸ Society has organized itself around there being a private insurance safety blanket for much of today's risky conduct, from driving to owning a business or a home.⁴⁹ So liability insurance serves an important and expected societal accident compensation goal.

However, these are not the reasons why liability insurance is designed and marketed by insurers, or purchased by policyholders. Liability insurance is bought and sold as a risk transfer product to protect the assets of a policyholder in the event that policyholder becomes legally liable to pay for another's loss. This wealth protection purpose is very different from the broader compensatory purpose that liability insurance serves in society. Insurance as wealth protection focuses on the concerns of the policyholder who purchased the insurance product. Insurance as

⁴⁷ See Baker, *supra* note 5, at 4–6 (arguing that liability insurance has become “a de facto element of tort liability”).

⁴⁸ *Id.* at 4; Tom Baker, *Blood Money, New Money, and the Moral Economy of Tort Law in Action*, 35 LAW & SOC'Y REV. 275, 275 (2001) (detailing how tort suits are typically not brought unless there are valid, collectible insurance proceeds available); Adam F. Scales, *Following Form: Corporate Succession and Liability Insurance*, 60 DEPAUL L. REV. 573, 614 (2011) (noting that tort and insurance exist in “complementarity”).

⁴⁹ Wriggins, *supra* note 36, at 150 (noting the prevalence of insurance in society).

accident compensation focuses on the concerns of the injured accident victim in society (or, more broadly, on the concerns of society for compensating accident victims). One can be fairly certain that most policyholders do not purchase liability insurance out of altruistic concern for the well-being of some future accident victim who is a complete stranger. At most, that effect is a secondary offshoot of the insurance purchase. Yet, of course, most policyholders would wish and expect that anyone or any entity who injures them would carry sufficient liability insurance so that appropriate compensation would be forthcoming to that policyholder victim. The accident compensation purpose of liability insurance thus raises an interesting collective action concern. The accident compensation purpose is the reason why injured accident victims hope others have purchased liability insurance yet the wealth protection purpose is the reason why the policyholder actually purchases the insurance. The focus changes from victim to policyholder as one examines these two purposes of liability insurance.

Liability insurance is therefore a very strange market product: it is something we think we buy to help us protect our wealth but it additionally helps someone else as well. This is all the more strange when one adds the fact that most policyholders would not be able to pay for a tort judgment out of their own personal assets in any event.⁵⁰ The result of a tort suit against most uninsured people would be either no tort suit at all or bankruptcy. So there is, quite literally, often little to no wealth to protect. Yet, at the same time, those with modest assets to protect may actually value the wealth protection aspect of insurance even more than a wealthy policyholder, simply because the loss of their modest assets would mean financial destitution. Policyholders' subjective value of the wealth protection aspect of insurance therefore is mediated by the value placed on that policyholder's wealth.

However, this tension between the two purposes of liability insurance informs much of the interpretive process when courts are faced with having to interpret fortuity clauses. In that context, can these two purposes of liability insurance co-exist, or are they mutually exclusive? As will be shown, both purposes need to be balanced against each other, but in the liability insurance context, the actual effect of the wealth protection purpose on those with modest assets to protect can be less significant in most instances whereas the effect of the accident compensation purpose on a severely injured victim is certainly tangible, but is left to hang in the

⁵⁰ See, e.g., Giles, *supra* note 42, at 606; Baker, *supra* note 5, at 7.

balance. Surprisingly, this is often forgotten in the shift from fortuity to morality clause as will next be described. The wealth protection purpose controls the rhetoric at the expense of the accident victim's – and ultimately society's – compensatory needs.

B. FROM FORTUITY CLAUSE TO MORALITY CLAUSE

Having dynamic tension between the two purposes of liability insurance creates opportunities for using different explanatory rhetoric about what fortuity clauses are supposed to be doing. This creates much of the unprincipled inefficiencies and unfairness as noted above in the previous Part. Quite simply, courts can get mired in misleading rhetoric. Litigants in an insurance dispute (especially insurers) are incentivized to use this competing rhetoric to their advantage. The rhetoric goes something like this: do fortuity clauses ensure that insurers only indemnify for fortuitous losses? Or instead do fortuity clauses provide a mechanism for punishment and deterrence by ensuring that wrongdoing policyholders are deprived of the wealth protection benefit of liability insurance? The answer depends on how one views what liability insurance is supposed to be doing: protecting a policyholder's wealth or acting as a source of compensation for an injured accident victim.

1. The Move from Morality to Fortuity

To explain how a fortuity clause can be rhetorically mutated into a “morality” clause,⁵¹ one needs to understand the origins of the choice of language for fortuity clauses in liability insurance. Historically, insurance has had a societal challenge: it has had to separate itself from gambling, once seen as an immoral act.⁵² It is not difficult to understand, even with today's sensibilities, that profiting by guessing on whether or not some terrible disaster will befall a policyholder can be an activity tinged with moral undertones. One only has to think about life insurance, a product that essentially hedges a bet on when the policyholder will die, to see the moral implications and concerns – all the more so if a policyholder or some wrongdoer attempts to tip the scales of chance by controlling the risk of an outcome actually occurring.

⁵¹ Knutsen, *supra* note 8, at 103–11 (fortuity clauses shift to morality clauses).

⁵² Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237, 244–49 (1996) (describing the genesis of the insurance concept of moral hazard).

The term “moral hazard” as understood today in insurance law is used to describe the situation whereby the presence of insurance reduces incentives to minimize losses because the losses will be insured.⁵³ But originally, in the nineteenth century, “moral hazard” was about a financial concern to insurers that was simultaneously a full-fledged moral concern to a society not used to the concept of insurance. The “moral” hazard was about altering the odds of the insurance arrangement so as to make a chance loss a certain loss.⁵⁴ Purchasing fire property insurance and then burning down one’s own house to get the insurance proceeds is the classic example.

At the time, the insurance market consisted largely of maritime, fire and property insurance, not liability insurance.⁵⁵ Insurance was bought and sold purely as a wealth protection product. There was no need to consider victim compensation because there was no market for liability insurance. There did not yet exist the societal web of compensatory structures designed to address accident victims’ needs. Insurance was not expected to provide injury compensation.

Specific to concerns about insurance and morality was the longstanding legal notion that a criminal should not be able to profit from his crime.⁵⁶ This “public policy” rule holds, for example, that a murderer should not be able to obtain the proceeds of life insurance from the policyholder he murdered if he was also the beneficiary of the policy. Behavior such as willful arson to one’s own home to cash in on insurance proceeds would be deemed “immoral” by society, illegal by the courts, as well as unprofitable to insurers. Policyholders tinkering with those odds were a particularly “moral” hazard for (mostly fire) insurers of the nineteenth century because those insurers were struggling with a public relations image problem set squarely in morality concerns. By removing the “moral” hazards from insurance, insurers could create a more profitable enterprise and, at the same time, a more socially palatable form of institutional risk transfer.

⁵³ *Id.* at 242.

⁵⁴ KENNETH S. ABRAHAM, *THE LIABILITY CENTURY: INSURANCE AND TORT LAW FROM THE PROGRESSIVE ERA TO 9/11* (2008) (detailing the rise of liability insurance in the marketplace and its role in society).

⁵⁵ Baker, *supra* note 52, at 240.

⁵⁶ See generally, e.g., Mary Coate McNeely, *Illegality as a Factor in Liability Insurance*, 41 COLUM. L. REV. 26 (1941) (explaining how illegality is a mediating concept in early insurance law).

To an insurer concerned about insuring only risky, not certain, losses, it was important to remove coverage for losses intentionally and thus certainly brought about by a policyholder's conduct. This, in turn, would solve not only the very practical commercial efficacy concerns of the insurer, but also the concerns about insurance violating the public policy rule and the concerns about insurance incentivizing loss-causing behavior. In law, there are two categories of behavior that involve policyholders' intentional conduct: intentional torts and criminal behavior. To remove the incentive for policyholders to bring about certain losses, any insurance policy would therefore have to target that kind of intentional or criminal behavior, which would either violate the public policy rule or result in policyholders obtaining coverage for losses they intentionally caused. The intentional act fortuity clause was written to remove insurance coverage for intentional torts. A criminal acts fortuity clause would ensure that certain losses arising from criminal conduct would also be removed from coverage.

Excluding from insurance coverage losses arising from a policyholder's criminal conduct had a three-fold effect. First, criminal law by nature typically assumes an element of intent or *mens rea*: one has to intend to do the crime in order to be convicted.⁵⁷ At the time of the clause's genesis, the criminal law was far less complex and nuanced than it is today, with fewer regulatory offences or fluctuating states of intent that could be considered criminal. This original batch of largely specific intent-based crimes served up a ready-made category of intentional conduct which is precisely the type of conduct targeted by the very moral hazard concerns of insurers of the day. Second, the clause contractually enshrined the public policy rule that criminals could not profit from their crimes through insurance proceeds. Finally, removing from coverage losses brought about by criminal behavior served the additional purpose of again separating the insurance business from the moral concerns about policyholders seeking to profit from their crimes. The criminal act fortuity clause appeared to target wrongful behavior that people naturally do not like. If crime made up a category of behavior which society did not condone, and if crime happened to be the same type of behavior that was also non-fortuitous and thus uninsurable, this appeared to be the perfect exclusion. The clause thus deters criminals and those intent on causing harm from using insurance to reap ill-gotten gains. It also punishes those same bad actors because their

⁵⁷ For those crimes that have a specific intent element like murder, assault, and arson.

insurance coverage – the very benefit for which they paid – is removed based on their conduct. To the insurance-shy audience of the time, this second message undoubtedly played better than the first. They could rest assured that insurance was not incentivizing crime.

The intentional act and criminal act fortuity clauses then found their way into a burgeoning liability insurance market many years later. The early years of the liability insurance market existed without the societal expectation that liability insurance would be the backbone of the accident compensation system.⁵⁸ People whose injuries were not compensated by liability insurance proceeds were largely expected to “lump it.” Liability insurance was marketed and constructed much as property insurance: as a wealth protection mechanism for a policyholder concerned about having to pay for potential legal liability (and, as a byproduct, was a source of compensation for the accident victim). Because liability insurance provides coverage for a policyholder’s legal liability, it stands to reason that, if the legal liability was brought about by a loss a policyholder intentionally caused, the policyholder’s conduct resulting in the intentional loss is a moral hazard and should be excluded from coverage. The intentional act fortuity clause therefore performs that same moral hazard gatekeeping function it would in a property policy. The same could be said for the effect of the criminal act fortuity clause in liability insurance policies except it additionally maintained the function of underscoring that criminals could not enjoy wealth protection from legal liability arising from crimes they committed. The crimes targeted were those specific intent crimes of the day like murder and arson. Criminal law was, as has been mentioned, far simpler than the laundry list of crimes comprising most penal codes today.

Another way to separate the insurance business from the moral undertones of gambling on the happenstance (or not) of another’s disaster, and the fear that some would consciously influence events in order to bring about an insured loss, was to shift the language of discourse about insurance from morality to fortuity. Concepts of risk can then be discussed in essentially amoral terms. At some point in time, the insurance industry shifted its public identity from being a business concerned about separating itself from immoral gambling to being a business offering wealth protection through risk exchange.⁵⁹ Perhaps this occurred over time as insurance proliferated and people became used to seeing insurance operate

⁵⁸ ABRAHAM, *supra* note 54.

⁵⁹ Baker, *supra* note 52, at 258–59.

without many nefarious moral hazard concerns being realized. Perhaps instead it was a concerted industry effort to further separate insurance from morality and thus sanitize the business of insurance as it entered into regular commerce. Regardless, insurance became less about moral public image and more about risk and fortuity. Liability insurance proliferated and became the backbone of the accident compensation system. The criminal law became far more complex beyond mere specific intent crimes. The concept of moral hazard shed its “moral” roots and became aimed instead at an insurer’s concern for incentivizing overly risky behavior due to the presence of available insurance. Yet, the intentional act and criminal act fortuity clauses originally aimed at not only insurer profitability and fortuity concerns, but morality concerns as well, remained in liability insurance policies. The attempt to get morality out of insurance was largely successful, except for the potential throwback effect of these fortuity clauses.

However, a partially successful fortuity story could be told using these clauses, giving them the appearance that they still operated as intended in the new world of fortuity. It is true that intentionally caused losses are borne of the very fortuity-frustrating behavior that wreaks havoc with the insurance arrangement. But unless what is excluded from coverage is actually only behavior that turns a fortuitous event into a certain event, the fortuity clause is doing something else. Herein lies the problem, and the source of the inconsistency in the court decisions construing fortuity clauses in insurance coverage disputes. The only behavior in a liability insurance context that takes a fortuitous event and makes it a certain event is that behavior in which the policyholder engages with the specific and subjective intent to bring about the realized loss. If the policyholder did not intend the specific type of loss, the loss is still fortuitous to the policyholder. Therefore, removing liability insurance coverage for behavior that results in an unintended loss does not influence the policyholder’s behavior and is done at the expense of the accident victim awaiting compensation. The moral hazard problem, in fortuity terms, is not affected.

2. The Move from Fortuity Back to Morality

However, the moral trappings of the intentional act and criminal act fortuity clauses remain. In fact, liability insurers are incentivized to hearken back to the moral bases of these clauses because they are

compelling (if misleading) platforms for arguing for policyholders' coverage denial.⁶⁰ In this regard, the fortuity clauses can frequently transform into morality clauses in an insurance coverage dispute.⁶¹ The conversation shifts from one about fortuity and risk transfer concepts to one about morality involving how denying insurance coverage produces desirable social effects of punishment and deterrence. At the same time, and via the same dynamic, the notion of liability insurance as accident victim compensation source is eclipsed by a return to an exclusive notion of liability insurance as wealth protection for the policyholder. These two planes of discourse converge to warp judicial analysis about insurance coverage and produce inconsistent and troubling results because no purposes of insurance are actually fulfilled in the end result: not victim compensation or wealth protection nor fortuity or punishment concerns. The rhetoric just does not work.

For example, a policyholder is showing to his friend a firearm he believes is unloaded. The policyholder slips and the gun accidentally discharges and injures the friend.⁶² The policyholder did not intend to harm the victim but nonetheless is charged with criminal negligence causing bodily harm. The criminal act fortuity clause ousts coverage for legal liability for a loss resulting from a "criminal act" of the policyholder. On its face, this has been categorized as a criminal event – the policyholder was charged with a crime. However, he did not intend to commit the crime. He did not intend to harm the friend. The main element of criminal negligence is the negligence standard – the marked departure from reasonable conduct in society. There is no specific intent required to prove this crime. It is a "negligence-based" crime targeting risky conduct.

How, then, does an insurer argue that the legal liability resulting from this loss is excluded by the criminal act fortuity clause? More

⁶⁰ See, e.g., JAY FEINMAN, *DELAY, DENY, DEFEND: WHY INSURANCE COMPANIES DON'T PAY CLAIMS AND WHAT YOU CAN DO ABOUT IT* (2010) (canvassing the variety of tactics insurers are incentivized to undertake in denying claims); Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1410–11 (1993) (exploring the way in which insurers weave the narrative in claims denials); Baker, *supra* note 36 (describing how moral considerations affect interpretation of the criminal act fortuity clause);

⁶¹ Knutsen, *supra* note 8, at 103.

⁶² Similar to what occurred in the Ontario case of *Eichmanis v. Wawanesa Mutual Insurance Co.* (2007), 278 D.L.R. 4th 15 (Can. Ont. C.A.), except that the case involved thirteen- and fifteen-year-old boys.

specifically, based on the wording of that clause, how can an insurer articulate the reasoning behind why a policyholder's loss should not be covered? This is an important point, because the result may be a denial of vital compensation to the injured friend. An insurer could of course argue that the policyholder committed a criminal act and this policy ousts coverage for criminal acts, so there is no coverage, regardless as to the nature of the crime. That is a literalist argument and it meets some success in some courts.⁶³ However, again, the result is dire: the injured victim is left with nothing and the wealth protection aspect of insurance is not realized for the policyholder. Many courts (though not all), operating in a pro-coverage insurance law environment, are compelled to look further to satisfy themselves that this is indeed the result intended by this clause and this insurance policy.⁶⁴

A fortuity-based argument falls short. The loss was fortuitous to the policyholder. The policyholder did not intend for the firearm to discharge. He did not intend the specific harm to his friend. Indeed, he did not intend any harm to occur at all. He thought the gun was unloaded. So it is not possible to argue that the criminal act fortuity clause here is designed to circumvent fortuity-frustrating behavior by removing from coverage those losses that are certain. The loss was fortuitous. The policyholder could not have adjusted his gun-showing behavior to have *ex ante* avoided it. Furthermore, liability insurance is broad-spectrum tort or behavior insurance, and perhaps this is just the sort of fortuitous behavior

⁶³ See, e.g., *Wilderman v. Powers*, 956 A.2d 613 (Conn. App. Ct. 2008) (denying coverage for liability for neighbor's alleged psychological injuries when insured peeping tom photographed naked neighbor and was sued because his conduct was criminal in nature); *Auto Club Grp. Ins. Co. v. Booth*, 797 N.W.2d 695 (Mich. Ct. App. 2010) (denying coverage for accidental shooting when drunk held gun against tenant's wrist, even though he did not intend the gun to discharge); *SECURA Supreme Ins. Co. v. M.S.M.*, 755 N.W.2d 320 (Minn. Ct. App. 2008) (holding that youth's attack of neighbor was a "criminal act," regardless of intent of youth to harm neighbor); *Gruninger v. Nationwide Mut. Ins. Co.*, 905 N.Y.S. 2d 391 (N.Y. App. Div. 2010) (denying coverage when insured accidentally shot other hunter); *Progressive N. Ins. Co. v. McDonough*, 608 F.3d 388 (8th Cir. 2010) (interpreting plain language of criminal act exclusion as having no intent requirement so insured's intent irrelevant at time of accident).

⁶⁴ See, e.g., *Allstate Ins. Co. v. Zuk*, 574 N.E.2d 1035 (N.Y. 1991) (discussing whether accidental shooting while cleaning gun was an accident that could "reasonably be expected to result" from a "criminal act," despite insured's guilty plea to crime of recklessly causing death).

the policy is expected to cover. So, under fortuity reasoning, this is the type of loss that liability insurance should cover – behavior courting some risk of loss.

An insurer who then cannot make a compelling argument on fortuity grounds for ousting coverage via the criminal act fortuity clause often is then incentivized to return to the original moral basis for the clause. In doing so, insurers move from contract law principles to tort to criminal law, all in the context of an insurance policy interpretation issue that is typically and rightfully dealt with on contract-based insurance law principles alone. Shifting legal spheres allows the insurer greater leeway to argue for the applicability of the fortuity clause while all the time moving up the moral ladder in persuasiveness. Additionally, insurers shift the focus of discussion from the injured accident victim to the wrongdoer policyholder to those also in the insurance risk pool to society as a whole.

Coverage should be denied the policyholder here, the moral argument goes, because we want to hold the wrongdoer accountable for his actions. By denying the policyholder the wealth protection aspect of the insurance, the policyholder will have to pay for the loss himself, unaided by insurance. This is a return to classic corrective justice reasoning from tort law involving redress between wrongdoer and victim,⁶⁵ except the victim here appears to be the insurer and not the accident victim. As has been mentioned, there is little possibility that the policyholder ever benefits in today's standard tort litigation settings because most do not have sufficient personal wealth to satisfy a tort judgment against them.⁶⁶ Furthermore, an insurer is also incentivized to argue that policyholders who behave in socially unacceptable ways are not deserving of liability insurance protection because this type of socially unacceptable conduct is not the sort that well-intentioned, premium-paying policyholders would want to support through payment out of their own risk pooled insurance funds.⁶⁷ This shifts the focus again from the policyholder to the perceived desires of other allegedly upstanding policyholders in the risk pool. Other policyholders would not want to subsidize a loss brought about by a

⁶⁵ See, e.g., John C. P. Goldberg & Benjamin C. Zipursky, *Torts as Wrongs*, 88 TEX. L. REV. 917, 926 (2010); Ernest Weinrib, *The Special Morality of Tort Law*, 34 MCGILL L.J. 403, 410–13 (1989); see generally, e.g., JULES L. COLEMAN, *RISKS AND WRONGS* (1992); ERNEST J. WEINRIB, *THE IDEA OF PRIVATE LAW* (1995).

⁶⁶ Giles, *supra* note 42, at 606; Baker, *supra* note 48, at 291–92.

⁶⁷ Baker, *supra* note 36, at 75; Knutsen, *supra* note 8, at 105.

careless, gun-toting person who had the poor judgment to point the firearm at his friend. The shift is a decidedly moral one, designed to appeal to a collective sense of moral conduct judgment on the part of a group not present in the lawsuit – other policyholders. The sense is that reasonable policyholders would not behave like that, and therefore would not want their hard-earned premium dollars to go towards indemnifying for conduct they would deem unfit to insure. Finally, insurers are incentivized to argue that coverage should be denied in these instances because we want to deter this kind of behavior from happening again.⁶⁸ People should not point guns at other people. The wrongdoer policyholder needs to be punished in order to achieve this deterrence goal, so the benefit of liability insurance should be denied to him. These wrongdoer policyholders are, as Baker dubs them, the “moral monsters.”⁶⁹ This shifts the argument to criminal law principles of punishment and deterrence. The target of the argument is now not the accident victim, the policyholder or other policyholders but instead society as a whole. The policyholder needs punishment so that this kind of bad act does not happen again. The removal of wealth protection via insurance will accomplish that important societal goal. But can it really?

3. Problems with the Moves

There are many structural problems with this shift from fortuity clause to morality clause. First, it produces incoherent and inconsistent judicial decisions because some courts rely on fortuity-based arguments to determine insurance coverage, while others are swayed by the moral arguments, and still others a little of both. The reasoning patterns are different. The underlying assumptions for the reasoning are different. But the cause of much inconsistency is this very vacillation from fortuity to morality, from policyholder to insurer to society, and from the purpose of victim compensation to the purpose of wealth protection. There are just too many exclusive structural axes to shift and combine in the analysis when the whole exercise is supposed to be about determining the presence or absence of liability insurance coverage based on principles of insurance policy interpretation.

Second, the argument takes the moral origins of the fortuity clause and reverses them to apparently indicate that insurance can now do something that it actually is not designed to do at all. At one time, the

⁶⁸ Baker, *supra* note 36, at 77 (calling this the “moral monster” argument).

⁶⁹ *Id.*

insurance industry strove to separate its business from anything to do with morality. That was the industry's reason to shift to the discourse about fortuity and risk. That was the reason why the fortuity clauses were inserted into the early policies. Yet here, in the present, the insurance industry is incentivized to again return to morality but this time in a completely different way: insurer as morality crusader. Instead of resiling from the idea that insurance is a potential mechanism for immorality to occur, the denial of insurance (now apparently a social good) is presented as a mechanism to provide socially desirable, moral benefits, like deterrence and punishment of criminals or bad actors.

Insurance as presently constituted cannot achieve punishment and deterrence goals for a variety of reasons. Most policyholders are unable to personally satisfy a tort judgment from their finances, so the ability to mete out punishment by denying liability insurance coverage would frequently be impossible.⁷⁰ Even with a financially capable policyholder, the threat of losing liability insurance protection pales in comparison to the threats possible under civil or criminal law for the same conduct.⁷¹ For example, few criminals would say they were deterred from the crime due to fears of losing liability insurance coverage. If fears of going to jail or of harming others do not deter the conduct, how can liability coverage concerns do the same? Finally, few would condone insurers acting as quasi-public intermediaries for states in doling out some kind of social punishment.⁷²

⁷⁰ Giles, *supra* note 42, at 606.

⁷¹ Malcolm Clarke, *Insurance: The Proximate Cause in English Law*, 40 CAMBRIDGE L.J. 284, 302 (1981) (denying insurance coverage is an insignificant behavioral deterrent); Knutsen, *supra* note 8, at 109–10.

⁷² See TOM BAKER & KYLE D. LOGUE, INSURANCE LAW AND POLICY: CASES, MATERIALS, AND PROBLEMS 505 (2003), in reference to a pre-publication form of Jonathan Simon's book, GOVERNING THROUGH CRIME: HOW THE WAR ON CRIME TRANSFORMED AMERICAN DEMOCRACY AND CREATED A CULTURE OF FEAR (2007). Baker and Logue note that there is an increasing gap between insured and uninsured conduct, which is the direct result of crime being defined as more than just intentional conduct. Not offering coverage for losses from criminal conduct sort of "deputizes" insurers "to serve as private law enforcement agencies empowered to mete out the 'punishment' of refusing insurance benefits without having to comply with the procedural requirements and protections that govern public law enforcement." See *id.* at 198–200 (noting that "one-strike insurance exclusions," like the criminal act fortuity clause, hit the middle class hardest as they rely on homeowners and commercial liability policies for a compensatory source; using crime as a category for insurability can result in a ghettoizing effect on policyholders by disproportionately affecting certain policyholders who are

Insurance law, based as it is largely on contract law principles, contains none of the standard liberty-protecting safeguards found in criminal law. Selling insurance policies to the public does not make insurers some sort of deputized private attorneys general who provide a contractually premised social vehicle through which anti-social behavior can be corrected. Despite all of this, and most importantly, the fact remains that there is a competing expectation for the insurance proceeds beyond that of the policyholder. The accident victim's compensation hangs in the balance of whatever moral considerations are weighed, making whatever punishment leveled on a policyholder felt, instead, by the victim herself, for it is the victim who is the ultimate recipient of the insurance indemnity.

As the example about the policyholder's accidental firearms discharge shows, insurers often cannot support both a fortuity-based and a morality-based argument at the same time because one explanation for coverage denial cancels out the other. If the morality-based argument is misleading and inaccurate, as it most assuredly is, then that leaves the insurer with only fortuity-based arguments to buttress fortuity clause coverage denials. And that is probably the way it should be. The focus would remain on simple actuarial risk management principles and not on slippery moral concerns. The focus would also remain on the policyholder's conduct and whether or not the loss is certain or fortuitous, as opposed to some perceived social engineering wishes of an insurer, other policyholders in the risk pool, or society as a whole.

But the shift from fortuity to morality also forces the conversation away from one about insurance as accident victim compensation source. There is no morality story to tell there about coverage denial. In fact, the moral thing to do may well be to ensure that compensation is somehow available for the victim in some fashion or another, as long as the loss was realized fortuitously. Turning a fortuity clause into a morality clause, however, prevents that consideration because the morality story is squarely focused on the purpose of insurance as a wealth protection mechanism for policyholders. Keeping the analysis grounded in fortuity discourse is most compatible with an approach that at least does not lose sight of the fact that it is the accident victim's compensation hanging in the balance.

Is it possible to have an insurance story about the applicability of fortuity clauses where the discourse is grounded in neutral fortuity concerns, not morality concerns, and that still is compatible with both

more likely to engage in criminal behavior, from drug use to misdemeanors and beyond).

notions of insurance as wealth protection and insurance as victim compensation source? Perhaps. The key would be to ensure that, whenever concerns about one purpose of liability insurance are driving the interpretive analysis, those concerns do not unsettlingly trump concerns of the other purpose. The purposes do not have to compete but can be complementary. This is only possible by avoiding morality discourse and keeping the insurance analysis grounded in fortuity discourse.

For example, take the case about the policyholder negligently injuring his friend with the firearm. Whether or not his liability insurance coverage should be ousted by his “criminal act” can be assessed using fortuity discourse. His actions and the loss were entirely fortuitous. What he did may have been careless, but it did not transform the shooting from possibility to certainty. To that end, coverage should be maintained, despite his criminal charge. Fortuity was not frustrated here. This was still a chance loss. This was, in other words, not a “criminal act” for insurance purposes resulting in a certain loss, even though the conduct may have triggered the criminal law for state sanction purposes. By the same token, depriving the injured accident victim of his compensation also weighs against denying insurance coverage for anything but a non-fortuitous loss.

So, if the same policyholder intentionally murdered his friend with the firearm, the situation would be different. Here, his actions purposely changed the loss from a possibility to a certainty. The policyholder had complete control as to whether or not that loss would be brought about. He knew the gun was loaded. Fortuity would be frustrated and the insurance arrangement breaks down. This is the very risk that the fortuity clause targets. It is the very thing insurance does not insure. While the injured accident victim would lose his source of compensation, insurance based on fortuitous risk transfer is not the vehicle best tuned to provide that compensation. One must look elsewhere at another compensatory solution for those injured victims who are harmed by losses that were made certain to occur at the hands of the policyholder.

VII. SOLUTIONS: SUBJECTIVE INTERPRETIVE PERSPECTIVE

At present, the most sensible solution to interpreting the applicability of either the intentional act fortuity clause or the criminal act fortuity clause is to only deny coverage when fortuity is truly frustrated – when a loss has been made certain to occur by the purposeful conduct of a policyholder. Otherwise, the clauses get bogged down in discourse about morality and about the rightful purpose of liability insurance itself. Insurance coverage decisions will then be more streamlined. It will be

clearer to insurers, policyholders and third party accident victims that private liability insurance is presently designed to “pay the prankster but not the arsonist, and the risky fool but not the premeditated murderer.”⁷³ Such a practice will go a long way to closing the compensatory gap for injured accident victims so that the only accident victims left in it are those who miss out on compensation from a policyholder’s liability insurance because that policyholder acted to make a loss a certainty. For that smaller group, another compensation solution needs to be devised, layered on top of the existing liability insurance scheme.

It makes sense to interpret the criminal act fortuity clause as one that ousts liability insurance coverage for only specific-intent crimes where the policyholder had the intent to bring about certain loss. To do otherwise is to doom the insurance interpretation analysis to a quagmire of morally muddy analytics. The simple, literal answer to the question “when does the clause apply?” provides a troubling practical answer if coverage is ousted for any loss arising from some related criminal act of the policyholder. Courts have struggled with “what” criminal acts count as “criminal acts.”⁷⁴ Does a charge for speeding oust liability coverage? What about negligence-based crimes or regulatory offences? In the face of broad-based coverage for legal liability, a blanket exclusion for “anything catching the attention of the criminal law” can leave uninsured a wide variety of loss-causing behavior, to the surprise of many policyholders (and probably a few insurers) *ex post*. That leaves many accident victims in an unpredictable situation, with no source of compensation despite suffering a loss fortuitous to the policyholder. Policyholders cannot adjust their behavior accordingly, as they are unable to predict what behavior is covered and what is not.

That interpretive approach, however, does not comport with a literal reading of the criminal act fortuity clause. Is the criminal act fortuity clause essentially doing the same job as the intentional act fortuity clause, rendering it superfluous? One explanation for interpreting the clause in an expansive fashion is simple rigid contract law: the insurer put those words

⁷³ Knutsen, *supra* note 8, at 115.

⁷⁴ See, e.g., *Horace Mann Ins. Co. v. Drury*, 445 S.E.2d 272, 273–74 (Ga. Ct. App. 1994) (including the illegal use or possession of firecrackers as a “crime”); *Harris v. Dunn*, 45,619, p. 6–7 (La. App. 2 Cir. 9/22/10); 48 So. 3d 367, 372 (stating that there was coverage for a policyholder, who struck a person who was getting back into a vehicle, despite guilty plea to misdemeanor battery offense); *Herbert v. Talbot*, 26, 009 (La. App. 2 Cir. 9/21/94); 643 So. 2d 323 (indicating that policyholder’s cruelty to youth does not oust coverage);

in and, as insurance is a contract, the policyholder accepted those conditions when she purchased the policy and is now bound by them. Some courts have buttressed coverage denial using this contractual argument.⁷⁵ This, however, ignores the fact that there is increasing evidence that insurance – especially liability insurance – is much more than a simple contract.⁷⁶ At the very least, hinging on this contractual decision is access to compensation for the injured accident victim. There is little room for such considerations in a literalist contractual interpretation of the criminal act fortuity clause. That makes it problematic as an analytical approach. By not at least addressing some potential purpose as to why the clause is in the policy, the accident victim's compensation becomes the automatic sacrifice. In an insurance law environment with pro-coverage interpretive tools like *contra proferentem* and reasonable expectations, many courts struggle against this literalist interpretation (perhaps for good reason).

One possible explanation for the clause beyond a simplistic “these are what the words say,” as held by some courts, is that insurers mean to exclude from coverage any losses arising from criminal conduct because those losses are a riskier category than some other category of behavior.⁷⁷ Insurers are free to determine which risks they will underwrite and which they will not. That is a market-based decision on the part of an insurer. However, second-guessing what an insurer “wants” to do, without evidence

⁷⁵ See, e.g., *Progressive N. Ins. Co. v. McDonough*, 608 F.3d 388, 391 (8th Cir. 2010) (explaining that the plain language of criminal act exclusion had no intent requirement, so policyholder's intent irrelevant at time of accident); *Allstate Ins. Co. v. Peasley*, 932 P.2d 1244, 1249 (Wash. 1997) (holding that a criminal acts exclusion ousts coverage for reckless endangerment crime from accidental shooting, regardless of policyholder's intent; “this court must enforce the Policy as written”).

⁷⁶ See generally, e.g., Erik S. Knutsen, *Auto Insurance as Social Contract: Solving Automobile Insurance Coverage Disputes Through a Public Regulatory Framework*, 48 ALBERTA L. REV. 715 (2011); Daniel Schwarcz, *A Products Liability Theory for the Judicial Regulation of Insurance Policies*, 48 WM. & MARY L. REV. 1389 (2007); Jeffrey W. Stempel, *The Insurance Policy as Statute*, 41 MCGEORGE L. REV. 203 (2010); Jeffrey W. Stempel, *The Insurance Policy as Social Instrument and Social Institution*, 51 WM. & MARY L. REV. 1489 (2010).

⁷⁷ See, e.g., *Allstate Ins. Co. v. Berube*, 854 A.2d 53, 57 (Conn. App. Ct. 2004) (holding that an accidental gun discharge while getting into bed with loaded sawed-off rifle was a “criminal act”, even though determined to be an accident, because act risked injury to child in bed).

of an insurer's drafting and underwriting intent, meets with some skepticism when the injured accident victim's compensation is the collateral at stake in such a "guess." As has been explained above, today's policyholders are often unable to *ex ante* predict what behavior will lead to a criminal charge, except for those obvious traditional, specific intent-based crimes like murder, assault, or arson. So if it is the insurer's intention to exclude from coverage any and all losses arising out of a policyholder's criminal actions, regardless of the policyholder's subjective intent to bring about the loss, that intention, in today's modern world, has to be based on something other than a moral concern for crime prevention, which, as mentioned above, this clause cannot effectively accomplish in any event.

This explanation for the clause's interpretation also ignores the fact that the very coverage offered is for legal liability arising from risky behavior: negligence. There is no evidence that all behavior branded as "criminal" after the behavior occurs is any more or less costly to insure, as a category of behavior, than any negligent behavior. It is not the type of exclusion that deals with an *ex ante* palpable effect on risk simply because the behavior is often categorized by the state as "criminal" after it occurs. This is different than exclusions in a homeowner's liability policy for running a commercial business like a hair salon in the home without telling the insurer, thereby increasing the risk of loss by having more traffic in and out of the house and operating equipment not normally found in all homes. This is arguably different than other traditional exclusions for property insurance coverage like excluding losses arising from pollution or water damage or earthquake. By contrast, those specific property insurance losses are the sort that are inherently more financially risky to insure because the losses, if realized, are more expensive and might have the potential to affect multiple policyholders at once, across multiple lines of insurance products.⁷⁸ Such is not the case with a loss resulting from a criminal act.

In addition, whether or not a certain type of conduct is criminal or not has no bearing on whether or not losses are arising in non-fortuitous ways. Penal statutes are not written with an eye to what behavior actually realizes a certain loss but rather are conduct based, not results based. Crime is about something different than the presence or absence of insurable losses. Insurers have no control over what crimes are included or

⁷⁸ Michelle E. Boardman, *Known Unknowns: The Illusion of Terrorism Insurance*, 93 GEO. L.J. 783, 784 (2004) (warning of "clash events" which affect multiple policyholders across multiple lines of insurance).

not in penal statutes. Furthermore, what is considered “criminal” behavior is ever-changing over time. At the time an insurer drafts an insurance policy, behavior not considered criminal may, in the future, be deemed criminal. A few decades ago, who could have predicted the crimes associated with the internet and identity theft? Nowadays there are criminal investigations and prosecutions against teenagers for hacking into websites for fun or for cyber-bullying a classmate, despite the intent sometimes being to “tease.”

So if the clause is ineffective at deterring crime and if it is essentially no riskier to insure losses arising from criminal acts as a distinct category of *ex ante* behavior than those arising from negligent acts in terms of size or frequency of losses, and if, in fact, the very behavior targeted by the clause is a mutating continuum of behavior as the criminal law changes over time, then why are insurers not providing coverage for losses arising from criminal acts? Could it be that, as many courts note, crime is uninsurable?⁷⁹

This, too, does not bear out in reality. Only a subsection of crime is conceptually uninsurable: those losses intentionally brought about by a criminal policyholder. Other losses arising from criminal behavior are fortuitous and insurable, as long as the policyholder did not intend to bring about the loss. In fact, there are many instances in insurance where crimes of one nature or another are insured and insurers still profit. One example is property insurance for theft. Another is coverage for a legal defense in a director’s and officer’s liability policy if the director or officer faces a criminal charge. Some liability insurance policies insure policyholders against awards of punitive damages. Still others provide liability coverage for vicarious liability for an employee’s intentional actions, including assault and sexual assault. Liability insurers are still able to underwrite these risks and turn a profit in the insurance business.

The only available rationale for the criminal act fortuity clause is that it enshrines the public policy notion – still relevant today – that

⁷⁹ See, e.g., *Minn. Fire & Cas. Co. v. Greenfield*, 855 A.2d 854, 866 (Pa. 2004) (maintaining that insurance policy was not designed to protect a drug dealer, so no coverage existed when a houseguest died of a heroin overdose); *Am. Family Mut. Ins. Group v. Kostaneski*, 688 N.W.2d 410, 415 (S.D. 2004) (insuring intentional wrongdoers is against state public policy, so criminal exclusion is valid); *Unified W. Grocers, Inc. v. Twin City Fire Ins. Co.*, 371 F. Supp. 2d 1234, 1243 (D. Haw. 2005) (holding that one cannot insure restitution of an “ill-gotten gain” under California law), *rev’d*, 457 F.3d 1106 (9th Cir. 2006).

insurance will not be used by a criminal to profit from his crime.⁸⁰ It also assists in an evidentiary fashion by ousting coverage for specific-intent crimes so that tortious intent need not be proven by the insurer seeking to remove coverage. The work has already been done in the criminal case. So the clause acts as a sort of doctrinal shortcut to proving the necessary intent required in making coverage determinations. As long as the policyholder is not profiting from a crime, or intentionally causing a loss that is the result of a crime, the clause's purpose is upheld.

If the purpose of insurance is seen as a wealth protection product only, this public policy notion of the clause fits with more modern fortuity concerns. The only way a policyholder insured by liability insurance could ever "profit" from his crimes (here, "profit" meaning enjoying the wealth protection aspect of the insurance) would be if he brought about a certain loss. So a bar brawler picks a fight and slugs another patron because he knows that if he injures that patron and is sued, at least his liability insurer will cover the losses. If, however, the policyholder did not commit a crime with intent to cause the insured loss, there is no way the policyholder could "profit." The act of profiting itself requires some implicit intent that the policyholder aims to profit from his actions.

There is, of course, a valid argument that the liability insurance policyholder could never "profit" from the insurance proceeds because the insurance proceeds go to the third party accident victim, not the policyholder. Because the wealth protection purpose of insurance can compete with the compensation function of insurance in the liability insurance context, the public policy rationale for the criminal act fortuity clause is weakened. The historical nature of the clause, arising out of moral and public policy concerns, does not port well into the modern liability insurance landscape. It functions, as has been shown, as a very nearly always unbalanced concept whereby so much law and policy mash together and the result of which is very often a compensation gap for an injured accident victim.

The simplest solution to fairly and predictably balance concerns with the compensation gap while still maintaining efficacy of fortuity clauses as written is to interpret fortuity clauses as clauses that are triggered by fortuity concerns which frustrate the insurance relationship. To do anything else is to introduce unpredictability in the form of morality-based mutable legal concepts from tort and criminal law into an insurance

⁸⁰ See *Minn. Fire & Cas. Co.*, 855 A.2d at 869; *Am. Family Mut. Ins. Group*, 688 N.W.2d at 415; *Unified W. Grocers, Inc.*, 371 F. Supp. 2d at 1243.

interpretation exercise. To that end, the intentional act fortuity clause should be interpreted so as to remove coverage for a loss only when the policyholder subjectively intends to bring about the harm that was caused by the intentional act. Similarly, the criminal act fortuity clause should only oust coverage for a loss when a policyholder subjectively intends the harm that was caused by the criminal act. Otherwise, coverage would be removed for fortuitous losses at the expense of an injured accident victim's compensatory needs. By interpreting these clauses as requiring a subjective causative element, the exercise restricts coverage removal to only those instances where the policyholder could actually subjectively have altered behavior to avoid the loss, thereby ensuring maximum effectiveness for moral hazard insurance concerns. Otherwise, the deterrent effect (if any) of the clause is ineffective and over-broad. This sort of approach would prevent fortuity clauses from inefficiently morphing into morality clauses. It would also more fairly balance the wealth protection aspect of insurance with the compensatory needs of accident victims while still not doing violence to the current language of the respective clauses. Litigation and insurance costs would be saved as a result. The compensation gap for fortuity victims would significantly narrow to predictably include only those harmed by specific-intent crimes or subjective intentional conduct on the part of the policyholder. While this still would leave some victims without compensation, it would at least provide a fixed category of people so that a sensible social solution could then be crafted, if necessary.

VIII. ADDRESSING THE COMPENSATION GAP

To address the remaining compensatory gap, it would be necessary to go further than what can be done by interpreting the presently worded insurance policies through a lens of fortuity. One must examine the web of accident compensation as it is presently constituted and perhaps reform it. There may well be reason to do this, as the injured victims comprising this particular gap would be those who were injured as a result of particularly extreme intentional or criminal actions on the part of the policyholder: the victims of assaults, attempted murders, actual murders and sexual assaults.⁸¹ This group of victims would likely exhibit particularly

⁸¹ See, e.g., Wiggins, *supra* note 36 (stating the need to view compensatory issues with the perspective of the injured party, not just the view of the

catastrophic and troubling injuries that, under tort, would typically be deserving of a significant level of compensation. As Rick Swedloff and Jennifer Wriggins point out, to ignore these victims in the compensatory gap is not only expensive, but doing so impinges on collective social conscience as well. A few solutions exist.

One solution would be to incentivize insurers to market an add-on portion for a variety of liability insurance policies specifically designed to pay the policyholder in the event she is injured by another party and cannot collect from that party's liability insurance because of the operation of a fortuity clause in that other party's policy. The add-on "fortuity clause insurance" could function similar to uninsured automobile motorist coverage, as an extra endorsement or rider on automobile, homeowners, personal, professional, or commercial liability insurance. For an additional premium, the policyholder could claim compensation from her own liability insurance policy if she found herself without compensation due to an inability to trigger a tortfeasor's liability insurance because of the conduct of the tortfeasor wrongdoer who harmed her.⁸² The risk of being found in the compensation gap due to the operation of a fortuity clause could be unbundled and sold as a separate insurance add-on.⁸³ While the payout under this type of insurance add-on may not be small when it occurs, it is certainly a very proscribed situation far less likely to occur than a standard automobile accident or any mishap that triggers homeowners insurance. In fact, its instance of trigger might be quite rare, comparatively. There may be a real market in this add-on, to the benefit of insurers, because people have a somewhat irrational fear of being harmed by crime. If offered at a modest price, most policyholders might well purchase it.

Of course, this solution only benefits those who are covered by liability insurance in the first place. While the group would be obviously large and include all drivers and homeowners, some particularly vulnerable members of society are simply not covered by any liability insurance. These are most often the poor, the unemployed, or those who lose liability

perpetrator); Swedloff, *supra* note 36 (documenting the challenging compensatory issues with fortuity victims).

⁸² Similar to Rick Swedloff's "uninsured assailant" insurance, except not a mandatory form of insurance. Swedloff, *supra* note 36, at 759–60.

⁸³ See Lee Anne Fennell, *Unbundling Risk*, 60 DUKE L.J. 1285 (2011) (advocating for more creative ways of unbundling traditional risk packages by unbundling the risk in innovative units).

insurance coverage for another reason (like failing to pay their premiums). For those, another solution would have to be invented if they, too, are to exit the compensatory gap left by the unpredictable application of fortuity clauses.

There are two potential solutions to address the needs of this still smaller group of uncompensated accident victims who are not themselves covered by liability insurance and who did not purchase the first party fortuity clause insurance add-on. In the face of a triggered fortuity clause, liability insurers could be legislatively forced to provide compensation to the victims of criminal and intentional conduct.⁸⁴ In exchange, insurers would be allowed to subrogate against their own policyholders in an attempt to recoup their losses from the actual wrongdoer. This provides at least some credence to the operation of the fortuity clause. However, the actual success of that subrogation exercise is speculative. If we know that most policyholders do not have sufficient personal assets to cover a civil judgment, why would insurer subrogation against an insured produce any better results? There would be substantial collection costs on the part of insurers, for somewhat sketchy proceeds as a result of the exercise.

Another solution to assist uninsured individuals who are left with no compensation as a result of a policyholder's triggered fortuity clause is for the government to create a new socialized compensation mechanism for these victims – a “Victims of Intentional Harm” program. Some government body would operate a program that steps in to compensate those left in the gaps created by fortuity clauses. The program would be funded by a small levy on the sale of every liability insurance policy. This is essentially the same as insurers providing add-on fortuity clause insurance except mandated in a socialized fashion. It would be paid for by all policyholders but would be accessed by those who could not access some other compensation source (i.e. those who did not have add-on fortuity clause insurance). If the private market add-on fortuity clause insurance failed in that it was not purchased by sufficient policyholders, this may be a workable alternative to that solution as well. The government body could also be given the right to subrogate against a wrongdoer, if any assets were attainable. Of course, there would be administrative costs to the program and the difficulty of determining the

⁸⁴ Similar to, but broader than, Jennifer Wiggins' proposed Domestic Violence Torts Insurance Plan, which she proposes should be tacked onto automobile liability insurance in order to provide compensation for a wide cross-section of victims of domestic violence. See Wiggins, *supra* note 36.

price of the levy on the sale of liability insurance policies. But one would expect the cost of operation to be at a minimum due to the limited amount of victims who would have to resort to the fund, especially if there were some reasonable limits on compensation provided by the fund.

Finally, a more fundamental solution to fortuity clauses would be to legislatively outlaw fortuity clauses in liability insurance. This step places the compensatory purpose of insurance squarely at the forefront, well ahead of the wealth protection purpose. It enshrines private insurance as a fundamental part of the accident compensation system. However, it also passes the costs of paying for non-fortuitous losses onto all liability insurance policyholders. Providing coverage for losses certain to occur appears counter to standard insurance risk fundamentals and, frankly, insurance profitability.

But such a move is not impossible.⁸⁵ Indeed, in Canada, the decision was made to disallow fortuity clauses in automobile liability insurance, such that any act of automobile use, no matter how criminal or intentional, results in compensation for the accident victim via the wrongdoer's liability insurance policy.⁸⁶ The result has been that the costs of these allegedly certain losses are spread amongst the risk pool of insured drivers. While premiums may have increased as a result, automobile insurance is not catastrophically unaffordable in that country. The policy move was to favor victim compensation over wealth protection or even fortuity concepts in the auto accident sphere. Driving was considered a dangerous activity and the driving public would have to self-fund a source of victim compensation within a liability insurance market.

The real question here is this: if such was the thinking for the victims of automobile insurance accidents, why is there not similar thinking going on for the victims of crimes and other intentional acts? Is the move from auto victim to assault victim really so fundamentally different that the former is more deserving of a compensation scheme whereas the latter is not? Or is it simply because it is more administratively easy to create a compensation scheme with a pool of risk-creators like automobile drivers

⁸⁵ And, in fact, in the automobile context especially, a number of American courts have alluded to the importance of compensating third-party accident victims as a reason for allowing coverage despite the insured's intentional conduct. *See, e.g.,* *Salamon v. Progressive Classic Ins. Co.*, 841 A.2d 858 (Md. 2004); *Proformance Ins. Co. v. Jones*, 887 A.2d 146 (N.J. 2005); *Tapp v. Perciful*, 120 P.3d 480 (Okla. 2005).

⁸⁶ *See, e.g.,* Knutsen, *supra* note 8, at 80.

who would be more comfortable to pay into such a scheme for the privilege of operating a dangerous motor vehicle? If that is the case, then why is auto accident risk creation different than any other risk creation behavior covered by homeowners or commercial liability insurance policies?

IX. CONCLUSION

Keeping fortuity clauses firmly grounded in fortuity-based thinking would help to restrict whatever compensation gap does exist for fortuity victims injured by fortuitous losses. That means that the intentional act and criminal act fortuity clauses require a subjective interpretation. Morality needs to be taken out of the equation. That would also save significant litigation costs in the solving of fortuity clause insurance coverage disputes. Those fortuity victims still left in the compensation gap would be a smaller, more predictable group to be expected in keeping with the principle of fortuity in insurance. But the situation is no less tragic. In a society which relies so heavily on private, market-based insurance as the main compensatory source for accident victims, it is surprising that, of all victims, these fortuity victims frequently have the least options for compensation. Some other solution for them is required.

Such a solution, or indeed any solutions proposed in this final section, would require not only insurer buy-in, but serious political buy-in as well. They are social solutions to a social problem. Such change is never easy. Staid institutions would have to change. But it is important to keep in mind that the genesis of these fortuity clauses in the first place was a concern over social problems. These clauses designed to circumvent morality problems associated with insurance products are now themselves causing other morality problems in the form of unfairly and unpredictably leaving a serious and expensive compensation gap in society for a sub-set of injured accident victims. Perhaps then the argument that insurers need to be part of the social solution is a reasonable one. It is a social move that will require a shift in thinking from the purpose of insurance as wealth protection to that of victim compensation. This Article has outlined the importance of balancing that tension. Perhaps that shift is not as difficult to make in today's society as it was when liability insurance first surfaced.

BIG DATA AND INSURANCE SYMPOSIUM

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This Article reproduces the keynote address delivered by Connecticut Attorney General George Jepsen at the University of Connecticut School of Law's Spring 2014 Big Data and Insurance Symposium. In his address, Attorney General Jepsen describes the opportunities and challenges associated with the use of big data technologies. He stresses the need to consider personal privacy concerns at every step of the data collection and analysis processes. Moreover, he argues that self-policing is not enough and that it is vital for the government to play a role in defining and enforcing individual privacy protections. Attorney General Jepsen concludes by calling for regulators and industry to remember that they share the common goal of achieving an effective balance between protecting personal privacy and promoting the use of big data to create new business opportunities and more efficient service delivery.

I would like to thank the University of Connecticut School of Law, the Insurance Law Center, and the *Connecticut Insurance Law Journal* for hosting this important event and for inviting me to join the discussion here today.

We all know that big data has the power to change the world. In fact, it already has.

I like to imagine big data as the Colorado River in spring flood stage. It took a marvel of technology, the construction of the Hoover Dam – one of the largest man-made structures in the world when it was built in the 1930s – to contain that river and use its flow to generate electricity.

Harnessing big data – the torrents of information being generated every day – will take equivalent feats of technology. Engineers and data scientists are coming up with new ways to aggregate data and filter it to extract patterns and other information useful to consumers and business, such as the insurance industry.

But perhaps the biggest challenge is protecting the privacy of the men, women, and children whose personally identifiable information, patterns of behavior, preferences and buying habits, medical risks, and even their location can be filtered from the data stream.

As Attorney General, responsible for protecting the public interest of Connecticut and its citizens, I believe that this is an issue of paramount importance.

A White House working group voiced the same concern in May after a 90-day study of big data and its impact on the way we live and work.

Their report concluded that every sphere of life will be transformed by big data technologies. However, for society to enjoy the benefits of the knowledge they generate, personal privacy must be protected from the potential harm.

How data is collected raises one important privacy concern. How data is used and how it is protected are equally important questions. As the White House report noted, "volumes of data that were once unthinkable expensive to preserve are now easy and affordable to store on a chip the size of a grain of rice." The consequence of unlimited storage is that data, once created, is effectively permanent.

Another unfortunate corollary to the collection of data is that it can be lost or stolen, and it can be misused to illegally discriminate against individuals and groups. Loss of personal information – from Social Security and credit card numbers to medical and tax records – can result in the nightmare of identity theft. This crime is on the rise and the resulting legal and financial morass can take years and a great deal of money to correct, both for the victim and for the businesses and industries involved.

The Federal Trade Commission (FTC) reports that identity theft continues to top its national ranking of consumer complaints as it has for more than ten years. Last year, identity theft accounted for nearly 300,000 or 14 percent of all complaints to the FTC. Those numbers have continued to grow year after year. Connecticut is not immune to this frightening trend.

Soon after I took office in 2011, I created a multidisciplinary privacy task force chaired by Assistant Attorney General Matthew Fitzsimmons, who is one of the afternoon's panelists. The five attorneys who comprise the task force investigate data breaches that result in the loss of personally identifiable information of state residents, and seek appropriate remedies.

While my Office had responsibility to investigate data breaches, I worked with the Legislature to require that my Office be notified whenever a breach of security occurs involving the personal information of Connecticut residents. When that law took effect on October 1, 2012, the number of data breach reports nearly tripled overnight, underscoring the extent of the problem.

The notice requirement is triggered when unencrypted, computerized information is lost containing an individual's name and their Social Security, state identification or driver's license number, or bank account, credit or debit card number and any security code, access code, or password required for access to the account.

In the first year since the breach reporting law took effect, my Office received 427 reports of security breaches involving the personal information of nearly 588,000 Connecticut residents, more than sixteen percent of the state's population of nearly 3.6 million residents. Those are serious numbers.

What has been lost? Any and all information that can be collected: health records, tax data, student and faculty records, and credit card numbers by the thousands. The breaches can result from a sophisticated hacker invasion to something as simple as a lost laptop containing unencrypted data.

Breaches of security involving Social Security numbers are particularly serious. Because of the severity of the potential damage, we recommend that companies reporting such breaches offer two years of credit monitoring or identity theft protection service. Credit monitoring provides alerts to a consumer whenever an application for new credit is submitted to a credit-reporting agency. This early warning allows a consumer to take immediate action to dispute or even prevent a new account from being opened.

Connecticut is now one of forty-seven states with data breach notification laws, but I agree that a uniform federal approach through national data breach legislation would benefit business and better protect consumers.

While many companies do a good job at protecting sensitive data, others do not. The retail giants Target and Neiman Marcus reported massive data breaches last year that compromised the credit card numbers and other personal information of tens of millions of customers. The breach cost Target \$61 million through the end of last year and will likely cost substantially more, as Target is facing more than eighty lawsuits and is under a number of government investigations. The National Association of Attorneys General (NAAG), for example, allows individual states to work on a bipartisan basis to resolve issues of nationwide concern. The NAAG multistate investigation into the Target and Neiman Marcus data breaches is being led by my Office, together with my counterpart in Illinois.

Target says "criminals forced their way" into its computer system, gaining access to guest credit and debit card information. Target said it has since closed the access point the hackers used, and the breach remains

under investigation. But this case, the Neiman Marcus case, and other high-profile security breaches show that hacker attacks are becoming more sophisticated. For business, government regulators, and law enforcement, it is becoming tougher all the time to stay ahead of the criminals. Data security is a global problem and the threat to privacy is real.

Harnessing big data poses an even greater threat to personal privacy from unauthorized collection, access, re-use, misuse, or loss of personal information. How do we address it? We must consider personal privacy concerns at every step of the data collection and analysis process.

The Internet industry, for example, favors self-regulation and agreements between individual companies, such as Google and Facebook, and their users to safeguard users' privacy. But that will not protect consumers when information about them is bought, traded, and sold by brokers or third parties that have no direct relationship to the consumer.

As we learned in the financial industry, self-policing is not enough. It is vital for government to play a role in defining and enforcing individual privacy protections as the Federal Trade Commission and the state Attorneys General currently do under the Health Insurance Portability and Accountability Act (HIPPA) and the Fair Credit Reporting Act (FCRA). The current legal framework focuses on obtaining user permission prior to collecting data and defines how that information will be used. The White House report suggests that a better approach may be to allow individuals to participate in the use and distribution of their information after it is collected.

Federal Trade Commission Chairwoman Edith Ramirez has asked Congress to give the FTC greater authority over data security. The changes she is seeking include: requiring companies, when appropriate, to notify consumers affected by a data breach; giving the commission authority to seek civil penalties to help deter unlawful conduct; and giving the commission jurisdiction over non-profit entities.

In 2012, President Obama proposed a national standard for protecting consumer data privacy where existing federal privacy rules do not apply. As proposed, the national Consumer Privacy Bill of Rights would pre-empt state laws inconsistent with the policy. However, the Federal Trade Commission and the state Attorneys General would continue to share authority to enforce the privacy rules as they now enforce HIPPA and the FCRA.

The Consumer Privacy Bill of Rights, for example, would give consumers: the right to control how personal data is used; the right to keep information being collected for one purpose from being used for an

unrelated purpose; the right to have information held securely; and the right to know who is accountable for the use or misuse of that information.

The White House study was part of the ongoing national discussion about big data. Your work will add to the debate. However, as we focus on the opportunities and challenges of big data, it is important to remember that regulators and industry are not working at cross-purposes. Effective use of big data has the power to transform our lives and create new opportunities for business, particularly the insurance, health care, and energy industries, through better cost controls and more efficient delivery of services.

Protections from misuse of their personal data will make consumers more willing to share their information, to engage in commerce, to participate in the political process and to seek needed health care.

As a result, we all have an economic and public interest in making sure an effective balance is achieved in protecting personal privacy with the generation of knowledge promised by the free flow and use of big data.

Thank you.

PAYMENT PROTECTION INSURANCE (PPI) MISSELLING: SOME LESSONS FROM THE UK

ANDROMACHI GEORGOSOULI

The misselling of Payment Protection Insurance (“PPI”) is a longstanding problem in the UK. The Treating Customers Fairly (“TCF”) initiative was introduced to tackle this problem but, despite its sophisticated inception, its effectiveness has been limited. This Article canvasses the main features of TCF as a management-based approach to regulation and highlights its initial appeal. Against this backdrop, it draws on the recent UK experience with recurring instances of PPI misselling to offer an account of the principal causes of its shortcomings in the retail financial sector. It argues that the perceived failure of this regulatory approach may be attributed to the following three factors: (i) the rulification of TCF; (ii) several shortcomings of the existing data resource management; and (iii) the absence of a system of credible deterrence to support the Financial Conduct Authority’s attempts to be proactive and to inflict cultural change at regulated firm level. The Article concludes with a summary of key lessons that may be drawn from the UK experience.

I. INTRODUCTION

Financial misselling describes selling practices in the retail financial sector that exploit the customer’s reliance on the expertise, advice, and professionalism of the provider of the financial product or service in question. Typically, it is a deliberative strategy to sell financial products that customers do not need.¹ Financial misselling has a long

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history in the UK. In the 1990s, misled workers pulled out of company final-salary pension schemes and enrolled in plans that were linked to stock market returns.² During the same period, mortgage endowment policies and Card and Identity Protection Insurance (“CIPI”) were missold to consumers.³ The misselling of Payment Protection Insurance (“PPI”) has perhaps been worse.⁴ It started off in the 1980s and has been recurring ever since.⁵ In view of its magnitude, this Article will focus on the regulatory response to PPI misselling as a case study.

an earlier version of this Article and to Matteo Angelini for his assistance. Any errors are my own.

¹ Practices of predatory lending in the US are similar but not identical to financial misselling in the UK. A major difference concerns the locus of these phenomena. The majority of predatory lending has been associated with the subprime sector. In the UK, financial misselling occurs in the mainstream retail financial sector. *See* Richard V. Ericson & Aaron Doyle, *The Institutionalization of Deceptive Sales in Life Insurance: Five Sources of Moral Risk*, 46 BRIT. J. CRIM. 993, 993–1010 (explaining the impact on the life insurance sector by financial misselling in the US through empirical studies); Nicole L. Fuentes, *Defrauding the American Dream: Predatory Lending in Latino Communities and Reform of California’s Lending Law*, 97 CALIF. L. REV. 1279, 1279–1335 (2009) (discussing predatory lending in the United States); SYNOVATE LTD., CONSUMER MARKET STUDY ON ADVICE WITHIN THE AREA OF RETAIL INVESTMENT SERVICES – FINAL REPORT (2011), *available at* http://e.c.europa.eu/consumers/archive/rights/docs/investment_advice_study_en.pdf (providing investment advice to 27 member states of the EU).

² Nearly one million of them eventually won compensation totaling £11.8 billion. FIN. SERVS. AUTH., NATIONWIDE AVC & PENSION SCHEME INTEREST RATE FINAL RETURNS, *available at* <http://www.fsa.gov.uk/static/pubs/fsavc-review/fsavc-bs-returns.pdf>.

³ *Card and Identity Protection Policyholder to Claim Compensation by 30 August 2014*, FIN. CONDUCT AUTH. (Mar. 3, 2014), <http://www.fca.org.uk/news/compensation-for-card-and-identity-protection-policyholders>; *see also* FIN. SERVS. AUTH., ENDOWMENT MORTGAGE COMPLAINTS: FEEDBACK ON CP75 AND ‘FINAL’ TEXT (2001), *available at* <http://www.fsa.gov.uk/pubs/policy/ps75.pdf>.

⁴ *See* Luis Lobo-Guerrero, *Uberrima Fides, Foucault, and the Security of Uncertainty*, 26 INT’L J. SEMIOTICS L. 23, 31–32 (2013) (explaining the practice of PPI misselling and its history in the UK).

⁵ Julia Black & Richard Nobles, *Personal Pensions Misselling: The Causes and Lessons of Regulatory Failure*, 61 MOD. L. REV. 789, 789–820 (1998) (pointing out that misselling is one of the key drivers that led to reform of the system of financial regulation in the late 1990s); James Pickford, *PPI Dominates as Consumer Complaints*

PPI provides insurance against the risk that a borrower will be unable to maintain credit repayments for specified reasons as, for example, when he is unable to work or due to an accident.⁶ PPI is not suitable for everyone. Suppose, for instance, that X is applying for a loan in order to buy a car. He is perfectly healthy, he is educated, and his family can help him out financially if he finds himself temporarily out of work in the future. He does not need a PPI, but he is forced to buy PPI. For example, he is told that it is better to purchase PPI, because otherwise he will have to pay an increased interest for the loan that he is applying for. In other instances, it may be the case that PPI goes together with a personal loan (or a mortgage) as a compulsory component, but customers are never alerted of that fact.

The predecessor of the Financial Conduct Authority (“FCA”) on matters of consumer protection and conduct of business – the Financial Services Authority (“FSA”) – made PPI misselling an early priority when it assumed responsibility for the regulation of general insurance intermediation in 2005.⁷ Initially, the FSA tried to work with the industry. The Treating Customers Fairly initiative (“TCF”) stood at the epicentre of the regulator’s approach and it was launched in 2006 with the aim of intensifying the FSA’s attempt to attune business culture with the delivery of fair treatment for customers as part of its consumer protection mandate.⁸

The TCF is sophisticated in its inception, but thus far has proved to be ineffective in deterring instances of financial misselling. Between 2006 and 2008, selling practices in the retail financial sector revealed poor suitability checks and training, ineffective systems and controls, and

Hit Record High, FIN. TIMES (May 19, 2014), <http://www.ft.com/cms/s/0/24610976-df6d-11e3-a4cf-00144feabdc0.html#axzz38gfKumLG>.

⁶ See Ellis Ferran, *Regulatory Lessons from the Payment Protection Insurance Mis-selling Scandal in the UK*, 13 EUR. BUS. ORG. L. REV. 247, 250 (2012) (providing various working definitions of PPI); Final Notice from Fin. Servs. Auth. to Lloyds TSB Bank plc and Bank of Scotland plc (Feb. 15, 2013), *available at* <http://www.fca.org.uk/static/fca/documents/final-notices/lloyds-banking-group.pdf>.

⁷ FIN. SERVS. AUTH., TREATING CUSTOMERS FAIRLY AFTER THE POINT OF SALE 7 (2001), *available at* <http://www.fsa.gov.uk/pubs/discussion/dp7.pdf>; Clive Briault, Managing Dir. Retail Markets, Fin. Servs. Auth., Treating Customers Fairly: Progress and Future Plans at the FSA Treating Customers Fairly Conference (Oct. 4, 2005) (transcript *available at* <http://www.fsa.gov.uk/library/communication/speeches/2005>).

⁸ See *infra* pp. 8–12 (discussing the nature of TCF).

inadequate provision of information to customers. There were also problems with the resolution of disputes, the taking of disciplinary action, and delays in the provision of financial redress. For example, it was not until the second half of 2011 that large-scale redress of past misselling began. Things do not seem to have improved.⁹ In July 2014, a new set of complaints about “another PPI scandal” hit the news this time challenging the capabilities of the new regulator – the Financial Conduct Authority – to do a better job than its predecessor.¹⁰ As it transpired, more than 60,000 small businesses were missold fixed-rate business loans to protect them against interest rate changes without being informed that a swap was added to the transaction or that the swap could possibly have the reverse effect.¹¹

These introductory remarks give rise to the following question: Why is TCF failing to deliver? In this Article, I will attempt to offer an answer to this question. I will start with a brief account of the legal underpinnings and the nature of the TCF. Against this background, I will try to demonstrate that the shortcomings of this approach may be attributed to a combination of the following three factors: (a) the rulification of TCF namely a regulatory strategy that was originally conceived as informal, flexible, and responsive in nature; (b) certain flaws in the data resource management that is currently in place to facilitate the electronic reporting of PPI related data and other conduct of business and consumer protection issues; and (c) the absence of a system of credible deterrence to back up proactive intervention that aims to inflict cultural change and to attune business ethics with the delivery of public policy objectives – here, that of fair treatment for customers.

These parameters do not exhaustively account for all of those market, institutional, legal, behavioural, and cognitive conditions that inhibit the effective implementation of TCF. Poor standard setting, capture, creative compliance, the implementation of a regime of corporate governance regulation that falls short of providing rewards for the delivery of good quality of services to retail financial customers, and the level and nature of competition in the relevant industry are only some of a plethora of other considerations that could be enlisted as factors that circumscribe the effectiveness of TCF. However, in view of space constraints, the purpose of this Article is not to offer a comprehensive account of all the causes of

⁹ See *infra* pp. 14–24 (examining the main causes).

¹⁰ Adrian Quine, *Banks Face New Mis-selling Scandal*, BBC NEWS (Jul. 3, 2014), <http://www.bbc.co.uk/news/business-28037608>.

¹¹ *Id.*

the TCF failings, but to discuss those of them that, in the opinion of the author, have not received the attention they deserve.

II. THE REGULATION OF PPI: A BRIEF OVERVIEW OF THE LEGAL FRAMEWORK

Pre-crisis, the Financial Services Authority was the single UK mega-regulator with a wide range of powers at its disposal. Consumer protection was one of the four FSA statutory objectives under the Financial Services and Markets Act (“FSMA”) 2000.¹² The other three were market confidence, financial stability, and the reduction of financial crime.¹³ The Financial Services Act 2012 changed this. As of April 2013, the FSA was abolished and replaced by the Financial Conduct Authority (“FCA”) and the Prudential Regulation Authority (“PRA”), the latter being a subsidiary of the Bank of England.¹⁴ The FCA and the PRA are focus-specific with a separate set of statutory objectives to deliver. They are operationally independent and at least on paper of equal institutional standing. The strategic objective of the FCA is to ensure that financial markets function well.¹⁵ To this effect, the FCA is responsible for consumer protection, market integrity, and competition in the interests of consumers.¹⁶ The PRA is the primary micro-prudential regulator and part of its mandate is to offer a helping hand to the Financial Policy Committee of the Bank of England in delivering its financial stability objective.¹⁷

Despite their distinct institutional standing, the statutory objectives of the PRA and the FCA are not exclusive to the regulatory agency that they are attached to. This is particularly evident in relation to the regulation of the insurance sector for the purposes of policyholder

¹² See Financial Services and Markets Act, 2000, c. 8, § 5 (U.K.).

¹³ *Id.* at §§ 1(3), 6, 26(1)(a), 3, 3A, 9 (showing that the fifth objective, “public awareness,” § 4, was eventually omitted by virtue of amendments that were introduced under §§ 2(3) and 26(3) of the Financial Services Act, 2010 (Commencement No. 1 and Transitional Provision) Order 2010, S.I. 2010/2480, 2)).

¹⁴ Andromachi Georgosouli, *The FCA-PRA Coordination Scheme and the Challenge of Policy Coherence*, 8 CAP. MARKETS L.J. 62, 62–65 (2013).

¹⁵ Financial Services Act, 2012, c. 1, § 1B(2) (U.K.) (amending Financial Services and Markets Act 2000).

¹⁶ *Id.* at §§ 1B(2), 1(C), 1D, 1E, 3 (promoting consumer protection, market integrity, and competition).

¹⁷ *Id.* at § 2B (“The PRA’s general objective”).

protection. Granted that policyholders are a sub-group of consumers, one would expect that their protection would fall within the remit of the FCA in view of the FCA's statutory objective of consumer protection. However, the UK legislator opted for a more complex route. The Financial Services Act 2012 entrusts the protection of policyholders to the PRA and not the FCA, presumably to highlight the fact that the protection of this special group of consumers is a matter of prudential regulation calling primarily for solvent and sound insurance firms.¹⁸ Nevertheless, the FCA complements the work of the PRA. The tackling of PPI misselling, in particular, falls within the competence of the FCA, given its primary responsibility on matters of conduct of business, part of which is the fair treatment of customers.

A combination of primary and secondary legislation alongside common law doctrines on contract, agency, and tortious liability comprises the regulation of PPI. Until recently, the regulation of consumer credit fell under the province of the Office of Fair Trading ("OFT") under the Consumer Credit Act ("CCA") 1974.¹⁹ Credit agreements financed PPI premiums under CCA, while the writing and marketing of the policies were regulated under the FSMA, causing unnecessary overlaps and inconsistencies.²⁰ As of April 2014 and in light of amendments to the Financial Services and Markets Act 2000, which were introduced by the Financial Services Act 2012, the FCA is now the regulator of consumer credit, taking over the responsibilities of the OFT and thus bringing consumer credit firms under its consumer and conduct of business mandate.²¹

¹⁸ *Id.* at § 2C ("Insurance objective").

¹⁹ *See* Consumer Credit Act, 1974, c. 39, §§ 1(1), 3 (U.K.).

²⁰ *See* Consumer Credit Act, 2006, c. 37 §§ 9(4), 20(1), 60, 61, 54 (U.K.). *See generally* Consumer Credit (Total Charge for Credit), 2010, S.I. 2010/1011, 4 (U.K.) (TCC Regulations); Consumer Credit (Agreements), 2010, S.I. 2010/1014 (U.K.); Financial Service Act (Consumer Credit), 2013, Stat. R. & O. 2013/1882 (U.K.) (transferring regulatory powers from the Office of Fair Trading to the Financial Conduct Authority, which became responsible for consumer credit as of April 2014); *see also* Eva Lomnicka, *The Future on Consumer Credit Regulation: A Chance to Rationale Sanctions for Breaches of Financial Services Regulatory Regimes*, 34 COMPANY LAW., 13, 13 (2013) (documenting the problems with the previous regime).

²¹ FIN. CONDUCT AUTH., CONSUMER CREDIT SOURCEBOOK (2014), *available at* <http://fshandbook.info/FS/html/FCA/CONC> (setting out the main rules for those firms providing consumer credit).

Not unlike the FSA, the FCA has a wide range of disciplinary and enforcement powers at its disposal.²² Some of them are discussed in further detail later.²³ For the time being and as a general remark, it is important to note that the FCA has, *inter alia*, the power to (a) impose administrative fines, (b) withdraw authorisation and permissions, (c) apply for injunctions and restitution orders, and (d) prosecute certain criminal offences.²⁴ Of particular relevance to the tackling of PPI misselling is new section 138D (former section 150) establishing a civil law remedy for the aggrieved party to seek compensation,²⁵ sections 225 to 233 setting out the role of the Financial Ombudsman Service (“FOS”) in handling consumer complaints and in granting compensation where appropriate, and section 404 on consumer redress schemes.²⁶ To ensure that the regulator’s disciplinary action will be visible enough to have an impact on the conduct of market actors, new section 391 (1ZB) also enables the FCA to publish information about warning notices in certain cases.²⁷ On paper, this looks like a significant departure from the previous regime, under which the earliest that the FSA could publish details of a disciplinary matter was when it issued a final notice at the conclusion of a case (e.g., after the Tribunal had reached a decision). In reality, the effect of this amendment must not be blown out of proportion. A careful reading of the relevant provision reveals that the regulator must, *inter alia*, consult with the person to whom the notice is given. In addition, the FCA’s power to publish information

²² See Financial Services and Markets Act, 2000, Part XI (amended 2012) (U.K.), for the disciplinary powers of the FCA. See *id.* at Part XIV for the powers of FCA to gather information and conduct investigation.

²³ See *infra* note 30 and accompanying text.

²⁴ See FIN. CONDUCT AUTH., ENFORCEMENT INFORMATION GUIDE (2013), available at <http://www.fca.org.uk/your-fca/documents/enforcement-information-guide>.

²⁵ Only “private persons” are eligible to make use of this statutory civil law remedy. See Financial Services and Markets Act 2000 (Rights of Actions), 2001, S.I. 2001/544 (U.K.); *Titan Steel Wheels Ltd. v. The Royal Bank of Scot. PLC*, [2010] EWHC (Comm) 211, [76] (Eng.) (finding a corporation did not qualify to bring an action under § 150 of the FSMA because it was acting in the course of business); *Figurasin v. Cent. Capital Ltd.*, [2014] EWCA (Civ) 504 (Eng.).

²⁶ These are to be read in conjunction with the Consumer Redress Schemes Sourcebook (CONRED) of the FCA Handbook. See generally FIN. CONDUCT AUTH., CONSUMER REDRESS SCHEME SOURCEBOOK (CONRED) (2014), available at <http://fshandbook.info/FS/html/FCA/CONRED>.

²⁷ See Financial Services Act, 2012, c. 21, § 37 (U.K.).

about warning notices is restricted by virtue of section 391(6), which prohibits the FCA from publishing information when the publication would be (a) unfair to the person against whom that action was proposed to be taken; (b) prejudicial to the interests of consumers; or (c) detrimental to the stability of the UK financial system.

Secondary legislation adds a further layer of detail with regard to the conduct of business in the retail financial sector and the procedural aspects of supervision, compliance, and enforcement.²⁸ Of particular relevance here is the Insurance Conduct of Business Sourcebook (“ICOBS”). This constitutes a more concrete statement of the FCA Principles for Businesses and comprises the main body of rules and guidance that underpins the conduct of business of insurance services providers.²⁹ Alongside general and transitional provisions, the ICOBS sets out, *inter alia*, the details regarding the identification of, and provision of advice to, clients (chapter 5), product information, including PPI requirements (chapter 6), cancellation rights (chapter 7), and claims handling (chapter 8). Further, and with respect to the selling of PPI, firms are under the legal obligation to establish the eligibility of the customer in question (ICOBS, 5.1.2R) and to bring to the customer’s attention the importance of reading the policy contract documentations prior to the expiry of the period of cancellation (ICOBS, 6.4.5R).³⁰ Finally, the FCA Handbook contains a comprehensive set of rules and guidance on dispute resolution and complaints handling, including the handling of PPI complaints.³¹

III. THE NATURE OF TCF AND THE GROUNDS THAT INFORMED ITS IMPLEMENTATION

Under Principle 6 (customers’ interests) of the FCA Principles for Businesses, “a firm must pay due regard to the interests of its customers

²⁸ See FIN. CONDUCT AUTH., INSURANCE: CONDUCT OF BUSINESS SOURCEBOOK ch. 5–6 (2014), *available at* <http://media.fshandbook.info/content/full/ICOBS.pdf>.

²⁹ The Principles for Businesses are set out in PRIN 2.1.1 and they are identical to the FSA High Level Principles for Business. FIN. CONDUCT AUTH., PRINCIPLES OF BUSINESS § 2.1.1 (2014), *available at* <http://fshandbook.info/FS/html/FCA/PRIN/2/1.pdf>.

³⁰ FIN. CONDUCT AUTH., *supra* note 28, ch. 5–8.

³¹ FIN. CONDUCT AUTH., DISPUTE RESOLUTION: COMPLAINTS §§ 1.3, 3, app. 3 (2014), *available at* <http://fshandbook.info/FS/html/FCA/DISP>.

and treat them fairly.” In pursuance of this Principle, TCF asks the industry to work out for itself what practices guarantee fair treatment for clients in a manner that is attuned to the policy goals and priorities of the regulator. These goals are encapsulated in the following six TCF outcomes:³²

“Outcome 1: Consumers can be confident that they are dealing with firms where the fair treatment of customers is central to the corporate culture.

Outcome 2: Products and services marketed and sold in the retail market are designed to meet the needs of identified consumer groups and are targeted accordingly.

Outcome 3: Consumers are provided with clear information and are kept appropriately informed before, during, and after the point of sale.

Outcome 4: Where consumers receive advice, the advice is suitable and takes account of their circumstances.

Outcome 5: Consumers are provided with products that perform as firms have led them to expect, and the associated service is of an acceptable standard.

Outcome 6: Consumers do not face unreasonable post-sale barriers imposed by firms to change product, switch provider, submit a claim, or make a complaint.”

TCF is not a new set of secondary legislation. It is a guidance that reflects key elements of the UK regulator’s strategy in the retail financial sector. The outcomes that firms are expected to deliver are communicated through informal means as, for example, Policy Statements (“PS”) and “Dear CEO Letters.” From this, however, it does not follow that this otherwise informal guidance has no bearing on the taking of enforcement action.³³ Indeed, the six TCF outcomes enlisted above do not stand in isolation from the FCA Handbook, despite the fact that strictly speaking they do not form part of secondary legislation.³⁴ For all intended purposes,

³² See FIN. SERVS. AUTH., *TREATING CUSTOMERS FAIRLY – A GUIDE TO MANAGEMENT INFORMATION* (2007), available at <http://www.fca.org.uk/firms/being-regulated/meeting-your-obligations/fair-treatment-of-customers.pdf>.

³³ Ferran, *supra* note 6, at 259 (characterizing the TCF outcomes as “non-binding guidance”).

³⁴ John Tiner, Address at the Ins. Sector Conference (Sept. 21, 2006), available at http://www.fsa.gov.uk/pages/Library/Communication/Speeches/2006/0320_jt.shtml.

they echo the FCA Principles for Businesses.³⁵ Further, they are linked to a range of other Handbook provisions in the sense that they constitute a set of more concrete benchmarks against which compliance is to be assessed.

Arguably, TCF can be described as a management-based approach to regulation.³⁶ It combines elements of performance-based and process-oriented strategies whereby the focus is on processes, systems and controls, internal management, and the monitoring of performance in delivering tangible outcomes pertaining to the fair treatment of customers. Quite often, the management-based, performance-based, and process-oriented approaches to regulation are used interchangeably in the literature, but for systematic purposes, it is important to highlight some key differences. In the case of management-based regimes, firms are expected to develop plans and monitoring systems for the delivery of certain public policy objectives. Accordingly, compliance is assessed in terms of whether the implemented systems and controls are fit for purpose. Process-oriented regulation focuses on the firms' engagement in a process of comprehensive self-evaluation, design, and management of their business. Finally, performance-based regulation constitutes an extension of principles-based regulation in the sense that it focuses on the attainment of outcomes, leaving the regulated population to decide how best these can be achieved.

Similar to the approach that was adopted by its predecessor, the FCA's intervention takes the form of a combination of proactive and reactive measures. The purpose of proactive measures is to mitigate the risk that the customers of a specific firm will not be treated fairly. Reactive intervention typically takes the form of disciplinary and enforcement action, the aim of which is primarily to provide some sort of redress to the aggrieved party and to deter future misconduct. Over the years, there has been a clear preference for proactive intervention and industry engagement (e.g. through road shows, working with the industry, mystery shopping, etc.), while enforcement has been generally regarded as a measure of last resort.

³⁵ These were formerly labelled as the FSA High-Level Principles of Business. FIN. CONDUCT AUTH., *supra* note 29.

³⁶ See Andromachi Georgosouli, *The FSA's Treating Customers Fairly (TCF) Initiative: What is so Good About it and Why it May Not Work*, 38 J.L.S. 405, 410 (2011); Cary Coglianese & David Laser, *Management-Based Regulation: Prescribing Private Management to Achieve Public Goals*, 37 LAW & SOC'Y REV. 691, 693–694 (2003) (considering the distinction between management-based, process-oriented and performance-based approaches).

Specifically, in pursuing its proactive intervention agenda, the UK regulator has the power to take a range of intrusive measures with respect to issues such as the allocation of resources and competences, the nature of staff training, and the kind of remedial action that may be deemed necessary in the event of a customer complaint. Moreover, the regulator has a comprehensive toolkit to attune business culture and patterns of self-governance to match TCF targets.³⁷ For example, the “product life-cycle” is a regulatory device that guides firms in their attempt to align their TCF strategy with the priorities and the expectations of the FCA from the early stages of planning and production through to after-sale services. Other regulatory measures that work in a similar fashion include the FCA’s Culture framework, which intends to help firms build TCF into their culture, and Management Information (“MI”), the purpose of which is to make it easier for senior managers to keep things in perspective when managing data, while making it possible for the FCA to get a more accurate view of the firms’ capacity to deliver TCF outcomes.³⁸

The regulator’s reactive intervention essentially reflects its strategy of compliance and enforcement. The case of Alliance & Leicester (“A&L”) is a classic example not least because it set the tone of the regulator’s policy of compliance and enforcement that is still implemented today.³⁹ A&L was ordered to pay the biggest fine for serious failings in the selling of PPI pre-crisis.⁴⁰ However, A&L also agreed to implement a customer contract programme overseen by third-party accountants. Under

³⁷ *Alliance and Leicester to Pay £7 million Fines for PPI Failings*, FIN. SERVS. AUTH. (Oct. 7, 2008), available at <http://www.fsa.gov.uk/library/communication/pr/2008/115.shtml>; Georgosouli, *supra* note 33, at 415–16.

³⁸ *TCF Culture*, FIN. CONDUCT AUTH. (Apr. 5, 2013), <http://www.fca.org.uk/firms/being-regulated/meeting-your-obligations/fair-treatment-of-customers/Culture>; FIN. SERVS. AUTH., *TREATING CUSTOMERS FAIRLY – TOWARDS FAIR OUTCOMES FOR CONSUMERS* (2006), available at <http://www.fca.org.uk/static/fca/documents/fsa-tcf-towards.pdf>.

³⁹ Georgosouli, *supra* note 36, at 416.

⁴⁰ A&L was fined £7,000,000. Post crisis, financial firms were made to pay much higher fines. See Press Release, Fin. Cond. Auth., FCA Fines Lloyds Banking Group First a Total of £28,038,800 for Serious Sales Incentive Failings (Nov. 12, 2013), available at <http://www.fca.org.uk/news/press-releases/fca-fines-lloyds-banking-group-firms-for-serious-sales-incentive-failings>; Final Notice from Fin. Conduct Auth. to Lloyds TSB Bank plc and Bank of Scotland plc (Dec. 10, 2013), available at <http://www.fca.org.uk/your-fca/documents/final-notices/2013/lloyds-tsb-bank-and-bank-of-scotland>.

this programme, A&L undertook, amongst other things, to contact all customers that purchased PPI in conjunction with an unsecured loan, to review its policy in respect of product information that was sent to these customers, to review any rejected complaints and claims, and to pay redress where appropriate. A&L demonstrates that, at least in theory, the regulator's enforcement strategy goes beyond penalizing unacceptable forms of business conduct. The offender's failure to comply with TCF is seen as an opportunity for the offender to reflect on what went wrong and make things right by taking remedial action, revising processes, practices, and ultimately its corporate culture.⁴¹ This approach survived the upheaval of regulatory reform in the aftermath of the recent financial crisis and it is now crystallised in various dispute resolution provisions of the FCA Handbook. Accordingly, it remains a key element of the regulator's strategy.⁴²

⁴¹ See Howard Becker, *Culture: A Sociological View*, 71 YALE REV. 513 (1982) (describing culture as shared understandings that permit a group of people to act in concert with each other); Roger Cotterrell, *Law and Culture – Inside and Beyond the National State*, 31 NORDIC J.L. & JUST. 23, 23–36 (2008) (Nor.) (identifying four cultural components namely 'beliefs/values', 'traditions', 'instrumental matters' (economic, technological) and 'matters of effect' (emotions)); Justin O'Brien et al., *Culture and the Future of Financial Regulation: How to Embed Restraint in the Interests of Systemic Stability*, 8 L. & FIN. MARKETS REV. 115, 126 (2014) (identifying five sources of cultures); Jasper Sorensen, *The Strength of Corporate Culture and Reliability of Firm Performance*, 47 ADMIN. SCI. Q. 70, 72 (2002) (offering a narrow definition of culture as a system of shared values).

⁴² FIN. CONDUCT AUTH., *supra* note 31, at 2, 4 (2014) (reflecting the recommendations made by the FSA in FIN. SERVS. AUTH., THE ASSESSMENT AND REDRESS OF PAYMENT PROTECTION INSURANCE COMPLAINTS (2009)); FIN. SERVS. AUTH., THE ASSESSMENT AND REDRESS OF PAYMENT PROTECTION INSURANCE COMPLAINTS §§ 3.26, 4.7 (2009), available at http://www.fsa.gov.uk/pubs/cp/cp09_23.pdf (recommending firms to proactively reassess all complaints and consider whether a wider redress programme would be appropriate, namely one which would include the proactive redress of PPI customers who have not complained); H. Osborne, *PPI Mis-Selling: Banks to Write to up to 12 Million Customers*, GUARDIAN (March 6, 2012), <http://www.theguardian.com/money/2012/mar/06/ppi-misselling-banks-write-customers>.

In implementing the TCF agenda, the FCA is further assisted by the Financial Ombudsman Service (“FOS”).⁴³ Although it is not the purpose of this Article to examine the powers and role of the FOS as a guardian of best practice in the retail financial sector, it is important to note that its involvement goes beyond dispute resolution and consumer redress. FOS decisions are instrumental in the cultivation of a common understanding of what TCF entails in practice. They inform the interpretation of TCF requirements and, in the long run, they provide guidance on the expected level of performance in delivering fair treatment to customers.

Several considerations informed the decision of the UK regulator to implement TCF.⁴⁴ As with any other typical scheme of management-based regulation, TCF embraces self-regulation. This makes it morally appealing because it subscribes to a vision of the regulatory community, the members of which are assumed to be capable of working out for themselves the public standards that ought to govern their relationships. Self-regulation also tends to create a sense of legitimacy, as it bears out standards of conduct that are made by the industry and for the industry, albeit under the watchful eye and quasi-approval of the regulator.

The management-based and performance-oriented elements in TCF also have the potential to tackle a series of persistent problems that are associated with the old-school ‘command and control’ regulation. Examples include those of creative compliance, the cost of rulemaking and enforcement, lack of flexibility, and problems of over and under inclusiveness.⁴⁵ As the argument goes, the articulation of a specific set of outcomes helps firms concentrate on what matters, namely performance in delivering certain goals rather than sticking to the letter of the law. The informal means of communicating the regulator’s TCF expectations are

⁴³ In the past, FOS alerted the UK regulator about emerging trends concerning poor standards of conduct of business practices and the case for regulatory action. See FIN. CONDUCT AUTH., COMPLAINT HANDLING PROCEDURES OF THE FINANCIAL OMBUDSMAN SERVICE (2014), available at <http://fshandbook.info/FS/html/FCA/DISP/3>.

⁴⁴ See Georgosouli, *supra* note 36, at 417–420, for a more detailed discussion.

⁴⁵ On the limitations of rules as instruments of social organisation and control see generally JULIA BLACK, RULES AND REGULATORS ch. 1 (1997); Colin Diver, *The Optimal Precision of Administrative Rules*, 93 YALE L.J. 65 (1983) (approaching the matter from a law and economics perspective); Doug McBarnet & Christopher Whelan, *The Elusive Spirit of the Law: Formalism and the Struggle for Legal Control*, 54 M.L.R. 848 (1991).

also thought to be more flexible and less time consuming. Moreover, they arguably place the regulator in a better position to obtain crucial and timely information that is essential for the formation of judgments with respect to compliance, the expediency of enforcement action, and even the case for reform.

TCF also affords a more participatory and discursive approach to regulation. The latter carries with it the promise of being more effective in aligning the industry's perceptions with the goals and views of the regulator.⁴⁶ As the argument goes, long-term cultural change is more likely to happen with industry engagement, not least because in this manner, the regulatees are expected to become more cognizant of their responsibilities in delivering TCF outcomes and also more sophisticated in sensing what TCF requires even in the presence of new or unforeseen circumstances. Moreover, regulatees who are given the chance to decide how best to proceed in their attempt to incorporate TCF into their business culture are more likely to view it as reasonable and thus worthy of compliance. Finally, by granting firms the flexibility to develop their own strategies, TCF enables firms to experiment and seek out better and more innovative solutions.

Finally, there are several advantages to note in relation to the FCA's policy of reactive intervention in the context of the TCF initiative. The desirability of enforcement action is assessed in light of its likely impact on the industry's capacity to develop patterns of self-regulation. It is forward-looking in the sense that it aims to educate the regulated industry and to encourage a change of culture.⁴⁷ Being partly premised on negotiation, the enforcement procedure itself creates opportunities for the alleged offender to deliberate with the regulator, become cognizant of its failure to comply, remedy any wrongdoing, and revise its business practice where appropriate.

⁴⁶ See Black, *supra* note 45, at 37–44, for a classic exposition of the nature of conversational regulation. See also Andromachi Georgosouli, *Regulatory Interpretation: Conversational or Constructive?*, 30 O.J.L.S. 361, 361–84 (2010), for a critical evaluation of the view of regulation as conversational.

⁴⁷ See Sorensen, *supra* note 41, at 15.

IV. TRACING THE CAUSES OF THE TCF FAILURE TO DETER PPI MIS-SELLING

A. THE RULIFICATION OF TCF

In its original inception, TCF departs from the traditional rulebook approach. It seems to be based on the belief that, in the absence of rules, problems like, for example, that of legal uncertainty – vanish automatically. However, the reality is different. Legal certainty may no longer be a function of the design of rules, but it is certainly contingent to the informal means through which regulatory expectations are communicated. Judging from past experience, the text of these informal means of communication is no less authoritative than the content of the FCA Handbook. In the case of TCF, informal communication failed to convey with clarity the regulator's expectations.⁴⁸

One would expect that the informal and flexible nature of TCF would compensate for the perceived legal uncertainty surrounding its implementation, but this is not what happened. By and large, firms have been reluctant to take initiative and exercise the level of discretion that was delegated to them. They preferred more detailed regulatory guidance. Conversely, when they did exercise discretion, the outcomes were not to the regulator's satisfaction. In view of this, TCF soon evolved into a rulified regime.⁴⁹ The response of the UK regulator was a conspicuous proliferation of detailed and legally binding rules and guidance. In 2007, in particular, and after repeated failings to combat misconduct, the UK regulator introduced more detailed ICOBS rules⁵⁰ in the name of clarity and certainty.⁵¹ At the same time though, it continued to communicate its expectations regarding TCF through informal guidance.

Indeed, the UK regulator did not give up the idea of self-regulation as the main conduit of change in the business culture of retail firms. In this spirit, it reassured the industry that the changes in the ICOBS did not amount to a 'command and control' approach and that informal communications and non-legally binding guidance would continue to be

⁴⁸ See FIN. SERVS. AUTH., *supra* note 32.

⁴⁹ See Frederick Schauer, *The Tyranny of Choice and the Rulification of Standards*, 14 J. CONTEMP. LEGAL ISSUES 803 (2004), for a general discussion.

⁵⁰ See *supra* pp. 7-8 (discussing new ICOB rules).

⁵¹ See *infra* pp. 20-24 where formal enforcement is discussed in the context of credible deterrence.

relied upon. This was thought appropriate to allow for a degree of flexibility that would make possible for firms to develop patterns of self-regulation, however, legal uncertainty remained an issue.⁵² So did the firms' reluctance to commit to the ideal of self-regulation.⁵³

B. TCF AND THE CRUCIAL ROLE OF 'BIG DATA'

The implementation of TCF requires increasing capacity to collect and process data, as, for example, for the purposes of managing emerging risks as a preventive measure, or for the purposes of effective enforcement. The UK regulator recommends the Management Information ("MI") framework as a tool for the management and processing of data.⁵⁴ Essentially, MI standardises the process of collecting information during a period of business activity with respect to key issues that are of relevance to TCF. It makes it easier for managers to put information in perspective and align it with the regulator's expectations. Furthermore, the data collected serves as evidence of the firm's capacity to meet performance targets.

The data that is produced and accumulated at the level of each regulated firm is then fed into the regulatory system via GABRIEL (Gathering Better Regulatory Information Electronically).⁵⁵ The latter is an online reporting platform for the collection, validation and storage of data. The nature of the data that a firm is expected to report to the FCA via GABRIEL varies. In any case, it depends on the regulated activities that the firm undertakes and the prudential category into which the firm is classified. GABRIEL makes a special reporting provision for PPI related data. This signifies the importance of data collection and processing as a necessary precondition for the timely identification of TCF-related risks and, where appropriate, for the taking of disciplinary action.

Although, both the MI and the special PPI reporting through GABRIEL are welcome developments, they are subject to limitations. There is no doubt that MI makes it easier for firms to deal with a tangible problem, that of information management and the associated cost of

⁵² See Andromachi Georgosouli, *Judgment-led Regulation: Reflections on Data and Discretion*, 14 J.B.R. 209, 210 (2013).

⁵³ See *infra* p. 24.

⁵⁴ The FSA introduced the MI framework. FIN. SERVS AUTH., *supra* note 32, 4.

⁵⁵ See generally GABRIEL, FIN. CONDUCT AUTH. (Aug. 26, 2014), <http://www.fca.org.uk/firms/systems-reporting/gabriel>.

processing an ever-growing volume of information.⁵⁶ However, this is as far as it goes. MI cannot guarantee the reliability of the data that is made available to the regulator. The data that is eventually channelled through the regulator's system of decision-making is as good as the data produced at regulated firm level.

As we learn from empirical studies on the use of big data by the medical professions in the US, there are several pitfalls and shortcomings in the process of electronic reporting.⁵⁷ Apart from errors due to software failures, problems may occur as a result of typing quickly, ticking the wrong boxes, or copying and pasting out-dated or otherwise wrong information.⁵⁸ To the extent that the reporting forms allow for the addition of free text, contradictions may also occur between the content of the free text and the content of the standard text. There is no reason to think that the electronic reporting systems that are currently deployed by the industry and the FCA are immune from shortcomings like those reported in the medical profession.

The accumulated data is the product of self-assessment exercises, which are riddled with human bias. For example, firm employees are unlikely to disclose non-favourable information, especially when there is a little chance that the regulator will ever find out about this.⁵⁹ Similarly, they are unlikely to pass on information that is harmful to them or their fellows. Human judgement is also subject to "automation" bias namely the tendency to disregard information which contradicts information that is generally accepted as correct.⁶⁰ Last but not least, the reward and incentive structure

⁵⁶ See, however, PRICEWATERHOUSECOOPERS, INTELLIGENT MANAGEMENT AND COMPLIANCE COST REDUCTION 10–12 (2008) (demonstrating that management-based regulation is expensive in its implementation).

⁵⁷ See, e.g., Sharona Hoffman & Andy Podgorski, *The Use of Biomedical Data: Is Bigger Really Better?* 39 AM. J.L. & MED. 497, 499–502 (2013). Nevertheless, the authors point out that digitalization can prevent some data quality problems, such as those associated with illegible handwriting.

⁵⁸ *Id.* at 515–16, 519–20.

⁵⁹ See John C. Coffee Jr., *Beyond the Shut-Eyed Sentry: Toward a Theoretical View of Corporate Misconduct and an Effective Legal Response*, 63 VA. L. REV. 1099, 1146, 1242 (1977).

⁶⁰ See generally Steven T. Schwarcz & David E. Wallin, *Behavioural Implications of Information Systems on Disclosure Fraud*, 14 BEHAV. RES. IN ACCT. 197 (2002) (arguing that the use of computer data increases the likelihood of this pattern of behaviour).

of firms gives rise to another type of bias namely, the “self-serving bias”.⁶¹ This describes the tendency to interpret ambiguous information in a manner that is favourable to one’s self.

The quality of information may be further compromised due to certain structural features of the electronic reporting system – most notably that of data fragmentation. In the case under examination, it is interesting to note, for example, that the special PPI reporting requirement applies only to those firms that have been asked to provide monthly data on specific PPI management information.⁶² The rest must follow the usual path and submit electronically information that is classified as data pertaining to product sales, complaints handling, etc. This differential treatment that is reflected in terms of ‘who’ is to submit PPI-related data makes sense especially when seeing through the lens of risk-based regulation, according to which resources should be directed in priority to the monitoring of those firms that pose a higher risk to the delivery of TCF outcomes. However, this approach can be problematic.

Data that is submitted for the purposes of reporting on product sales and complaints handling can also be PPI-sensitive despite the fact that it is not earmarked as such at the time of its submission to GABRIEL. Accordingly, a danger here is that its PPI-relevance will escape the regulator’s attention. There is an additional issue of concern here. Due to its structural features, GABRIEL is bound to produce more data for those firms that are already put under the spotlight because they present a higher risk of failure to meet TCF targets. Conversely, GABRIEL is expected to produce less data for the purposes of proactive intervention and in particular with respect to lower risk retail financial services providers whose business culture may nevertheless call for attention as it may not be compatible with TCF goals in the long run. The suboptimal production of data for the purposes of proactive intervention is not a trivial matter. It is liable to undermine the regulator’s attempt to map out the prevailing business culture of the firm in question accurately and to decide appropriate course of action in a timely fashion.

⁶¹ See generally Jeffrey Rachlinski, *The Uncertain Psychological Case for Paternalism*, 97 NW. U. L. REV. 1165, 1172–73 (2003) (offering a classification of various types of self-serving bias).

⁶² FIN. CONDUCT AUTH., PAYMENT PROTECTION INSURANCE (PPI) REPORTING FORM (2014), available at <http://www.fca.org.uk/firms/systems-reporting/ppi-reporting-forms>.

The UK regulator has not done enough to put in place interoperable data systems and take steps to ensure that collected data is integrated into a single data. This could ameliorate the difficulties that are associated with data fragmentation.⁶³ For example, the so-called Integrated Regulatory Reporting (“IRR”) does not serve as a universally integrated system of data resource management.⁶⁴ It does harmonize inconsistent reporting formats, but its scope of application is very limited. On the one hand, it is calibrated to comply with the transparency requirements of the Capital Requirements Directive (“CRD”) and the Markets in Financial Instruments Directive (“MiFID”).⁶⁵ On the other hand, it applies to a very specific group of regulated firms, namely investment management firms, securities and futures firms, and firms that enter into regulated mortgage contracts or administer regulated mortgage contracts.⁶⁶

The problem of data fragmentation is further exacerbated by the fact that the FCA and the PRA collect data separately.⁶⁷ Although the two regulators are expected to share information along the lines of a Memorandum of Understanding, delays and turf wars cannot be precluded over sensitive information.⁶⁸ Furthermore, the two regulators may not necessarily share the same view when they assess whether a piece of information should be brought to the attention of the other regulator in the first place or as a matter of priority.

⁶³ See generally Hoffman & Podgorski, *supra* note 57, at 517–518 (discussing the harms and causes of incomplete or fragmented data).

⁶⁴ FIN. CONDUCT AUTH., FCA-PRA COMBINED HANDBOOK § 16.12 (2014), available at <http://fshandbook.info/FS/html/handbook/SUP/16/12> (making IRR mandatory); see also CPAAUDIT LLP, GUIDE TO INTEGRATED REGULATORY REPORTING (RII) AND MANDATORY ELECTRONIC REPORTING (MER) FOR INVESTMENT FIRMS (2008), available at <http://www.cpaaudit.co.uk/pdfs/IRRandMERGuide.pdf>.

⁶⁵ See Rebecca Atkinson, *FSA Issues Integrated Regulatory Reporting Paper*, MORTGAGE STRATEGY (June 1, 2006), <http://www.mortgagestrategy.co.uk/isa-issues-integrated-regulatory-reporting-paper/123106.article>.

⁶⁶ See CPA AUDIT LLP, *supra* note 64, at 1.

⁶⁷ HM TREASURY, MEMORANDUM OF UNDERSTANDING (MOU): BETWEEN THE FINANCIAL CONDUCT AUTHORITY (FCA) AND THE PRUDENTIAL REGULATION AUTHORITY (PRA) (Apr. 22, 2013), available at <https://www.gov.uk/government/publications/memorandum-of-understanding-between-the-financial-conduct-authority-and-the-bank-of-england-including-the-prudential-regulation-authority>.

⁶⁸ See generally Georgosouli, *supra* note 14, 63–66, for a critical evaluation of the FCA and PRA coordination arrangements under the Financial Services Act 2012.

An integral aspect of the creation of computer software is the reduction of regulatory commands into code. The latter poses a range of challenges. The code is bound to reflect the professional programmers' beliefs about how TCF should be interpreted in practice. When these beliefs are not consistent with those of the regulator, there is a risk that firms end up using computer software (e.g. computer software that supports a firm's system of data resource management pertaining to TCF) whose code encapsulates an understanding of TCF that may actually be words apart from that which was originally envisaged by the regulator. As a result of this incompatibility, important risks are unlikely to be detected or indeed properly identified and responded to.

In view of this problem, one would expect that at least some form of quasi-monitoring be in place at the production stage of computer software so that a minimum calibration and compatibility is secured. This would also keep at bay several inconsistencies and unnecessary discrepancies in the design of the code, however, at the moment, the FCA goes as far as to provide a list of Independent Software Vendors ("ISVs") for the purpose of assisting the industry in finding software suppliers. Moreover, and in order to avoid any misconception to the contrary, this list is followed with a disclaimer that the "FCA does not endorse or recommend any ISV listed."⁶⁹

C. TCF AND THE DESIDERATUM OF CREDIBLE DETERRENCE

Credible deterrence requires enforcement action that is visible enough so that wrongdoers realise that they face a real risk of being held accountable and of bearing the tangible consequences of disciplinary action.⁷⁰ The UK regulator did not always give emphasis to formal enforcement as a tool for credible deterrence.⁷¹

Pre-crisis, the motto was "prevention is better than cure." Initially, the FSA relied on a combination of principles and rules in order to regulate

⁶⁹ *Independent Software Vendors*, FIN. SERVS. AUTH. (Jul. 11, 2014), <http://www.fca.org.uk/firms/systems-reporting/gabriel/tech-publications/list-of-isvs>.

⁷⁰ Howard Rockness & Joanne Rockness, *Legislated Ethics: from Enron to Sarbanes-Oxley, the Impact of Corporate America*, 57 J. BUS. ETHICS 21, 50–51 (2005) (highlighting the need for meaningful sanctions and fines that exceed gains).

⁷¹ Ferran, *supra* note 6, at 260–61.

the sale of PPI ranging from the Eleven High Level Principles for Business (“PRIN”) to rules on systems and controls (“SYSC”), training and competence (“TC”), and rules on how to handle customer complaints (“DISP”). Eventually, these were further supplemented by a more detailed version of the ICOBS. The legal enforcement of these rules was not at the top of the priorities of the UK regulator. The emphasis was on persuasion and the industry was expected to voluntarily adhere to Handbook provisions. The industry’s enrolment was viewed as key to proactive regulation and self-regulation was relied upon as the main conduit of cultural change. The fact that the FSA’s policy of deterrence was not enforcement-led does not mean that enforcement was missing. Even in the early years, enforcement –for example, through the imposition of administrative fines- had a role to play in sending the message that non-compliance would not be tolerated, but it was clearly employed as a last resort.⁷²

Post-crisis, and after an increasing number of instances of financial misselling, the FSA became concerned that its enforcement strategy was neither preventive nor visible enough to change industry attitudes.⁷³ The probability of enforcement was not considered a credible threat as much as a consideration that it would make firms think twice before breaking the rules.⁷⁴ Scepticism also started to grow about the extent to which it is

⁷² See generally Margaret Cole, Dir. of Enforcement, Fin. Servs. Auth., Annual Financial Crimes Conference: Delivering Credible Deterrence (Apr. 27, 2009), available at http://www.fsa.gov.uk/pages/Library/Communication/Speeches/2009/0427_mc.shtml; Margaret Cole, Dir. of Enforcement, Fin. Servs. Auth., Enforcement Law Conference: How Enforcement Makes a Difference (June 18, 2008), available at http://www.fsa.gov.uk/pages/Library/Communication/Speeches/2008/0618_mc.shtml.

⁷³ See Letter from Andrew Tyrie, Member of Parliament, U.K., to Fin. Ombudsman Serv. (Dec. 19, 2012), available at http://www.parliament.uk/documents/commons-committees/treasury/121_219-FOS-PPI-capacity-planning.pdf; see also NICK WAUGH & CHRISTIE SILK, THE COST OF REDRESS: THE LESSONS TO BE LEARNED FROM THE PPI MIS-SELLING SCANDAL 8 (2014), available at http://www.citizensadvice.org.uk/index/policy/policy_publications/er_consumertravelandtransport/the_cost_of_redress.htm.

⁷⁴ See Tracey McDermott, Dir. of Enforcement & Fin. Crime, Fin. Conduct Auth., Enforcement and Credible Deterrence in the FCA, Address at the Thompson Reuters Compliance and Risk Summit, at 3–5, 7–8 (clarifying that the regulator’s role is to test and challenge assertions about what the culture of an institution is)

feasible to attune business culture to the delivery of public policy goals and to foster patterns of self-governance in an industry that was demonstrably hostile to self-regulation. In view of this, the FSA introduced a new strategy. This made its first appearance in the FSA 2007/8 Annual Report and was labelled “credible deterrence” to mark a toughening up of the regulator’s enforcement action.⁷⁵

The FCA continues this approach, but also enjoys more powers to become a credible enforcer of TCF.⁷⁶ As pointed out above, the parent legislation now entrusts the FCA with enhanced powers to use transparency as an enforcement tool in the sense that it is now possible for the regulator to publish information about a disciplinary action at an earlier stage than in the past provided that certain conditions are met.⁷⁷ Product intervention is another key element of the new strategy. At least on paper the FCA has more interventionist powers at its disposal under new sections 137C to 137D and 137M to 137N of the FSMA 2000 as recently amended by the FSA 2012.⁷⁸ These are further complemented by new sections 137P to 137Q, which set out more powers to intervene in respect of financial promotions.⁷⁹

(June 18, 2013) (transcript available at <http://www.fca.org.uk/static/documents/enforcement-credible-deterrence-speech.pdf>).

⁷⁵ FIN. SERVS. AUTH., ANNUAL REPORT, 2007-8, H.C., at 6 (U.K.).

⁷⁶ FIN. SERVS. AUTH., THE FINANCIAL CONDUCT AUTHORITY: APPROACH TO REGULATION 25 (2011).

⁷⁷ Financial Services and Markets Act, 2000, c. 8, § 391 (U.K.) (amended 2010). Section 391 incorporates further extension of transparency-enhancing changes made by the Financial Services Act 2010. *Id.* The FSA’s use of these powers has already been challenged by way of judicial review and in the Upper Tribunal. *See R ex rel. S v. X*, [2011] EWHC (Admin) 1645, [4]–[10] (Eng.) (addressing the claimant’s appeal of the FSA’s decision notice to the Upper Tribunal and granting an interim injunction to restrain the FSA from publishing the notice); *R ex rel. Can. Inc. v. Fin. Servs. Auth.*, [2011] EHCW (Admin) 2766 (Eng.).

⁷⁸ Financial Services Act, 2012, c. 21, § 137C–137D, 137M–137N (U.K.).

⁷⁹ Some of the FCA’s key priorities in respect to consumer credit reveal the intention of the UK regulator to make use of its new powers. These priorities include (a) the review of financial promotions, (b) the improvement of debt management standards, (c) considering the introduction of price caps on what payday lenders can actually charge, (d) assessing regularly how the industry treats financial difficulties, and (e) getting a better understanding of the economic behavior of consumers. FIN. CONDUCT AUTH., BUSINESS PLAN 2014/15 (2014),

Firms are still required to demonstrate an ongoing commitment, right up to the board level, in securing right outcomes for their customers, particularly consumers.⁸⁰ Furthermore, senior managers that repeatedly fail to deliver now face greater chances of becoming the target of the FCA's enforcement action.⁸¹ Last but not least, there is now the possibility of mass consumer redress, the aim of which is to ensure consistent redress outcomes for consumers in a timelier fashion.⁸²

There is no doubt that these amendments to the TCF legal framework bear the potential of cementing the FCA's enforcement action if indeed the FCA decides to move from simply expressing intentions to the taking of action. Nevertheless, the fact remains that post-crisis, visibility of enforcement action of the UK regulator is still lacking. Although it is true that we witnessed a peak in formal enforcement between 2006 and 2008, it is equally true that enforcement action regarding PPI tailed off more recently, given that the regulator's priority remains that of securing redress for the numerous victims of PPI misselling rather than to punish wrongdoers for their misconduct.⁸³ Formal enforcement is still considered a measure of last resort while dialogue and persuasion continue to be the preferred course of action for behaviour modification.⁸⁴ There is a good reason for this. Formal enforcement takes time to bring fruits let alone secure large-scale consumer redress. In a similar fashion, early settlement is thought to be in the public interest because it secures redress for the victims of PPI misselling, and it is speedier and less expensive relative to other alternatives.

available at <http://www.fca.org.uk/static/documents/corporate/business-plan-2014-2015.pdf>.

⁸⁰ FIN. SERVS. AUTH., *TREATING CUSTOMERS FAIRLY: PROGRESS UPDATE 15* (2008), available at http://www.fsa.gov.uk/pubs/other/tcf_progress.pdf.

⁸¹ McDermott, *supra* note 74, at 5–7.

⁸² Financial Services and Markets Act, 2000, c. 8, §§ 404–404G (U.K.) (amended 2010); Richard Peat et al., *Imposing Consumer Redress Schemes*, 32 COMPANY LAW. 183 (2011).

⁸³ See Financial Services and Markets Act § 2(2) (providing that the primary regulatory objectives include the protection of consumers); see Patrick Collinson, *Ombudsman Still Receiving 1,000 Complaints a Day on PPI Mis-Selling*, GUARDIAN (Mar. 4, 2014), <http://www.theguardian.com/money/2014/mar/04/ombudsman-receives-1000-ppi-misselling-complaints> (indicating a steep drop in number of enforcement cases for PPI misselling).

⁸⁴ See generally Financial Services and Markets Act §§ 225–34 (providing a mechanism for adjudication of certain disputes with “minimum formality”).

The credibility of enforcement also calls for consistent policy. Otherwise it is difficult for the regulator to convey the seriousness of its intention. Experience in the UK suggests that the intensity of enforcement action varies and that it is by and large driven by the prevailing political climate. For example, the FSA's willingness to proceed to formal enforcement gained momentum during the recent financial turmoil, that is to say, at a time when there has been great political pressure to bring cases to court. As collective memory of the financial crisis of 2008 fades away, the regulator's commitment to formal enforcement is expected to recede.

The possibility of early settlement and the tendency to resort to private warnings at the supervisory stage and in exclusion from any further enforcement action are two further features of the UK regulator's approach that undermine the visibility of disciplinary action. Specifically, under the current regime, the industry is given several incentives to opt for early settlement, such as discounts and the reduction of financial penalties.⁸⁵ The downside of this is that nobody takes notice given that these early stages of disciplinary action are carried out away from the public eye. Private warnings at the supervisory stage are arguably the most serious form of reprimand during ongoing supervisory correspondence. They communicate the regulator's concerns about the firm's conduct and that disciplinary action may follow as a result of this, but again this correspondence is kept confidential and may never materialise into a widely publicized formal enforcement action.

The credibility of deterrence practices of the UK regulators has been further eroded by the industry's reluctance to genuinely engage with the regulator to secure fair treatment for customers.⁸⁶ This is evident, for example, (a) in the large number of PPI complaints being referred to the FOS, (b) in the discrepancy in outcomes between PPI complaints that were referred to the FOS and those that were handled by firms⁸⁷ and (c) more recently, in the industry's attempt to challenge the FSA's decision to take

⁸⁵ FIN. CONDUCT AUTH., DECISION PROCEDURE AND PENALTIES MANUAL § 6.7 (2014), *available at* <http://media.fshandbook.info/content/FCA/DEPP.pdf>. For information on the discount rates, see *id.*

⁸⁶ See Final Notice from the Fin. Servs. Auth. to the Co-operative Bank PLC (Jan. 4, 2013), *available at* <http://www.fca.org.uk/static/fca/documents/final-notice/co-op.pdf>; Lloyds TSB Bank Plc, *supra* note 6. See also McDermott, *supra* note 74 (discussing this erosion).

⁸⁷ See Collinson, *supra* note 83 (noting the increased flow of PPI complaints that was referred to the FOS); Ferran, *supra* note 6 at pages 252 and 255 (discussing the dismissiveness of the industry).

enforcement action following the industry's failure to take into account FOS decisions in handling customer complaints, contrary to the regulator's expectations, as these were communicated informally in a Policy Statement ("PS").⁸⁸

In its judicial review action the industry argued that PRIN are not actionable by suit by a private person in view of the wording of old section 150 of the FSMA 2000.⁸⁹ Accordingly, they could not give rise to redress obligations. In addition, the industry claimed that regulatory principles could not conflict with or augment specific rules.⁹⁰ Finally, it contended that the existence of an alternative statutory collective redress scheme precluded the FSA from taking the action that was set out in the Policy Statement.⁹¹ The industry eventually lost its case on all three grounds.⁹² In the course of bringing the action, several firms put on hold the handling of nearly all PPI complaints. This caused significant delays in the system, eventually leading to the large pay-outs in the second term of 2011.⁹³ Most importantly though, it aggravated the situation in the eyes of the UK regulator and undermined past attempts to build trust.

V. CONCLUSION

The principle that customers must be treated fairly has a long history in the UK. So does the problem of PPI misselling, which the Treating Customers Fairly initiative aims to tackle. I tried to demonstrate in this Article that TCF looks good on paper. It intends to be flexible enough to let firms adapt regulatory mandates according to their individual circumstances and it encourages firms to develop their self-regulatory capacities in a manner that bolsters TCF targets, namely tangible public policy outcomes. However, in practice, the recurring instances of PP misselling indicate that TCF has, thus far, made little difference.

⁸⁸ *R ex rel. British Bankers Ass'n v. Fin. Servs. Auth.*, [2011] EWHC (Admin) 999.

⁸⁹ *Id.* at [60].

⁹⁰ *Id.* at [95].

⁹¹ *Id.* at [210]–[211].

⁹² *Id.* at [264].

⁹³ FIN. SERVS. AUTH., *supra* note 42; Press Release, Fin. Servs. Auth., Lloyds Banking Grp. Fined £4.3 Million for Delayed PPI Redress Payments (Feb. 19, 2013), *available at* <http://www.fsa.gov.uk/library/communication/pr/2013/017.shtml>.

This Article traced the causes of this shortcoming, focusing in particular on the rulification of TCF, some difficulties associated with the system of data resource management that is currently in use, and the absence of a system of credible deterrence to back up the regulator's attempt to inflict long-term cultural change in the interests of consumers. Several lessons may be drawn from the UK experience with TCF. All of them illustrate that the focus on "outcomes" rather than "principles" does not necessary guarantee better performance in attaining public policy objectives.

For a start, the implementation of TCF in the UK demonstrates that the choice to depart from the traditional rulebook approach does not necessarily offer a better solution to the pervasive problem of striking the proper balance between, on the one hand, certainty and predictability and, on the other hand, flexibility and adaptability. TCF was informal in its inception, but eventually it became rulified and sclerotic, in view of the measures that were taken to respond to the industry's constant pressure for more detailed guidance.

Further, the regime of intensive supervision that has been associated with the implementation of the rulified TCF is likely to have contributed to the regulatees' general reluctance to exercise judgement and discretion and to adopt an attitude of reflective compliance with rules and guidance. Instead of being "enabling" and "engaging," in all probability the regulator's near omnipresence in the internal affairs of the regulated firms left hardly any scope for reflection and healthy experimentation and made the regulatees either more complacent or less confident in their expertise and judgement.

The UK experience with the implementation of TCF also highlights the relevance of big data in making the whole initiative a success. Specifically, it reveals how the computer software that supports data resource management can actually hinder regulators from making sound judgments. This occurs when the software is not properly designed or when errors, undermining the reliability and accuracy of the data produced, are not identified and properly addressed at an early stage. Who develops computer software for data resource management is also of practical importance. Professional programmers do not necessarily understand what TCF requires in practice in the same way as the regulator does. To the extent in which the articulation of TCF outcomes may turn out to be different from what was originally intended, computer software that is specifically calibrated to ensure compliance with TCF may in reality be at odds with the intended TCF goals.

In view of the fact that technology shapes the meaning of TCF goals and may even translate TCF goals into a course of action that is worlds apart from what the regulator would recommend, some further issues that require immediate attention include, but are not limited to, the following: (a) The determination of the respective roles of the State and the market in developing the software that would support the operationalization of a consolidated system of data resource management; (b) whether some sort of a licensing regime would be appropriate as a mechanism that would ensure consistency between the regulator's understanding of TCF and that of software developers'; (c) how to make sure that the relevant software is constantly updated so that it keeps pace with market developments; (d) whether it is desirable to have in place inter-operable data systems with means for monitoring and correcting data errors built into them (e.g., automatic alerts regarding the entry of anomalous values); and (e) whether it is expedient to standardize terms and industry jargon.

Finally, the lack of credible deterrence brings to the surface an inevitable trade off between two conflicting policy considerations that cannot be ignored: on the one hand, the need to secure timely and cost-efficient consumer redress and, on the other, the need to ensure that law enforcement is visible enough to deter. The UK experience highlights that it is not possible to have both. While securing financial redress in a timely fashion justifies early settlement, credible deterrence pulls in the opposite direction because it calls for a course of action that is more time consuming (typically this would involve bringing a case to the courts) and a gamble to retail customers.

The increasing emphasis on business culture suggests that the FCA is cognisant of this trade off and that it has made a deliberate choice to boost market discipline by challenging the business culture that prevails in the industry. This is a welcome development, but it will take time to bring fruits. In any case, the potency of culture as a regulatory tool should not be blown out of proportion.

At least in part, the efficacy of the regulator to instigate cultural change depends on the willingness of the firms to genuinely engage with the regulator and – when challenged – to reflect on the soundness of their respective culture in order to amend business practices where appropriate. Persistent industry regression leaves little scope for optimism. In this regard, it is interesting to note that in the past the policy of the FSA was to offer firms a “regulatory dividend” in the form of less scrutiny, as an incentive to make them behave well demonstrating essentially that customer interests were central to the corporate culture of the business in question. This policy reflected an assumption that the vast majority of

firms had the intention to treat their customers fairly and that the majority were willing to engage openly and positively with the regulator. Both assumptions proved to be naïve in reality.

Retail financial firms are not charities working in the interests of customers. They are profit-driven institutions. A business culture that ends up reflecting both the profit-driven character of the business and the firm's perceived commitment to public policy goals, like fair treatment for customers, is bound to be self-defeating because it constitutes a contradiction in terms. One must take priority, and quite intuitively this will have to be profit. Otherwise, the business will not be able to survive. This is not to say that no good can come out of business culture as a tool for improving the effectiveness of TCF. It can, but in all probability, it is going to be less than we are inclined to think. Profit-making considerations confine how far TCF can go in aligning the goals and priorities of the industry with those of the regulator and, by implication, to what extent it is possible to rely on business culture. Accordingly, when designing and implementing TCF, a healthy dose of pragmatism is called for to make it a credible policy in the first place.

MEDICAL BIG DATA AND BIG DATA QUALITY PROBLEMS

SHARONA HOFFMAN*

Medical big data has generated much excitement in recent years and for good reason. It can be an invaluable resource for researchers in general and insurers in particular. This Article, however, argues that users of medical big data must proceed with caution and recognize the data's considerable limitations and shortcomings. These include data errors, missing information, lack of standardization, record fragmentation, software problems, and other flaws. This Article analyzes a variety of data quality problems and then formulates recommendations to address these deficiencies, including data audits, workforce and technical solutions, and regulatory approaches.

I. INTRODUCTION

The term “big data” is suddenly pervasive. The *New York Times* deemed this the “Age of Big Data” in a 2012 article,¹ and a Google search for the term yields over 15 million hits. “Big data” is difficult to define precisely, but it is characterized by three attributes known as “the three Vs”: its large volume, its variety, and its velocity, that is, the frequency with which it is generated.² A particularly rich, but sensitive, type of big data is medical big data, which holds great promise as a resource for researchers and analysts in general, and insurers in particular. Public and private enterprises are launching numerous medical big data initiatives. One of the largest is scheduled to become operational in September 2015 and to link information from hospitals, academic centers, community clinics, insurers, and others sources. This data repository, funded by the

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¹ Steve Lohr, *The Age of Big Data*, N.Y. TIMES (Feb. 11, 2012), http://www.nytimes.com/2012/02/12/sunday-review/big-datas-impact-in-the-world.html?pagewanted=all&_r=0.

² Philip Russom, *Big Data Analytics*, TDWI BEST PRACTICES REPORT 1, 6 (4th Quarter 2011).

federal government, will contain information pertaining to twenty-six to thirty million Americans.³

Medical big data may consist of patient electronic health records (EHR), insurance claims, and pharmacy prescription drug information. It is of interest to a broad range of insurers, including those issuing health, life, disability, and long-term care policies, who may use it for purposes of underwriting, evaluating physicians, assessing benefits coverage, and detecting fraud. Medical big data is also invaluable for purposes of biomedical research, public health practice, institutions' quality assessment and improvement efforts, and post-marketing surveillance of drugs and devices, among other initiatives.⁴ Such data uses are known as "secondary uses" of medical information, to be distinguished from the data's primary use for clinical and billing purposes.⁵

This Article's primary argument is that as valuable as medical big data can be, it must be approached cautiously. Clinicians collect data for treatment and billing purposes, and thus, it may not always be a good fit for secondary uses.⁶

Anyone employing large collections of complex medical data must recognize the data's considerable limitations and shortcomings.⁷ Data quality problems are particularly relevant to insurers because they affect not only secondary use but also their primary work of processing benefit claims. Furthermore, because public programs, including Medicare, Medicaid, and the Children's Health Insurance Program, cover over thirty

³ Ariana Eunjung Cha, *Scientists Embark on Unprecedented Effort to Connect Millions of Patient Medical Records*, WASH. POST (Apr. 15, 2014), http://www.washingtonpost.com/national/health-science/scientists-embark-on-unprecedented-effort-to-connect-millions-of-patient-medical-records/2014/04/15/ea7c966a-b12e-11e3-9627-c65021d6d572_story.html.

⁴ Sharona Hoffman & Andy Podgurski, *The Use and Misuse of Biomedical Data: Is Bigger Really Better?* 39 AM. J.L. & MED. 497, 506–15 (2013).

⁵ Taxiarchis Botsis et al., *Secondary Use of EHR: Data Quality Issues and Informatics Opportunities*, AMIA JOINT SUMMITS TRANSLATIONAL SCI. PROC. 1, 1 (2010); Jessica S. Ancker et al., *Root Causes Underlying Challenges to Secondary Use of Data*, AMIA ANN. SYMP. PROC. 57, 57 (2011).

⁶ Brian J. Wells et al., *Strategies for Handling Missing Data in Electronic Health Record Derived Data*, 1 EGEMS 1, 1 (2013), available at <http://repository.academyhealth.org/egems/vol1/iss3/7/>.

⁷ See Hoffman & Podgurski, *supra* note 4 (for an additional discussion of data quality and analysis problems).

percent of the population,⁸ claims accuracy is of great importance to the government and taxpayers alike. While this Article will be illuminating for insurers, it has much broader applicability as well. All researchers and analysts using medical data for secondary purposes should be familiar with the data flaws analyzed here and may benefit from the recommendations that are developed.

This Article will proceed as follows. Part II of this Article details the purposes for which insurers may use big data. Part III analyzes a large number of data quality problems that may affect EHRs. These can be generally characterized as: 1) deficiencies in data veracity, 2) data voids, and 3) software problems. Part IV formulates recommendations to address data quality problems, including data audits, workforce and technical solutions, and regulatory approaches.

II. INSURERS' USE OF BIG DATA

Insurers have much to gain from using medical big data. Insurers' own claims databases constitute a rich resource for analysis. With medical releases from patients, insurers can also gain access to pharmacies' prescription drug databases and patients' full EHRs, including medical histories, diagnoses, treatments, and other details. Insurers may seek to analyze medical information for a variety of purposes, including underwriting, physician tiering, decisions about coverage scope, and fraud and abuse investigations.

A. UNDERWRITING

Underwriting is the process by which insurers choose whom they will insure and under what terms.⁹ To that end, insurers issuing policies for life, long-term care, and disability insurance generally require applicants to

⁸ *Health Insurance Coverage of the Total Population*, THE HENRY J. KAISER FAMILY FOUND. (2012), <http://kff.org/other/state-indicator/total-population/>.

⁹ 42 U.S.C. § 1395ss(x)(3)(E) (2012). The provision defines underwriting as including: "(i) rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy; (ii) the computation of premium or contribution amounts under the policy; (iii) the application of any pre-existing condition exclusion under the policy; and (iv) other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits."

sign medical releases that allow insurers to review their health records.¹⁰ Based on health information, insurers may reject applicants who are perceived to be at high risk for costly medical problems (or, in the case of life insurers, early death) or charge them high premiums. Some insurers purchase applicants' prescription drug histories from companies such as ScriptCheck and IntelliScript that obtain prescription information from pharmacy benefit management companies.¹¹ ScriptCheck, for example, advertises that it helps insurers "uncover crucial application omissions or assess the veracity of the application."¹² Specifically, ScriptCheck provides

Profiles [that] include the results of a five-year history search with detailed drug and insurance eligibility information, treating physicians, drug indications and pharmacy information. In addition, the likelihood that the applicant has a particular condition is included, which is derived from the predictive modeling that is performed by Optum MedPoint.¹³

Health insurers constitute a special case. Unlike life, disability, and long-term care insurers, they are subject to considerable regulatory restrictions and anti-discrimination mandates that govern underwriting. Under the Genetic Information Nondiscrimination Act, health insurers may not obtain or use genetic information for underwriting purposes.¹⁴ Furthermore, the Health Insurance Portability and Accountability Act (HIPAA) has long prohibited health insurers that issue group policies from charging particular group members different premiums or from denying policies to particular members of the group because of their health status. Thus, for example, if Blue Cross offers a group policy to an employer, it

¹⁰ *Fact Sheet 8: Introduction to Medical and Health Information Privacy*, PRIVACY RIGHTS CLEARINGHOUSE (Aug. 2014), <https://www.privacyrights.org/medical-records-privacy>.

¹¹ Chad Terhune, *They Know What's in Your Medicine Cabinet*, BLOOMBERG BUSINESSWEEK (July 22, 2008), <http://www.businessweek.com/stories/2008-07-22/they-know-whats-in-your-medicine-cabinet>; David Lazarus, *Your Prescription History Is Their Business*, L.A. TIMES (Oct. 21, 2013), <http://articles.latimes.com/2013/oct/21/business/la-fi-lazarus-20131022>.

¹² *ScriptCheck®*, EXAMONE, <http://wwwsw.examone.com/our-solutions/scriptcheck> (last visited Oct. 12, 2014).

¹³ *Id.*

¹⁴ 42 U.S.C. § 300gg-53 (2012); 26 U.S.C. § 9802(b)(3)–(c) (2012).

cannot decline to cover employees with a cancer history or charge them higher premiums than others.¹⁵ By contrast, traditionally, insurers offering individual policies were not subject to the same underwriting restrictions.¹⁶ The Patient Protection and Affordable Care Act (PPACA), however, now severely limits the discretion of health insurers operating in the individual market. The law establishes requirements for “fair health insurance premiums”¹⁷ and bans all preexisting condition exclusions.¹⁸ Nevertheless, the PPACA applies only to health insurers and does not extend to life, long-term care, or disability insurers.¹⁹

B. PHYSICIAN TIERING

Some insurers analyze claims data in order to rank or tier physicians within the same specialty type and geographic market.²⁰ Insurers frequently categorize doctors into tiers based on their cost and quality of performance. They then offer consumers financial incentives, such as lower co-payments, in order to encourage them to visit higher-tiered doctors.²¹

For purposes of tiering, insurers assess two factors: cost efficiency and performance quality. To evaluate the cost of physicians’ care, insurers divide each patient’s claim records into specific “episodes of care” by employing data-mining algorithms. Insurers attribute each episode of care (e.g. a patient’s pneumonia) to a treating physician and calculate an actual cost figure.²² This, in turn, is compared to an expected cost figure,

¹⁵ 42 U.S.C. §§ 300gg-1(b), -11 (2012).

¹⁶ 42 U.S.C. § 300gg-41 (2012); Sharona Hoffman, *Unmanaged Care: Towards Moral Fairness in Health Care Coverage*, 78 IND. L.J. 659, 678 (2003).

¹⁷ 42 U.S.C. § 300gg (2012).

¹⁸ *Id.*

¹⁹ 42 U.S.C. §§300gg, -4 (2012).

²⁰ CIGNA, *Cigna Care Designation & Physician Quality & Cost-Efficiency Displays 2013 Methodologies Whitepaper* (Feb. 2013), available at <http://www.cigna.com/pdf/2013-cigna-care-designation-methodology.pdf>.

²¹ See Anna D. Sinaiko & Meredith B. Rosenthal, *The Impact of Tiered Physician Networks on Patient Choice*, HEALTH SERVS. RES. 1348, 1357 (2014), available at <http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12165/pdf>.

²² Episodes are attributed to particular physicians based on attribution rules, as seen in the rule that dictates “responsibility is assigned to a physician who accounts for 30% or more of professional and prescribing costs included in the episode.”

determined by averaging the actual cost of all similar episodes managed by physicians in the same specialty. Each doctor's cost efficiency measure is the ratio of her total actual costs to total expected costs, and doctors are tiered based on their comparative ratios.²³

The quality of care figure is developed by analyzing information about the degree to which physicians comply with clinical guidelines relating to various conditions.²⁴ For example, analysts might assess whether patients with type II diabetes were given all the recommended tests and medications. Performance is scored either in terms of the physician's compliance rate compared to the average adherence rate for the specialty or in terms of a fixed compliance standard.²⁵

C. RESEARCH REGARDING BENEFITS COVERAGE AND FRAUD

Health insurers may also conduct research to determine if certain patients should be covered for and encouraged to obtain additional services in order to save costs in the long-run. For example, elderly patients may benefit from home visits by a nurse after a hospitalization in order to prevent medical problems that could result in a second hospitalization. Likewise, individuals with chronic diseases such as diabetes may benefit from care management programs.²⁶

Insurers can also mine medical data resources in order to detect health care fraud and abuse. They can establish claim norms and then identify anomalous claims patterns that might signify fraudulent conduct.²⁷

See Lewis G. Sandy et al., *Episode-Based Physician Profiling: A Guide to the Perplexing*, 23 J. GEN. INTERNAL MED. 1521, 1522 (2008).

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Care Management Analytics*, KNOWLEDGENT, <http://knowledgent.com/whitepaper/care-management-analytics> (last visited Oct. 12, 2014); Jennifer Valentino-DeVries, *May the Best Algorithm Win . . .*, WALL ST. J. (Mar. 16, 2011), <http://online.wsj.com/news/articles/SB10001424052748704662604576202392747278936>.

²⁷ See Hian Chye Koh & Gerald Tan, *Data Mining Applications in Healthcare*, 19 J. HEALTHCARE INFO MGMT. 64 (2005).

III. DATA QUALITY PROBLEMS

The validity of researchers' and analysts' findings will often depend on the accuracy and completeness of the information upon which they are based. Unfortunately, patient EHRs and the insurance claims and prescriptions orders that flow from them are often deeply flawed. They suffer from data veracity defects and data voids. In addition, software or programming problems may generate errors in the data itself, may limit researchers' ability to extract data, or may obstruct data analysis.²⁸ Researchers must understand and consider these many potential shortcomings and pitfalls as they proceed with their analysis.

A. DATA VERACITY

EHRs are created by very busy clinicians. On average, doctors spend only thirteen to eighteen minutes with each patient.²⁹ Whether they attempt to enter data during the patient encounter or attend to documentation afterwards, they are likely to work quickly and to make mistakes.

²⁸ K. Bruce Bayley et al., *Challenges in Using Electronic Health Record Data for CER Experience of 4 Learning Organizations and Solutions Applied*, 51 MED. CARE S80, S81 (2013); George Hripcsak & David J. Albers, *Next-Generation Phenotyping of Electronic Health Records*, 20 J. AM. MED. INFORMATICS ASS'N 117, 117–18 (2013).

²⁹ See Andrew Gottschalk & Susan A. Flocke, *Time Spent in Face-to-Face Patient Care and Work Outside the Examination Room*, 3 ANNALS FAM. MED. 488, 491 (2005) (finding that the average time per patient was 13.3 minutes); Kimberly S. H. Yarnall et al., *Family Physicians as Team Leaders: See "Time" to Share the Care*, PREVENTING CHRONIC DISEASE: PUB. HEALTH RES. PRAC. & POL'Y 1, 6, Apr. 2009, http://www.cdc.gov/pcd/issues/2009/apr/08_0023.htm (finding that the mean length for an acute care visit is 17.3 minutes, the mean for a chronic disease care visit is 19.3 minutes, and the average for a preventive care visit is 21.4 minutes, and that of total clinical time spent by physicians, these comprise 45.8%, 37.4%, and 16.8% respectively); Kevin Fiscella & Ronald M. Epstein, *So Much to Do, So Little Time: Care for the Socially Disadvantaged and the 15-Minute Visit*, 168 ARCHIVES INTERNAL MED. 1843, 1843 (2008) ("The average office visit in the United States lasts for about 16 minutes.").

1. Input Errors

Clinicians entering data into EHRs often mistype words, invert numbers, or select wrong menu items from drop-down menus. They may also choose erroneous diagnosis codes, check boxes incorrectly, or uncheck boxes inappropriately if the default setting has all boxes checked.³⁰

Presumably, such errors are made innocently. However, there are also some perverse incentives at play. If a clinician checks a few too many boxes, for example, she can make it look like she did more during the clinical encounter than she actually did, and consequently, she can bill a higher amount. Similarly, selecting a code for a slightly more serious condition than the patient has may justify increased charges. Such billing manipulations are known as “upcoding.”³¹ According to one study, upcoding services provided to Medicare patients is so common that it may account for as much as fifteen percent of Medicare’s expenditures for general office visits, or \$2.13 billion annually.³²

2. Data Entered Into Wrong Patient Charts

Data can be entered into the wrong patient chart if multiple patient charts are open at the same time or if a prior user did not log off properly after viewing another patient’s EHR.³³ Such errors are particularly likely in hospitals. During a typical hospitalization, approximately 150 individuals view each patient’s chart, and multiple records may be handled at once in nursing stations.³⁴

³⁰ Farah Magrabi et al., *An Analysis of Computer-Related Patient Safety Incidents to Inform the Development of A Classification*, 17 J. AM. MED. INFORMATICS ASS’N. 663, 665, 669 (2010); Sharona Hoffman & Andy Podgurski, *E-Health Hazards: Provider Liability and Electronic Health Record Systems*, 24 BERKELEY TECH. L. J. 1523, 1544–45 (2009) (discussing input errors); Botsis et al., *supra* note 5, at 1; Ancker et al., *supra* note 5, at 57.

³¹ Christopher S. Brunt, *CPT Fee Differentials and Visit Upcoding Under Medicare Part B*, 20 HEALTH ECON. 831, 840 (2011).

³² *Id.* (the \$2.13 billion figure is in 2007 dollars).

³³ Elizabeth Borycki, *Trends in Health Information Technology Safety: From Technology-Induced Errors to Current Approaches for Ensuring Technology Safety*, 19 HEALTH INF. RES. 69, 70 (2013).

³⁴ Judy Foreman, *At Risk of Exposure: In the Push for Electronic Medical Records, Concern is Growing about How Well Privacy Can Be Safeguarded*, L.A.

3. Copy and Paste Problems

The EHR copy and paste feature is notorious as a source of errors.³⁵ It is designed to save time, allowing physicians to copy narrative from a prior visit and paste it into new visit notes. However, if the copied information is not carefully edited and updated, the physician will inadvertently introduce errors into the record.³⁶ For example, in one reported case, the record of a patient hospitalized for many weeks because of complications from surgery indicated each day that this was “post-op day No. 2” because the note was never edited.³⁷ In another case, the statement “Patient needs drainage, may need OR” appeared in notes for several consecutive days, even after the patient successfully underwent a procedure to drain his abscess.³⁸ In yet another instance, a patient’s EHR indicated erroneously that he had a below-the-knee amputation (BKA) because a voice recognition dictation system entered “BKA” into the record instead of the real problem - diabetic ketoacidosis, whose acronym is DKA.³⁹

Copy and paste is very commonly used. In a study of 100 randomly selected hospital admissions, copied text was found in seventy-eight percent of medical residents’ sign-out notes (written when their shift ended) and fifty-four percent of patient progress notes.⁴⁰

TIMES (June 26, 2006), <http://articles.latimes.com/2006/jun/26/health/he-privacy26>.

³⁵ Eugenia L. Siegler & Ronald Adelman, *Copy and Paste: A Remediable Hazard of Electronic Health Records*, 122 AM. J. MED. 495, 495–96 (2009) (cautioning that cut and paste functions can lead to patient problem lists never changing, notes and errors being copied by multiple staff members, and loss of accurate narrative).

³⁶ Lena Mamykina et al., *Clinical Documentation: Composition or Synthesis?*, 19 J. AM. MED. INFORMATICS ASS’N. 1025, 1027 (2012).

³⁷ Kevin B. O’Reilly, *EHRs: “Sloppy and Paste” Endures Despite Patient Safety Risk*, AM. MED. NEWS (Feb. 4, 2013), <http://www.amednews.com/article/20130204/profession/130209993/2/>.

³⁸ *Id.*

³⁹ Paul Hsieh, *Can You Trust What's In Your Electronic Medical Record?*, FORBES (Feb. 24, 2014), <http://www.forbes.com/sites/paulhsieh/2014/02/24/electronic-medical-record/>.

⁴⁰ Jesse O. Wrenn et al., *Quantifying Clinical Narrative Redundancy in an Electronic Health Record*, 17 J. AM. MED. INFORMATICS ASS’N 49, 52 (2010).

The data quality problems that copy and paste generates have been widely recognized. In 2014, the American Health Information Management Association issued a statement calling for copy/paste functionality to be “permitted only in the presence of strong technical and administrative controls which include organizational policies and procedures, requirements for participation in user training and education, and ongoing monitoring.”⁴¹ In the absence of such measures, the errors caused by copying and pasting EHR text can confuse treating physicians and claims administrators, harm patients, and taint records that will later be employed for secondary use by insurers and other researchers.

4. Estimating Error Rates

A variety of studies have focused on error rates in EHRs. One study involved oncology patients at an academic medical center and, in part, examined duplicate data that was entered into two research databases.⁴² It showed that the rate of discrepancies between the two databases ranged between 2.3 and 26.9 percent, depending on the type of data, with demographic data having fewer inconsistencies and treatment data having many more discrepancies.⁴³ Another publication found an average error rate of 9.76 percent.⁴⁴ Australian researchers who audited 629 admissions at two Sydney hospitals identified 1,164 prescribing errors in

⁴¹ AM. HEALTH INFO. MGMT. ASS’N, *Appropriate Use of the Copy and Paste Functionality in Electronic Health Records* (Mar. 17, 2014), http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_050621.pdf.

⁴² Saveli I. Goldberg et al., *Analysis of Data Errors in Clinical Research Databases*, AMIA 2008 ANN. SYMP. PROC. 242, 242–43 (2008) (attributing errors to data entry mistakes, misinterpretation of hard-copy documents when information was typed into the database, and perpetuation of errors that were contained in the original paper documents and were not corrected during the transition to EHRs).

⁴³ *Id.* at 243–44.

⁴⁴ Meredith L. Nahm, *Quantifying Data Quality for Clinical Trials Using Electronic Data Capture*, PLOS ONE, AUG. 2008, at 1 (discussing a literature review of “42 articles that provided source-to-database error rates, primarily from registries” and finding that the “average error rate across these publications was 976 errors per 10,000 fields”); see also James J. Cimino et al., *Use of Clinical Alerting to Improve the Collection of Clinical Research Data*, AMIA 2009 SYMP. PROC. 218, 218 (2009) (discussing data error rates pertaining to research databases).

those patients' records, equivalent to 185 errors per 100 admissions.⁴⁵ They noted, however, that error rates had decreased significantly since the hospitals transitioned from paper medical records to EHRs, dropping from 625 inaccuracies per 100 admissions to 212 at one hospital and from 362 to 185 errors per 100 admissions at the other.⁴⁶

B. DATA VOIDS

EHR data is often incomplete, lacking elements that would be valuable for secondary uses.⁴⁷ Data voids may arise because available data is not recorded or important information is not gathered. They may also occur because of billing code limitations, lack of data standardization, and record fragmentation.

1. Missing Data

In some instances physicians do not carefully record all the data that is available to them. For example, they may neglect to indicate clearly that a patient does not have particular symptoms or conditions and instead leave blank data fields. Analysts who see these empty fields will not know how to interpret them: did the patient not suffer the symptom at issue or did the physician overlook the question?⁴⁸

In addition, data about treatment outcomes is often missing.⁴⁹ Patients who are given medications such as antibiotics often are not asked to return to the doctor and report on their progress. Therefore, the patient's EHR will detail the diagnosis and prescription, but will not indicate whether she recovered or failed to improve and sought treatment from a different physician or specialist.

⁴⁵ Johanna I. Westbrook et al., *The Safety of Electronic Prescribing: Manifestations, Mechanisms, and Rates of System-Related Errors Associated with Two Commercial Systems in Hospitals*, 20 J. AM. MED. INFORMATICS ASS'N 1159, 1161 (2013).

⁴⁶ *Id.* at 1164–65.

⁴⁷ Wells et al., *supra* note, 6 at 1–3.

⁴⁸ *Id.* at 2.

⁴⁹ Craig Newgard et al., *Electronic Versus Manual Data Processing: Evaluating the Use of Electronic Health Records in Out-of-Hospital Clinical Research*, 19 ACAD. EMERGENCY MED. 217, 225 (2012).

Graphical representations are another element that may be useful to analysts but missing from EHRs. In the era of paper records, some doctors were accustomed to drawing anatomical pictures to depict the patient's medical condition, specifying by way of illustration exactly where the problem was and what it looked like. EHR systems' graphical representation tools are cumbersome and inadequate at best.⁵⁰ The inability to draw on paper is frustrating for some clinicians who feel that the absence of depictions compromises the quality of their documentation.

Studies that have evaluated data completeness have found diverse results.⁵¹ Several studies focusing on patients' medication lists in EHRs found the following: 1) 27% of drugs were missing from ambulatory oncology patients' drug lists; 2) 53% of patient-reported medications were not recorded by primary care providers; and 3) an average of 3.1 medications were missing from the drug lists of Veterans Affairs (VA) patients who were 65 and older with five or more prescriptions.⁵² A study of EHRs at eight VA clinical sites found that the following percentage of patients had missing data: 24% to 38% had incomplete LDL (low-density lipoprotein) measurements; 3% to 31% had incomplete blood pressure measurements, and 5% to 23% were missing HbA1c (blood sugar) results.⁵³

⁵⁰ David S. Sanders et al., *Electronic Health Record Systems in Ophthalmology: Impact on Clinical Documentation*, 120 AM. ACAD. OPHTHALMOLOGY 1745, 1751–53 (2013).

⁵¹ Kitty S. Chan et al., *Review: Electronic Health Records and the Reliability and Validity of Quality Measures: A Review of the Literature*, 67 MED. CARE RES. & REV. 503, 506 (2010).

⁵² *Id.* at 515 (citing Saul N. Weingart et al., *Medication Reconciliation in Ambulatory Oncology*, 33 JOINT COMM'N J. QUALITY PATIENT SAFETY 750, 752 (2007)); Prathibha Varkey et al., *Improving Medication Reconciliation in the Outpatient Setting*, 33 JOINT COMM'N J. QUALITY PATIENT SAFETY. 286, 290 (2007); Peter J. Kaboli et al., *Assessing the Accuracy of Computerized Medication Histories*, 10 AM. J. MANAGED CARE 872, 872 (2004).

⁵³ Joseph L. Goulet et al., *Measuring Performance Directly Using the Veterans Health Administration Electronic Medical Record: A Comparison with External Peer Review*, 45 MED. CARE 73, 81 (2007).

2. Records of Sicker Patients Are More Complete

Experts have noted that the records of sick patients contain much more information than those of healthy patients.⁵⁴ Sick patients have more clinical visits, testing, and procedures than do individuals who are well and rarely if ever seek medical care. This information disparity may be problematic for researchers who want to know as much about healthy individuals and their health habits as they do about those who are less robust. It can also lead to selection bias, which is an error in choosing the individuals that will take part in a scientific study that occurs when the participants are not representative of the population as a whole.⁵⁵ If selection bias is present, the study's results may be valid for the group that was studied (e.g. very sick people), but cannot be generalized as applicable to others (e.g. healthier patients).⁵⁶

3. Limitations of Billing Information

Billing information may be particularly vulnerable to data voids and insufficient specificity.⁵⁷ Diagnostic codes for billing may be too general to indicate the particulars of the patient's condition. For example, a billing code may indicate "myelodysplastic syndromes," which include a

⁵⁴ See, e.g., Susan Rea et al., *Bias in Recording of Body Mass Index Data in the Electronic Health Record*, AMIA SUMMITS ON TRANSLATIONAL SCI. PROC. 214, 217 (2013) ("[T]he BMI on higher disease status patients was also demonstrated when comparing the frequencies of patients having particular diagnoses between subgroups having versus not having a BMI recorded."); Nicole G. Weiskopf, *Sick Patients Have More Data: The Non-Random Completeness of Electronic Health Records*, AMIA SUMMITS ON TRANSLATIONAL SCI. PROC., 1472, 1476 (2013) ("Sicker patients tend to have more complete records and healthier patients tend to have records that are less complete.").

⁵⁵ For an example of selection bias, see generally KENNETH J. ROTHMAN ET AL., MODERN EPIDEMIOLOGY 135–36 (3d ed. 2008) (explaining selection bias in the context of epidemiologic studies).

⁵⁶ Hoffman & Podgurski, *supra* note 4, at 522.

⁵⁷ See generally William R. Hersh et al., *Caveats for the Use of Operational Electronic Health Record Data in Comparative Effectiveness Research*, 51 MED. CARE S30, S33 (2013) ("The most commonly known problematic transformation of data occurs when data are coded, often for billing purposes").

broad range of conditions.⁵⁸ Moreover, insurance claims may not contain important information, such as detailed medical histories or treatments that are not covered by insurance.⁵⁹ Insurers who rely on billing information alone for purposes of research and analysis may thus be relying on very incomplete information.⁶⁰

4. Lack of Data Standardization

Another data void arises from lack of data standardization and harmonization. Different EHR systems and different doctors use medical terms, phrases, acronyms, and abbreviations differently. They may use the same term to mean different things or different terms to mean the same thing. To illustrate, the abbreviation “MS” can mean “mitral stenosis,” “multiple sclerosis,” “morphine sulfate,” or “magnesium sulfate.”⁶¹ Such inconsistencies can lead to grave difficulties in data interpretation.⁶²

⁵⁸ See *id.* for a discussion of certain codes that indicate too broad a range of conditions.

⁵⁹ *Id.* at S32 (citing the example of hospital-acquired urinary tract infections from catheters for which Medicare will not provide reimbursement).

⁶⁰ *Id.*; Elmer V. Bernstam et al., Abstract, *Oncology Research Using Electronic Medical Record Data*, 28 J. CLINICAL ONCOLOGY e16501 (2010), available at http://meeting.ascopubs.org/cgi/content/abstract/28/15_suppl/e16501 (“Machine learning natural language processing techniques are more accurate than either billing data or text-word searches at identifying patients with malignancies within large data sets.”).

⁶¹ Christopher G. Chute, *Medical Concept Representation*, in MEDICAL INFORMATICS: KNOWLEDGE MANAGEMENT AND DATA MINING IN BIOMEDICINE 170 tbl.6-1 (Hsinchun Chen et al. eds., 2005).

⁶² Wells, *supra* note 6, at 2 (“[T]he free text areas of the patient chart . . . are difficult to analyze quantitatively due to the breadth of human expression, grammatical errors, “the use of acronyms and abbreviations, and the potential for different interpretations of the same phrase depending on context.”); Nicole Gray Weiskopf & Chunhua Weng, *Methods and Dimensions of Electronic Health Record Data Quality Assessment: Enabling Reuse for Clinical Research*, 20 J. AM. MED. INFORMATICS ASS’N 144, 147–48 (2013) (discussing terminology and dimensions of data quality).

5. Record Fragmentation

Further data inadequacies are attributable to record fragmentation. Patients see different doctors in different health care facilities that have different EHR systems.⁶³ If the separate EHR systems are not interoperable,⁶⁴ pieces of the patient's record will be housed in different locations and analysts may not be able to put it together into a comprehensive record that reflects the patient's full medical history.⁶⁵ In the alternative, if researchers collect information from multiple facilities and do not realize that different segments of the record belong to the same patient, they might count the same individual multiple times in their study, thus skewing their results. This is particularly likely to occur if the data that is analyzed by secondary users is de-identified in order to protect patient privacy.⁶⁶ In a February 2014 speech, Dr. Karen DeSalvo, National Coordinator for Health Information Technology, acknowledged that the health care community has "not reached . . . [its] shared vision of having . . . [a nationally] interoperable system where data can be exchanged and meaningfully used to improve care."⁶⁷

⁶³ Hersh et al., *supra* note 57, at S31-S32.

⁶⁴ Interoperable systems can communicate with each other, exchange data, and operate seamlessly and in a coordinated fashion across organizations. BIOMEDICAL INFORMATICS: COMPUTER APPLICATIONS IN HEALTH CARE AND BIOMEDICINE 952 (Edward H. Shortliffe & James J. Cimino eds., 3d ed. 2006).

⁶⁵ Botsis et al., *supra* note 5, at 4 (stating that the EHR system that was mined for purposes of the study did not contain records of patients who were transferred to dedicated cancer centers because of the severity of their disease or who had initially been treated elsewhere).

⁶⁶ For a discussion of data de-identification, see Sharona Hoffman & Andy Podgurski, *Balancing Privacy, Autonomy and Scientific Needs in Electronic Health Records Research*, 65 SMU L. REV. 85, 104–05, 128–33 (2012).

⁶⁷ Daniel R. Verdon, *ONC's DeSalvo Issues Next Health IT Challenge: Build Interoperable EHR Systems*, MED. ECON. (Mar. 4, 2014), <http://medicaleconomics.modernmedicine.com/medical-economics/news/oncs-desalvo-issues-next-health-it-challenge-build-interoperable-ehr-systems>. The Office of the National Coordinator for Health Information Technology is part of the U.S. Department of Health and Human Services and is charged with promoting and facilitating the country's transition to widespread use of health information technology.

C. SOFTWARE PROBLEMS

Analysis of medical data may further be hampered by software problems. Limitations in the software's capabilities may make it difficult or impossible to extract the narrative text portions of EHRs. Software or programming flaws may also generate errors in the data contained in EHRs or in their analysis.

1. Narrative Text

EHRs are composed of structured, coded data and narrative text (also called "free-text") consisting of clinicians' notes concerning patients.⁶⁸ The narrative text often includes very important information that is not recorded elsewhere, such as the date of the condition's onset, notes concerning medication use, care summaries, and more.⁶⁹ To illustrate, coded data may indicate that the patient's asthma has worsened, but the narrative may explain that she is smoking more frequently. Unstructured narrative is often difficult to extract from EHRs because contemporary natural language processing technology is imperfect.⁷⁰

In addition, at times, information in the free-text comments directly contradicts structured data in the EHR because of input errors.⁷¹ For example, the structured data may indicate that one dosage was prescribed, whereas the notes state that the patient was instructed to take a different dose.⁷² In such cases, analysts may not be able to determine whether the structured data or notes are correct.

⁶⁸ Hersh et al., *supra* note 57, at S33; Andrea L. Benin et al., *Validity of Using an Electronic Medical Record for Assessing Quality of Care in an Outpatient Setting*, 43 MED. CARE 691, 696 (2005).

⁶⁹ Hersh et al., *supra* note 57, at S33; Bayley et al., *supra* note 28, at S83.

⁷⁰ Bayley et al., *supra* note 28, at S83; Hersh et al., *supra* note 57, at S33.

⁷¹ Dean F. Sittig & Hardeep Singh, *Defining Health Information Technology-Related Errors: New Developments since To Err is Human*, 171 ARCHIVES INTERNAL MED. 1281, 1283 (2011), available at <http://archinte.jamanetwork.com/article.aspx?articleid=1105855>.

⁷² *Id.*

2. Software and Programming Defects

Software defects arising from errors in a computer program's source code or design can adversely affect both data analysis and the quality of the original data contained in EHRs. To ensure software integrity, highly skilled software professionals must carefully design and then thoroughly test their products.⁷³

Software bugs can cause computer programs to produce incorrect or unexpected results or to behave in unintended ways. While subtle errors are often difficult to detect, insurance analysts and other researchers should be vigilant and examine unanticipated or egregious results to determine whether they were generated by flawed software. To illustrate, when calculating the appropriate drug dosage for a patient, the weight-based dosing algorithm may fail to convert a weight measure that was entered in pounds to a weight measure in kilograms, the unit upon which the calculation is based. In such a case, the patient would receive approximately double the correct dose.⁷⁴

Software failures impact not only data analysis, but also the accuracy of the EHR data itself. Numerous instances of dangerous software problems have been reported. In one case, a woman's cervical cancer was not detected for four years because an EHR system's default setting displayed a prior, normal Pap smear result rather than her more recent abnormal test results. The patient, a young woman who had not yet had children, ended up needing a full hysterectomy.⁷⁵ In another case, a doctor ordered "daily" blood draws for a hospitalized patient, which conventionally means that they are performed at 6:00 a.m. Instead, however, the EHR system had been programmed to interpret the term

⁷³ Rebecca Sanders & Diane Kelly, DEALING WITH RISK IN SCIENTIFIC SOFTWARE DEVELOPMENT, 25 IEEE SOFTWARE 21, 25, 27 (2008), available at <http://ieeexplore.ieee.org/stamp/stamp.jsp?tp=&arnumber=4548404>; Diane F. Kelly, *A Software Chasm: Software Engineering and Scientific Computing*, 24 IEEE SOFTWARE 120, 118 (2007), available at <http://ieeexplore.ieee.org/stamp/stamp.jsp?tp=&arnumber=4375255>; Les Hatton, *The Chimera of Software Quality*, 40 COMPUTER 104, 104 (2007), available at <http://ieeexplore.ieee.org/stamp/stamp.jsp?tp=&arnumber=4292028>.

⁷⁴ Sittig & Singh, *supra* note 71, at 1283.

⁷⁵ Stacy Singer, *Electronic Medical Records May Cause Patient Care Errors, Florida Medical Board Says*, PALM BEACH POST (June 5, 2010), <http://www.palmbeachpost.com/news/news/electronic-medical-records-may-cause-patient-care-/nL7Yc/>.

“daily” to mean 4:00 p.m., so blood was taken in the afternoon. Because of the absence of updated bloodwork, the patient was given an excessive amount of the anticoagulant warfarin, which caused a serious bleeding risk, though no harm was ultimately suffered.⁷⁶ Such errors are not only potentially catastrophic for patient care, but also problematic for secondary use, because analysts may not realize that they are considering a prior year’s test results or medication dosages that were prescribed in the absence of updated blood chemistry values.

IV. RECOMMENDATIONS

While contemporary medical big data suffers from many shortcomings, it remains an extremely promising resource for insurers and other researchers. Improving data quality should be a priority goal not only for doctors and patients, but also for anyone interested in secondary use. A number of measures can be implemented to enhance data accuracy and usability. First, both analysts and patients can contribute to quality assessment and improvement efforts through data audits. Second, the public and private sectors can work together to support the health care workforce, to enhance EHR automation and data extraction capabilities, and to develop best practices and training materials. Finally, a variety of federal regulations can bolster oversight efforts. These include the Meaningful Use regulations that govern EHR systems, the HIPAA Privacy and Security Rules, and the Common Rule that governs medical research.

A. DATA AUDITS

Both clinicians and secondary users of EHR data should routinely conduct data audits to assess the records’ accuracy and error rates.⁷⁷

⁷⁶ Megan E. Sawchuk, CTR. FOR DISEASE CONTROL WHITE PAPER, THE ESSENTIAL ROLE OF LABORATORY PROFESSIONALS: ENSURING THE SAFETY AND EFFECTIVENESS OF LABORATORY DATA IN ELECTRONIC HEALTH RECORD SYSTEMS (on file with author).

⁷⁷ Stephany N. Duda et al., *Measuring the Quality of Observational Study Data in an International HIV Research Network*, 7 PLoS ONE 1, 1 (2012), available at <http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0033908>.

Insurers already conduct data audits in order to detect fraud.⁷⁸ Data audits should also focus on general data quality because even innocent mistakes can impact insurance claims. For example, physicians' entry of incorrect dosage amounts into prescription orders can cause patients to suffer costly complications, and inadvertent selection of wrong menu items or boxes regarding the services provided can cause insurers to pay excessive reimbursement amounts.

Insurance claims data can be verified by requesting further information from providers or patients or by examining source material such as laboratory reports and pharmacy records. Other types of data in EHRs, such as diagnoses or treatment plans, may also be substantiated by inspecting source documentation from laboratories or pharmacies, or they can be cross-checked against insurance claims.⁷⁹ Experts advise that data audits focus on the following five questions:

- 1) Are the data complete?
- 2) Are the data correct?
- 3) Are there data inconsistencies or contradictions between different elements of the EHR or between the EHR and other source material (e.g. insurance claims)?
- 4) Does information seem implausible in light of other data about the patient or general scientific knowledge?
- 5) Is information current (e.g. was it copied and pasted without proper editing)?⁸⁰

Auditors, who find that data is incomplete, clearly erroneous, inconsistent, implausible, or outdated, can follow up with physicians and require explanations and, where appropriate, corrections. An additional benefit of audits is their deterrent effect: clinicians who believe they are likely to be audited may be more cautious about EHR data entry.

Patients themselves can become active partners in efforts to enhance data quality. The HIPAA Privacy Rule furnishes patients with a right to inspect or obtain copies of their records and to request amendments if they detect mistakes.⁸¹ In order to balance patients' rights and providers' needs, the Rule allows healthcare providers to charge "reasonable, cost-

⁷⁸ Tammy Worth, *Spike in Retrospective Audits: But Industry Insiders Dispute Any Abnormalities*, HEALTHCARE FIN. NEWS (June 1, 2013), <http://www.healthcarefinancenews.com/news/spike-retrospective-audits>.

⁷⁹ Duda et al., *supra* note 77, at 2.

⁸⁰ Weiskopf & Weng, *supra* note 62, at 145.

⁸¹ 45 C.F.R. §§ 164.524–.526 (2013).

based” fees for copies of records⁸² and to deny requests for amendment on valid grounds, such as a determination that no mistake exists.⁸³ In addition, providers need only note the amendment once and then supply a link to the amendment’s location in other parts of the record that are affected by the change.⁸⁴ If patients more regularly scrutinize their records and ask for corrections, they could add an important layer of data quality oversight without over-burdening their physicians.

B. WORKFORCE AND TECHNICAL SOLUTIONS

Changes in workforce practices and technology can go far to alleviate the problem of inadequate data quality. Among these potential tools are the use of scribes, enhanced automation, improved natural language processing, and the creation of best practices guidelines and training programs.

1. Scribes

One approach that is favored by some clinicians is the use of scribes.⁸⁵ Scribes shadow physicians and do the work of entering data into the EHR while the doctor examines the patient. Thus, documentation is accomplished by a professional who is devoting all of her attention to the data-entry task.⁸⁶ Scribes, who reportedly numbered approximately 10,000 in early 2014, can be hired through companies such as PhysAssist and ScribeAmerica, which provide them with pre-employment training.⁸⁷ While some worry about patient privacy and the cost of hiring scribes, other

⁸² 45 C.F.R. § 164.524(c)(4) (2013).

⁸³ 45 C.F.R. § 164.526(a)(2) (2013).

⁸⁴ § 164.526(c)(1)).

⁸⁵ Katie Hafner, *A Busy Doctor’s Right Hand, Ever Ready to Type*, N.Y. TIMES (Jan. 12, 2014), http://www.nytimes.com/2014/01/14/health/a-busy-doctors-right-hand-ever-ready-to-type.html?_r=0; Scott A. Shipman & Christine A. Sinsky, *Expanding Primary Care Capacity by Reducing Waste and Improving the Efficiency of Care*, 32 HEALTH AFF. 1990, 1993 (2013).

⁸⁶ Hafner, *supra* note 85.

⁸⁷ See PhysAssist Scribes, <http://www.iamscribe.com/index.php> (last visited Oct. 15, 2014); ScribeAmerica, <https://www.scribeamerica.com/> (last visited Oct. 15, 2014).

physicians have found that scribes significantly improve their work quality and, consequently, job satisfaction.⁸⁸

2. Automation

Advances in technology are also likely to enhance data accuracy and completeness. Some medical devices that collect patient data could automatically transmit measurements to EHRs without requiring human intermediaries who might mistype information or make other mistakes. Examples are devices that measure vital signs, such as blood pressure, pulse, oxygen rates, and temperature.⁸⁹ In addition, voice recognition software that is of high quality could reduce the risk of typos and promote the inclusion of more details in EHRs because documentation by dictation rather than by typing would take less time.⁹⁰

EHRs could further be programmed to generate alerts if implausible or clearly erroneous data is entered.⁹¹ In one study focusing on height and weight measures, researchers had the EHR alert clinicians if they entered figures that deviated by ten percent or more from height and weight measurements that were previously recorded.⁹² Thus, for example, if a patient's weight was recorded as being 150 pounds in one visit and 190 pounds three months later, a message would ask the clinician to check the two entries because it is unlikely that the patient gained forty pounds in

⁸⁸ Hafner, *supra* note 85.

⁸⁹ ECRI Institute, *Making Connections*, HEALTH DEVICES 102, 104 (2012), available at [https://www.ecri.org/Documents/HIT/Making_Connections_Integrating_Medical_Devices_with_Electronic_Medical_Records\(Health_Devices_Journal\).pdf](https://www.ecri.org/Documents/HIT/Making_Connections_Integrating_Medical_Devices_with_Electronic_Medical_Records(Health_Devices_Journal).pdf); *Partners HealthCare and Center for Connected Health Launch Personal Health Technology Platform to Improve Care Delivery*, PARTNERS HEALTHCARE (June 20, 2013), <http://www.partners.org/About/Media-Center/Articles/Partners-Center-for-Connected-Health-Technology-Platform.aspx>.

⁹⁰ Robert Hoyt & Ann Yoshihashi, *Lessons Learned from Implementation of Voice Recognition for Documentation in the Military Electronic Health Record System*, 7 PERSP. HEALTH INFO. MGMT. 1, 1 (2010), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2805557/>.

⁹¹ Krystl Haerian et al., *Use of Clinical Alerting to Improve the Collection of Clinical Research Data*, 2009 AMIA SYMP. PROC. 218, 219–20, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2815392/pdf/amia-f2009-218.pdf>.

⁹² *Id.* at 219.

such a short period of time. The researchers observed that after the alerts were implemented, EHR error rates fell from 2.4% to .9%.⁹³

3. Natural Language Processing

For purposes of secondary use of medical data, improved natural language processing (NLP) tools would be particularly useful. NLP tools would enable analysts to extract more comprehensive data from EHRs, including information such as medical history and progress notes contained only in the narrative text portion of the record.⁹⁴ While applications such as the Electronic Medical Record Search Engine (EMERSE)⁹⁵ have long been available, experts note that NLP capabilities are “still far from perfect”⁹⁶ and leave much room for improvement.

4. Best Practices Standards and Training Programs

EHR users would benefit greatly from best practices standards and training programs concerning appropriate and efficient data entry practices. Best practices guidelines and training programs could be developed cooperatively by vendors, government experts, and health care providers’ professional organizations.⁹⁷ These resources should help users formulate strategies to enhance EHR accuracy and completeness, with special attention paid to the most pervasive challenges, such as copy and paste features.

C. FEDERAL REGULATIONS

Another critical component of efforts to improve EHR data quality is federal regulation. While many in today’s political climate are loath to impose regulatory constraints upon the free market, regulatory interventions have long been customary in the very complex and critically

⁹³ *Id.* at 220.

⁹⁴ Bayley et al., *supra* note 28, at S83.

⁹⁵ David A. Hanauer, *EMERSE: The Electronic Medical Record Search Engine*, 2006 AMIA ANNU. SYMP. PROC., 941, 941, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1839699/pdf/AMIA2006_0941.pdf.

⁹⁶ Hersh et al., *supra* note 57, at S33.

⁹⁷ AM. HEALTH INFO MGMT. ASS’N, *supra* note 41, at 2–3.

important realm of health care. Good data quality can be considered a “positive externality” because those responsible for it, namely vendors and clinicians, do not reap all the benefits of high EHR quality.⁹⁸ Rather, third parties such as patients, insurers, researchers, and others have much to gain from data accuracy and comprehensiveness as well. Because the public’s interest is at stake, the government is justified in intervening to induce those who produce and use EHR systems to meet high quality standards. In addition, because the federal government covers over thirty percent of American patients through Medicare, Medicaid, and the Children’s Health Insurance Program,⁹⁹ it has a direct interest in ensuring that providers do not submit erroneous claims. The federal government could pursue at least three well-established regulatory avenues to address data quality problems: the Meaningful Use Regulations, the HIPAA Security Rule, and the Common Rule.

1. Meaningful Use Regulations

The Meaningful Use regulations, issued by the Centers for Medicare and Medicaid Services (CMS), govern providers’ use of EHR systems.¹⁰⁰ The regulations, which are being rolled out in three phases, establish what health care providers need to do in order to demonstrate that they are meaningful users of EHR systems and thus are eligible for government incentive payments for adoption of the systems.¹⁰¹ The Meaningful Use regulations could be harnessed to promote interoperability, data harmonization, and routine data audits.

⁹⁸ Abigail McWilliams et al., *Guest Editors’ Introduction Corporate Social Responsibility: Strategic Implications*, 43 J. MGMT. STUD. 1, 9 (2006) (defining “externality” as “the impact of an economic agent’s actions on the well-being of a bystander” and citing innovation as an example of a positive externality because of its general social benefits).

⁹⁹ THE HENRY J. KAISER FAMILY FOUND., *supra* note 8.

¹⁰⁰ Sharon Hoffman & Andy Podgurski, *Meaningful Use and Certification of Health Information Technology: What about Safety?*, 39 J. L. MED. & ETHICS 77, 78 (2011); 42 C.F.R. §§ 495.2–495.370 (2013).

¹⁰¹ Hoffman & Podgurski, *supra* note 100, at 78. President Obama’s stimulus legislation, the American Recovery and Reinvestment Act of 2009, “provides for payments of up to \$44,000 per clinician under the Medicare incentive program and \$63,750 per clinician under the Medicaid program.” *Id.* at 77.

The current stage of Meaningful Use regulations, stage 2, begins to address interoperability and data standardization. The regulations require health care providers who transition patients to different care settings (e.g. from a hospital to a rehabilitation center) or refer them to other doctors to transmit electronically to the next provider a certain percentage of their summary of care documents. In addition, providers must submit data to immunization registries and furnish syndromic surveillance information to public health authorities.¹⁰² At the same time, EHR certification regulations require vendors to build data portability capabilities into EHR systems that will enable clinicians to meet these Meaningful Use standards.¹⁰³ Such data exchanges necessitate some degree of interoperability and data standardization so that the recipients can receive and understand the submitted health information.

Stage 3 regulations are under development and will take effect in 2017.¹⁰⁴ These regulations should focus to a greater extent on interoperability and data harmonization so that documentation can always be exchanged among healthcare providers with different EHR systems and understood by them.¹⁰⁵ Patient records should not be irreparably fragmented among different physician practices and hospitals, and terms or acronyms such as “MS” should not mean different things in different EHRs. Just as drivers can look at most car dashboards and have little difficulty reading all of the instruments and displays, clinicians who have

¹⁰² 42 C.F.R. §§ 495.6(e)(8)–(10) (2013); *see also* *Stage 2 Eligible Professional (EP) Meaningful Use Core and Menu Measures Table of Contents*, CTR. FOR MEDICARE & MEDICAID SERV. (Oct. 2012), http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_MeaningfulUseSpecSheet_TableContents_EPs.pdf.

¹⁰³ *See* 45 C.F.R. §§ 170.314(b), (f) (2014) (addressing care coordination and public health).

¹⁰⁴ Robert Tagalicod & Jacob Reider, *Progress on Adoption of Electronic Health Records*, CTR. FOR MEDICARE & MEDICAID SERV. (Dec. 13, 2013, 12:41 PM), http://www.cms.gov/eHealth/ListServ_Stage3Implementation.html.

¹⁰⁵ Anthony Brino, *Senators Press for EHR Interoperability*, HEALTHCARE IT NEWS (Jan. 6, 2014), <http://www.healthcareitnews.com/news/senators-press-ehr-interoperability> (reporting that House and Senate bills call upon the Department of Health and Human Services “to adopt a common interoperability standard by 2017, as part of the rules for meaningful use Stage 3”); Verdon, *supra* note 67 (reporting that Dr. Karen DeSalvo, National Coordinator for Health Information Technology, has declared that interoperability will be a national priority).

been trained on one EHR system should be able to navigate and operate other EHRs.

Furthermore, CMS would be wise to consider incorporating requirements for periodic data audits into future Meaningful Use regulations. Providers could be instructed to conduct audits in order to verify that they do not have an unacceptably high error rate and to assess mechanisms to improve data accuracy and completeness.

2. The HIPAA Privacy and Security Rules

Several provisions of the HIPAA Privacy and Security Rules could serve as additional tools to improve data quality. As already noted, the HIPAA Privacy Rule empowers patients to review their EHRs and to request corrections if they detect errors.¹⁰⁶ In addition, the HIPAA Security Rule's General Requirements section states that covered entities bear responsibility for ensuring "the confidentiality, integrity, and availability" of electronic health information that they create, receive, maintain, or transmit.¹⁰⁷ The term "integrity" should be interpreted broadly to include data quality.

The regulations detail a variety of enforcement mechanisms, including investigation, corrective action mandates, and penalties.¹⁰⁸ The Department of Health and Human Services' Office of Civil Rights ("OCR") is authorized to investigate complaints of HIPAA violations filed by complaining parties and to initiate its own investigations as well.¹⁰⁹ To that end, OCR has launched an audit program.¹¹⁰ The issue of data quality

¹⁰⁶ 45 C.F.R. §§ 164.524–.526 (2013).

¹⁰⁷ 45 C.F.R. § 164.306(a)(1) (2013). The HIPAA Security Rule covers health plans, health care clearinghouses, and health care providers who transmit health information electronically, and their business associates. 45 C.F.R. § 164.104(a)(1)–(3) (2013).

¹⁰⁸ 45 C.F.R. §§ 160.300–.426 (2013).

¹⁰⁹ 45 C.F.R. §§ 160.306–.308 (2013); *How OCR Enforces the HIPAA Privacy and Security Rules*, U.S. DEPARTMENT OF HEALTH & HUM. SERVICES, <http://www.hhs.gov/ocr/privacy/hipaa/enforcement/process/howocrenforces.html> (last visited Oct. 6, 2014).

¹¹⁰ *Audit Program Protocol*, U.S. DEPARTMENT OF HEALTH & HUM. SERVICES, <http://www.hhs.gov/ocr/privacy/hipaa/enforcement/audit/protocol.html> (last visited Oct. 6, 2014); Patrick Ouellette, *OCR Readies Pre-Audit Survey for HIPAA Covered Entities, BAs*, HEALTHITSECURITY.COM (Feb. 25, 2014),

should be among OCR's areas of focus during audits, and the agency should require covered entities to demonstrate that they have implemented measures to verify and improve data quality.

Furthermore, ensuring that patients have access to their records and that patients can have mistakes corrected in their EHRs should be enforcement priorities for OCR. In a March 31, 2014 report, OCR indicated that patients' lack of access to their health information was the third most frequently investigated complaint.¹¹¹ Failure to amend records in response to legitimate requests for correction is not listed among the top five complaints, but it is not clear if this is because providers generally comply with the requests or because patients do not submit such requests frequently.¹¹² OCR has been criticized for not being aggressive enough in its enforcement activities.¹¹³ Experts, however, note that the agency's oversight efforts have been intensifying recently.¹¹⁴ One hopes that this trend will continue and that government enforcement will be an important component of the data quality enhancement toolkit.

3. The Common Rule

The federal research regulations, known as the Common Rule,¹¹⁵ can further incentivize physicians to be vigilant about the accuracy and completeness of their EHRs. Many physicians are also researchers,¹¹⁶ and

<http://healthitsecurity.com/2014/02/25/ocr-readies-pre-audit-survey-for-hipaa-covered-entities-bas/>.

¹¹¹ *Enforcement Highlights*, U.S. DEPARTMENT OF HEALTH & HUM. SERVICES (Mar. 31, 2014), <http://www.hhs.gov/ocr/privacy/hipaa/enforcement/highlights/>. The report covers the period of April 2003 (the HIPAA Privacy Rule's effective date) through March 2014. *Id.*

¹¹² *Id.*

¹¹³ See Alaap B. Shah & Ali Lakhani, *OCR Lacks Insight into HIPAA Security Rule Compliance*, BLOOMBERG BNA (Feb. 21, 2014), <http://www.bna.com/ocr-lacks-insight-into-hipaa-security-rule-compliance/>. (“[O]CR’s report card, although somewhat changed, is not materially improved since the OIG’s 2011 report wherein a ‘need for greater OCR oversight and enforcement’ was recommended.”).

¹¹⁴ *Id.*

¹¹⁵ 45 C.F.R. §§ 46.101–.505 (2013).

¹¹⁶ See generally Acad. of Physicians in Clinical Research, *About APCR*, APCRNET.ORG, <http://www.apcrnet.org/FunctionalMenuCategory/AboutAPCR.aspx> (last visited Oct. 6, 2014).

some of the research projects that they conduct are observational studies that involve review of medical records.¹¹⁷

Research involving identifiable patient information¹¹⁸ is subject to oversight by institutional review boards (IRB) pursuant to detailed Common Rule guidance.¹¹⁹ The regulations specify the criteria for IRB approval of studies that are governed by the regulations.¹²⁰ Several provisions address data collection, requiring IRBs to consider how researchers plan to monitor data to ensure the safety of participants and to protect their privacy.¹²¹ An additional approval criterion should be added to the regulations: a requirement that investigators who will collect data from EHRs indicate in their research protocols what steps they will take to monitor data quality. A mandate that researchers conduct regular data audits or otherwise double-check information contained in EHRs could enhance the reliability of research findings. In addition, it may induce clinicians who are themselves researchers or are sensitive to the needs of researchers to be more careful about EHR data input.

¹¹⁷ 45 C.F.R. § 46.102(f) (2013) (explaining that research covered by the Common Rule can be conducted in two ways: (1) intervention or interaction with individuals or (2) study of “identifiable private information.”)

¹¹⁸ *Id.* (indicating that the regulations cover “[p]rivate information ... that is individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information.”) Thus, by contrast, record-based studies that use only de-identified information are exempt from the federal research regulations and IRB approval.)

¹¹⁹ 45 C.F.R. §§ 46.107–.109 (2013) (addressing IRB membership, functions and operations, and review of research. According to the U.S. Food and Drug Administration, an IRB is “an appropriately constituted group that has been formally designated to review and monitor biomedical research involving human subjects” with “authority to approve, require modifications in (to secure approval), or disapprove research.” *Institutional Review Boards Frequently Asked Questions — Information Sheet*, U.S. FOOD & DRUG ADMIN., <http://www.fda.gov/regulatoryinformation/guidances/ucm126420.htm> (last updated June 25, 2014). IRB review is conducted in order to protect “the rights and welfare of human research subjects”). *Id.*

¹²⁰ 45 C.F.R. § 46.111 (2013).

¹²¹ 45 C.F.R. § 46.111(a)(6), (7) (2013).

V. CONCLUSION

Medical big data is a growing resource for insurance analysts and other researchers. Yet, EHR data is often significantly flawed and deficient. EHR data quality inadequacies are particularly troubling in the insurance realm because they can cause insurers to pay excessive or inappropriate claims reimbursement amounts. This, in turn, can generate premium increases for consumers or a squandering of taxpayer money in the case of public programs such as Medicare. Moreover, incorrect EHR data that is put to secondary uses can lead to erroneous inferences and poor insurance coverage or other health-related policies. Consequently, it is critical that vendors, health care providers, and government authorities aggressively attack the challenges of data quality. Solutions must be formulated by all stakeholders, not least of which is the government. It is only with significant improvements that the great potential of medical big data can be realized.

INFORMATION & EQUILIBRIUM IN INSURANCE MARKETS WITH BIG DATA

PETER SIEGELMAN¹

Asymmetric information makes the behavior of insurance markets very difficult to predict. But this Article argues that the increasing use of Big Data by insurers will not result in forecasts of loss that are so accurate that they eliminate uncertainty, and with it, the possibility of insurance. Big Data techniques might lead to a “flip” in informational asymmetry, resulting in a situation in which insurers know more about their customers than the latter know about themselves. But the effects of such a development could actually be benign. Finally, the Article considers the potential for Big (or at least, More) Data to create new markets for spreading risks that are currently uninsurable.

I. INTRODUCTION

Big Data is a hot topic these days, at least in the nerdosphere.² Pundits proclaim it to be “revolutionary,”³ “transformative,”⁴ and “a tidal wave.”⁵ Some have even suggested that the further use of Big Data will overturn our outmoded reliance on primitive notions such as “causation”⁶

¹ I thank Peter Kochenburger, Rick Swedloff, and the editors of the CILJ for helpful comments, and Pat McCoy and Francois Ewald for initiating the conversation.

² VIKTOR MAYER-SCHÖNBERGER & KENNETH CUKIER, *BIG DATA: A REVOLUTION THAT WILL TRANSFORM HOW WE LIVE, WORK, AND THINK* (2013) (sitting at number 9,501 on Amazon.com’s sales rankings as of October 13, 2014: not bad for a book with “data” in its title).

³ *Id.* at 7.

⁴ ERIC SCHMIDT & JARED COHEN, *THE NEW DIGITAL AGE: TRANSFORMING NATIONS, BUSINESSES, AND OUR LIVES* (2014).

⁵ BILL FRANKS, *TAMING THE BIG DATA TIDAL WAVE: FINDING OPPORTUNITIES IN HUGE DATA STREAMS WITH ADVANCED ANALYTICS* 5 (2012).

⁶ “Petabytes [lots of data] allow us to say: ‘Correlation is enough.’” Chris Anderson, *The End of Theory: The Data Deluge Makes the Scientific Method Obsolete*, WIRED MAG. (June 23, 2008), http://archive.wired.com/science/discoveries/magazine/16-07/pb_theory; see also *Correlation*, XKCD, <http://xkcd.com/552/> (last visited Nov. 21, 2014).

and “privacy.”⁷

This Article has a much narrower focus, however: I want to reflect critically on the role of Big Data in insurance. In particular, I ask what economic theory has to say about whether Big Data will lead to new equilibria in insurance markets. I focus on three questions: Might Big Data lead to the collapse of insurance altogether by permitting predictions of such accuracy that risk and uncertainty are effectively eliminated? Even if it doesn’t have such drastic effects, might it alter insurance market equilibria, by reducing the scope for risk-spreading? And might it be used to create new types of insurance that are not currently practical given current informational constraints? At the risk of destroying the narrative suspense, my proposed answers are, respectively: “no,” “probably not,” and “possibly.”

So, what *is* Big Data, anyway? Big Data is not a precise term, and several definitions are currently competing for supremacy. For our purposes, it suffices to think of Big Data as (i) very large collections of observations, particularly those that also include very large numbers of variables;⁸ and (ii) associated statistical techniques for using these ultra-large datasets to make predictions or forecasts.

II. PROLOGUE: INSURANCE MARKETS ARE WEIRD

A classic method of economic analysis is known as “Comparative Statics:” assume a (small) change to some variable, and then compare equilibria before and after this change has worked its way through the model or system. Economists have come to realize, however, that this method tends to break down in markets where there are significant informational asymmetries, that is, where one party to a transaction knows more than their counterpart does.⁹ Insurance markets are the *locus classicus*

⁷ Claire Porter, *Little Privacy in the Age of Big Data*, GUARDIAN (June 20, 2014), <http://www.theguardian.com/technology/2014/jun/20/little-privacy-in-the-age-of-big-data> (“In the era of big data, the battle for privacy has already been fought and lost . . .”).

⁸ According to Google chief economist Hal Varian, “Google has seen 30 trillion URLs, crawls over 20 billion of those a day, and answers 100 billion search queries a month. Analyzing even one day’s worth of data of this size is virtually impossible with conventional techniques.” Hal R. Varian, *Big Data: New Tricks for Econometrics*, 28 J. ECON. PERSP. 3, 4 (2014).

⁹ See generally George A. Akerlof, *The Market For “Lemons”: Quality Uncertainty and the Market Mechanism*, 84 Q. J. ECON. 488 (1970) (using the used

of informational asymmetries, in the form of adverse selection and moral hazard,¹⁰ and this in turn implies that our ordinary intuitions about how markets work may fail decisively when it comes to insurance markets.

For example, we would predict that in ordinary markets, sellers would view demand for their product as a good thing, and indeed would be delighted to sell to anyone who wanted to buy from them: picture Lucy at her lemonade stand when a customer arrives and says “I’ll buy all the lemonade you have to sell at 25¢ a glass.” But insurance is different. How will Irene react when someone rushes up to her insurance stand and says “I’ll buy all the life insurance you’ll sell me at 25¢ per \$125 of coverage?” The explanation for the difference is, of course, the (fear of an) informational asymmetry that Irene faces but Lucy does not. The life insurance customer who desperately wants lots of coverage may well know something about his own prospects for longevity that her potential insurer does not know, and this information is obviously highly relevant to the insurer’s profitability from transacting with this customer.¹¹

It is by now well-known that informational asymmetries have a profound effect on the institutions of insurance markets, from the language of contracts to the scope and function of regulation. My point is that in the presence of such asymmetries, insurance market equilibria are highly sensitive to small and seemingly trivial details of how a market operates.

car market as an example to discuss the relationship between quality and uncertainty and the problem that relationship poses for the theory of market equilibrium); Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AMER. ECON. REV. 941 (1963) (explaining that the special economic problems of the medical care industry are adaptations to the existence of uncertainty in the incidence of disease and the efficacy of treatment); Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q. J. ECON. 629 (1976) (analyzing competitive insurance markets in which the characteristics of the insured are not fully known to the insurer).

¹⁰ Both concepts are central to virtually all aspects of modern economics; both began as terms of art in insurance. Adverse selection can loosely be defined as the tendency of the worst risks to find insurance price for an average risk to be especially attractive. Moral hazard (again, loosely) occurs whenever the presence of insurance causes insureds to take less care to prevent risks than they would exercise in its absence.

¹¹ See *USLife Credit Life Ins. Co. v. McAfee*, 630 P.2d 450 (Wash. Ct. App. 1981) (discussing how an insurance professional took out numerous credit life insurance policies that required no medical underwriting, on his wife, who he knew was suffering from terminal cancer).

Under some circumstances, there may be no equilibrium possible at all;¹² under slightly different circumstances, only “separating” equilibria (those in which each risk-type pays a premium that fully reflects its riskiness, with no cross-subsidization between types); under others, “pooling” (cross-subsidization from low-risk to high-risk insureds) is sustainable in equilibrium.¹³ Moreover, insurance supply and demand are not actually independent, as they are in ordinary markets.¹⁴ Thus, a mandate to buy insurance, rather than simply increasing demand and causing prices to rise, may actually lower costs and result in a *fall* in prices; it could even obviate the requirement to purchase insurance in the first instance.¹⁵

The situation gets even more complicated and unpredictable if we recognize that consumers are not perfectly rational, which the evidence overwhelmingly demonstrates is the case.¹⁶ Consumers often buy “insurance” products, such as extended warranties, that no rational person should want;¹⁷ conversely, they frequently shun coverage for losses due to floods or earthquakes that a rational person would want to insure against.¹⁸

¹² Rothschild & Stiglitz, *supra* note 9, at 634–37.

¹³ *Id.*; see also Georges Dionne & Neil Doherty, *Adverse Selection in Insurance Markets: A Selective Survey*, in CONTRIBUTIONS TO INSURANCE ECONOMICS 116 (Georges Dionne ed., 1992).

¹⁴ For a cogent explanation, see Liran Einav & Amy Finkelstein, *Selection in Insurance Markets: Theory and Empirics in Pictures*, 25 J. ECON. PERSP. 115, 118 (2011). The basic idea is that unlike a purchaser of, say, broccoli, the purchaser of insurance contributes to *both* sides of the market. A low-risk purchaser lowers the aggregate risk of the pool of insureds as a whole, and thus reduces the cost of supplying insurance to everyone. Demand and cost are not independent.

¹⁵ Raphael Boleslavsky & Sergio J. Campos, *Does the Individual Mandate Coerce?*, 68 U. MIAMI L. REV. 1, 4–8 (2012).

¹⁶ See generally HOWARD C. KUNREUTHER ET AL., INSURANCE AND BEHAVIORAL ECONOMICS: IMPROVING DECISIONS IN THE MOST MISUNDERSTOOD INDUSTRY (2013) (discussing examples of “anomalous” behavior by consumers, insurance companies, investors, and regulators).

¹⁷ For a detailed explanation and policy recommendations, see Tom Baker & Peter Siegelman, “You Want Insurance With That?” *Using Behavioral Economics to Protect Consumers from Add-On Insurance Products*, 20 CONN. INS. L. J. 1 (2013).

¹⁸ 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., 2014); David M. Cutler & Richard Zeckhauser, *Extending the Theory to Meet the Practice of Insurance*, in BROOKINGS-WHARTON PAPERS ON FINANCIAL SERVICES (2004);

And it turns out that correcting for some kinds of “mistakes” made by insufficiently-rational consumers may actually exacerbate informational asymmetries and reduce welfare for everyone.¹⁹

The moral of all this is simple: beware of anyone (including me) who confidently tells you anything about how insurance markets behave, including how they will react to the increased use by insurers of Big Data. There is little basis in theory or empirical evidence for any confident forecast about how Big Data will shape insurance markets. What follows, then, is more by way of cautious speculation than robust prediction.

III. COULD BIG DATA VANQUISH UNCERTAINTY (AND DESTROY INSURANCE)?

A. TMI AND THE ABSENCE OF INSURANCE

Economists have long understood that uncertainty is a prerequisite for insurance. Table 1 provides a simple numerical example. A village consists of 100 identical houses, each of which is worth \$200,000, and which constitutes each homeowner’s total wealth. There is a 25% chance that any individual house will be completely destroyed by the next earthquake. Each homeowner has the same utility function, $U_i = U(\text{Wealth}) = \ln(\text{Wealth})$, which implies that they are risk-averse.

Will the villagers demand insurance, assuming it can be purchased at the actuarially-fair premium (without any load)? To see that the answer is yes, we can compare each villager’s expected utility without insurance to her utility with it. Without insurance, a homeowner’s expected utility is

$$\Pr(\text{Loss}) \times (\text{Utility}|\text{Loss}) + \Pr(\text{No Loss}) \times (\text{Utility}|\text{No Loss}) =$$

$$0.25 \times \ln(\text{Wealth}|\text{Loss}) + 0.75 \times \ln(\text{Wealth}|\text{No Loss}) =$$

$$0.25 \times \ln(0) + 0.75 \times \ln(200,000) = 8.58.²⁰$$

KUNREUTHER ET AL., *supra* note 16, at 115.

¹⁹ See, e.g., Benjamin R. Handel, *Adverse Selection and Inertia in Health Insurance Markets: When Nudging Hurts*, 103 AMER. ECON. REV. 2643 (2013); Alvaro Sandroni & Francesco Squintani, *Overconfidence, Insurance, and Paternalism*, 97 AMER. ECON. REV. 1994, 1994 (2007); Justin Sydnor, *(Over)insuring Modest Risks*, 2 AMER. ECON. J.: APPLIED ECON. 177, 198 (2010).

²⁰ Since $\ln(0)$ is undefined, we innocuously substitute 0.001 for $(\text{Wealth}|\text{Loss})$.

100 times this amount is the village's aggregate utility when nobody buys insurance.

Suppose we now introduce the possibility of insurance, sold with no load. The actuarially fair premium is equal to the expected loss, which is just $0.25 \times 200,000 = \$50,000$. Thus, anyone who buys insurance pays a premium of \$50,000 and has guaranteed wealth of $(200,000 - 50,000 =)$ \$150,000.²¹ The utility of \$150,000 held with certainty is just $\ln(150,000) = 11.92$. Since this is larger than the *expected* utility of doing without insurance, everyone will want to purchase full coverage, and village aggregate utility is thus 1,192, which is higher than before.

²¹ If the earthquake does *not* occur, the premium is paid but there are no losses, so wealth is $200,000 - 50,000 = \$150,000$. If the earthquake *does* occur, the homeowner pays a premium of 50,000, loses 200,000, and then receives a check for the full amount of the loss, again leaving her with \$150,000 net.

Table 1: Insurance vs Non-Insurance,
No Individuation (homogenous risk)

| Assumptions | |
|----------------------------------|-----------|
| Population Size | 100 |
| Individual Wealth, W | 200,000 |
| Size of Loss ⁱ | 200,000 |
| Probability of Loss [*] | 25% |
| Utility function, $U(W)$ | $\ln(W)$ |
| No Insurance | |
| Aggregate Expected Loss | 5,000,000 |
| Aggregate Expected Utility | 858 |
| With Insurance (Pooling) | |
| Fair Premium | 50,000 |
| Wealth, After Premium | 150,000 |
| Utility | 11.92 |
| Aggregate Utility | 1,192 |

ⁱ **Need reference here**

^{*}For every individual.

Now imagine that we have access to some technology that generates perfect predictions: instead of each villager facing a 25% chance of having his or her home destroyed, we know with certainty which 25 homes will be destroyed and which 75 will escape any damage. The owners of the 75 known-to-be-safe houses will obviously have no demand for insurance at any positive premium, since they would be paying for coverage that would be of no use to them. Conversely, owners of the 25 known-to-be-destroyed houses will certainly want insurance. But the only coverage available to them will be at the fair premium for a certain-to-be-destroyed house ($100\% \times 200,000 =$) \$200,000, and there is no reason to buy coverage when the premium is equal to the actual loss.²² So once the forecasting technology is made available, nobody will purchase insurance.

The loss of risk-spreading that accompanies perfect forecasting leaves the community as a whole worse off.²³ Aggregate welfare is now the same as in the no-insurance state described earlier (858), which is 28% lower than when insurance is possible. Before the technology is introduced, behind Rawls' veil of ignorance, the community would want to ban its use. Too much information can reduce welfare.²⁴

²² Note that it is irrelevant whether the insurance company has direct access to this technology or not. Suppose homeowners are the only ones who know whether or not their house will be destroyed; by the logic above, those who want to buy insurance are only the owners who know they will lose their house for sure. The insurance company can thus infer that anyone who demands insurance will be a guaranteed house-loser, and will price its product accordingly. Cf. Alexander Tabarrok, *Genetic Testing: An Economic and Contractarian Analysis*, 13 J. HEALTH ECON. 75, 75–76, 79–82 (1994) (providing an example of this concept in the genetic testing context).

²³ In fact, it in some sense destroys the meaning of “community.” Before the forecast, everyone in the village was subject to the same risk, and all had a common interest in minimizing its effects via mutual insurance. After the forecast, however, those who will be spared are no longer interested in sharing their fortune with that of their known-to-be-less-fortunate neighbors.

²⁴ For an elegant discussion of the divergence between the private and social value of information, see Jack Hirshleifer, *The Private and Social Value of Information and the Reward to Inventive Activity*, 61 AMER. ECON. REV. 561 (1971). Hirshleifer's point is that in a pure exchange economy, “the community as a whole obtains no benefit . . . from either the acquisition or dissemination of private foreknowledge.” *Id.* at 565 (emphasis in original). Foreknowledge is defined as the accurate prediction of an event that will eventually come to pass (or not), as distinguished from the discovery of something new that need not be discovered at all. See, e.g., *id.* at 562. In my example, information prevents risk-

B. HOW GOOD CAN BIG DATA BE?

Speaking very broadly, Big Data can generate better predictions by uncovering new independent variables, or combinations of variables, that help explain the outcome of interest, and it can help uncover new ways in which the independent variables are related to the outcome.²⁵ But for most risks for which people seek insurance, it seems virtually impossible that any feasible improvement in the technology of prediction could so significantly increase accuracy as to make insurance impossible.

Assertions of seemingly miraculous predictions emerging from Big Data are often, on closer examination, grossly exaggerated. Two years ago, for example, *New York Times* reporter Charles Duhigg wrote a widely-discussed article about how Target was able to use Big Data techniques to predict, on the basis of their purchasing patterns, which customers were pregnant.²⁶ The story featured an account of an angry father whose teenage daughter received ads for diapers and wipes, even though (he believed) she was not pregnant. But it turned out that she actually *was*, and Target had apparently used Big Data to figure this out before he did.

Writing in the *Financial Times*, economist Tim Harford effectively debunks this story, however. It turns out that the reported success of Target's algorithm ignored the false positive problem: we didn't get to hear the stories about women who received coupons for babywear but who *were not* pregnant.

Hearing the anecdote, it's easy to assume that Target's algorithms are infallible—that everybody receiving coupons for onesies and wet wipes is pregnant. This is vanishingly unlikely. Indeed, it could be that pregnant women receive such offers merely because everybody on Target's mailing list receives such offers. We should not buy the idea that

spreading, and hence is actually destructive of social welfare.

²⁵ For a brief and appropriately skeptical view of the strengths and weaknesses of Big Data, see Sendhil Mullainathan, *Why Computers Won't be Replacing You Just Yet: A 25-Question Twitter Quiz to Predict Retweets*, N.Y. TIMES (July 1, 2014), <http://www.nytimes.com/2014/07/03/upshot/a-25-question-twitter-quiz-to-predict-retweets.html>.

²⁶ Charles Duhigg, *How Companies Learn Your Secrets*, N.Y. TIMES (Feb. 16, 2012), <http://www.nytimes.com/2012/02/19/magazine/shopping-habits.html>.

Target employs mind-readers before considering how many misses attend each hit.²⁷

C. IS THE TMI PROBLEM A REALISTIC CONSEQUENCE OF BIG DATA?

It is possible that Big Data may produce too much information, leading to the selective destruction of insurance markets. But is this theoretical possibility one we should be worried about? Although there may be some exceptions, I think the answer for most risks we care about is “no.”²⁸

For an example of how difficult prediction can be, consider forecasting someone’s future earnings at the time they graduate from high school. Economists Alan Krueger and William Bowen attempted this exercise, considering “an embarrassingly long list of [108] explanatory variables . . . including sets of variables measuring family income, parents’ education, parents’ occupation, students’ expected occupation [on graduating from high school], race, sex, religion, age, and achievement test scores.”²⁹ “Perhaps surprisingly,” the authors conclude, “an ordinary least squares regression with these variables accounted for only one-quarter of the variability in earnings.”³⁰ Big Data techniques could be used to reduce the list of 108 variables to a smaller number that were the most powerful explanatory factors. They could be used to find additional variables that might enable some further gains in predictive accuracy. But they cannot dramatically improve the prediction of events or outcomes with millions of independent causes, each of which contributes only a tiny share of the overall effect.

Suppose instead that we are trying to explain whether individual *i*’s house burns down over some fixed period. We might start with traditional underwriting information: the date the house was built, the kind of materials used, the owner’s smoking status, and so on. Now consider

²⁷ Harford attributes this insight to statistician Kaiser Fung. Tim Harford, *Big Data: Are We Making a Big Mistake?*, FIN. TIMES (Mar. 28, 2014), <http://on.ft.com/P0PVBF>.

²⁸ Kenneth S. Abraham & Pierre-André Chiappori, *Classification Risk and Its Regulation*, in RESEARCH HANDBOOK ON THE LAW AND ECONOMICS OF INSURANCE (Daniel Schwarcz & Peter Siegelman eds., forthcoming 2015).

²⁹ Alan B. Krueger & William G. Bowen, *Policy Watch: Income-Contingent College Loans*, 7 J. ECON. PERSP. 193, 196 (1993).

³⁰ *Id.*

expanding the set of possible explanatory variables, augmenting traditional underwriting data with new information of the kind Big Data techniques are designed to discover and utilize, such as the homeowner's high school GPA; the list of magazines she subscribes to; and the number of calls made from the home to area code 510.

It is possible that one or more of these new variables, separately or interacted with each other or existing variables, could improve predictive accuracy. For example, when it comes to predicting the chance of a fire this year, knowing that the homeowner had GPA of 2.3 or that she subscribes to *Soldier of Fortune* might be more useful than knowing that her home was built in 1956.

Big Data methods allow the researcher to consider many more variables and combinations of variables than has traditionally been possible, including "high dimensional" cases where the number of explanatory variables is greater than the number of observations.³¹ When analysts are searching for a parsimonious group of a few explanatory variables from among many possibilities, Big Data and machine learning techniques can be extremely useful. But that is *not* the same as saying that Big Data can explain the otherwise inexplicable.

There is no doubt that there may be gains to be achieved from using Big Data techniques to predict fire risk. But as Table 2 makes clear, it is almost algebraically impossible that any newly discovered variable (e.g., homeowner's GPA) or combination of variables (Female & Subscribes to *Soldier of Fortune* magazine & GPA less than 2.5) could enable highly-accurate predictions of fire risk. Imagine that, by using Big

³¹ For an introduction to the theory and some examples, see Alexandre Belloni et al., *High-Dimensional Methods and Inference on Structural and Treatment Effects*, 28 J. ECON. PERSP. 29, 33-34, 38-41 (2014). Moreover, these techniques are designed to prevent "over-fitting" or ad hoc specifications in which the researcher develops an explanatory model that fits the data for a given sample, but is useless for predictive purposes outside of the sample. Overfitting of this kind is more likely as the ratio of explanatory variables to observations increases. In the limit, there are exactly as many variables (plus a constant) as there are observations. In this case, the ordinary least squares estimator will fit the data perfectly, returning an R^2 of one. However, using the estimated model is likely to result in very poor forecasting properties out-of-sample because the model estimated by least squares is overfit: the least-squares fit captures not only the signal about how predictor variables may be used to forecast the outcome, but also fits the noise that is present in the given sample, and is not useful for forming out-of-sample predictions. *Id.* at 30.

Data, we found that being female, subscribing to *Soldier of Fortune*, and having a high school GPA of less than 2.5 are collectively associated with a 100-fold increase in fire risk. If Big Data techniques could generate a robust improvement in prediction of this magnitude, it would be truly shocking.³² But even if such an improvement were achievable, it would only raise the probability of a fire (for the small number of persons in this group) from 9/10,000 to 900/10,000, which is still less than 10 percent. A dramatic increase from the baseline case, to be sure, but nothing remotely approaching a risk so high as to be virtually certain, one that would shred the veil of ignorance needed to make risk-spreading possible.

| Table 2: Back-of-the-Envelope U.S. Fire Risk | |
|--|---|
| 236,200 | annual average one- and two-family residential fires in the period 2009-2011. ³³ |
| 90,742,000 | single unit homes. ³⁴ |
| 0.0026 | annual probability that a house will experience a fire (26/10,000) |

But what about rare medical conditions, such as Huntington's disease, you might ask? Estimates apparently vary quite widely, but one recent study estimated the annual incidence of Huntington's disease to be 0.38 per 100,000, which is only 1/685th as high as the US annual house-fire risk.³⁵ Yet some scholars have suggested that Huntington's is

³² By "robust," I mean that the correlation would hold up in the future, and would reflect not just a random association in the sample of cases on which the predictive model was estimated. In Mullainathan's example, a Big Data algorithm predicted "which [of a given pair of] tweet[s] gets retweeted [more often] about 67 percent of the time, beating humans, who on average get it right only 61 percent of the time." Mullainathan, *supra* note 25. Impressive as this is, it represents only a 10% improvement (6%/61%) over human performance.

³³ Nat'l Fire Data Center, U.S. Fire Admin., *One- and Two-family Residential Building Fires (2009-2011)*, 14 TOPICAL FIRE REP. SERIES 1, 1 (Sept. 2013), available at <http://www.usfa.fema.gov/downloads/pdf/statistics/v14i10.pdf>.

³⁴ *Table C-01-AH: General Housing Data—All Housing Units*, H150/11 AM. HOUSING SURV. FOR U.S.: 2011 at 3 (2013), available at <http://www.census.gov/content/dam/Census/programs-surveys/ahs/data/2011/h150-11.pdf>.

³⁵ "Meta-analysis of data from four incidence studies revealed an incidence of 0.38 per 100,000 per year," while a meta-analysis of eleven studies suggested that "[t]he [lifetime] service-based prevalence of HD . . . in Europe, North American

essentially uninsurable³⁶ because it is almost perfectly predictable based on genetic screening: the disease occurs because of a trinucleotide repeat, and anyone with more than 40 repeats is certain to be affected.³⁷

For insurance purposes, the relevant difference between Huntington's risk and house fire risk is not their relative magnitudes. Rather, it is that Huntington's has a single, identifiable predictor, the genetic defect is the only source of the condition, and everyone with the defect develops the disease. House fires, by contrast, are not mechanically linked to any single predictable-in-advance cause. Many women have low high school GPAs and read *Soldier of Fortune*, but even in our hypothetical world, only a small fraction of them will experience a house fire. The social world is inherently more complex than the bio-physical world in this respect. And even many medical conditions are more like type-2 diabetes than like Huntington's disease: they are the result of a complicated and poorly-understood mix of environmental and biological factors, and there is simply no clear-cut causal structure that explains when the risk will materialize and when it won't.³⁸

[sic], and Australia, . . . [was] 5.70 per 100,000." Tamara Pringsheim et al., *The Incidence and Prevalence of Huntington's Disease: A Systematic Review and Meta-Analysis*, 27 MOVEMENT DISORDERS 1083, 1083 (2012).

³⁶ Pierre-André Chiappori, *The Welfare Effects of Predictive Medicine*, in COMPETITIVE FAILURES IN INSURANCE MARKETS: THEORY AND POLICY IMPLICATIONS 55, 56, 65–66 (Pierre-André Chiappori & Christian Gollier eds., 2006).

³⁷ The defect involves the repetition of a group of three nucleotides (CAG: Cytosine, Adenine and Guanine). Healthy people have between 7 and 35 repetitions of this group. However, an incidence of more than 40 repetitions leads to the presence of the disease. Francis O. Walker, *Huntington's Disease*, 369 LANCET 218, 220 (2007). The condition is autosomal dominant, which means that a defective gene inherited from either parent is sufficient to cause the disease. *Id.*

³⁸ Consider diabetes (which is actually several different conditions). "Most patients with type 2 diabetes [which "accounts for 80% to 90% of cases of diabetes in the United States"] . . . have some degree of tissue insensitivity to insulin attributable to several interrelated factors These include putative (mostly as yet undefined) genetic factors, which are aggravated in time by further enhancers of insulin resistance such as aging, a sedentary lifestyle, and abdominal visceral obesity. Not all patients with obesity and insulin resistance develop hyperglycemia, however." Umesh Masharani & Michael S. German, *Chapter 17: Pancreatic Hormones and Diabetes Mellitus*, in GREENSPAN'S BASIC & CLINICAL ENDOCRINOLOGY (David G. Gardner & Dolores Shoback eds., 9th ed. 2011), available at <http://accessmedicine.mhmedical.com/book.aspx?bookid=380>.

The bottom line is that Big Data techniques are not all that useful for single-predictor risks such as Huntington's disease, the cause of which was discovered using ordinary scientific methods. And however useful they are for more complex predictive structures, Big Data techniques do not permit accurate prediction of multiply-caused rare events. While even small improvements in predictive accuracy can be quite valuable,³⁹ it seems highly unlikely that Big Data techniques will produce dramatic improvements in prediction. Mathematician Jordan Ellenberg recently put it this way:

There are lots of . . . problems where supplying more data improves the accuracy of the result in a fairly predictable way. If you want to predict the course of an asteroid, you need to measure its velocity and its position . . . The more measurements you can make of the asteroid and the more precise those measurements are, the better you're going to do at pinning down its track. But some problems are more like predicting the weather[,] [because weather is, in the technical sense of the word, *chaotic*.] . . . [H]uman behavior [is] even harder to predict than the weather. We have a very good mathematical model for weather, . . . [but] [f]or human action we have no such model and may never have one.⁴⁰

IV. WHAT IF INSURERS KNOW MORE THAN INSURED DO ABOUT INDIVIDUAL RISK?

Even if Big Data methods are not sufficient to generate perfect (or even very good) predictions, they could well have other effects that would be worth taking seriously. Since policyholders themselves are not very good at predicting their own riskiness in many situations, Big Data techniques might offer insurers an improvement on the status quo that

³⁹ Netflix offered a \$1M prize to anyone who could improve its movie-recommending algorithm by more than 10 percent. According to a Netflix official, a 10% improvement in their recommendations, small as that seems, would recoup the million in less time than it takes to make another *Fast and Furious* movie. JORDAN ELLENBERG, *HOW NOT TO BE WRONG: THE POWER OF MATHEMATICAL THINKING* 166 (2014).

⁴⁰ *Id.* at 164-65.

allows them to out-predict their customers. As we saw earlier, the economic theory of insurance suggests that market equilibria are highly sensitive to small changes in underlying assumptions or parameters, so things might look very different if insurers were able to use Big Data techniques to discover more about policyholders' riskiness than the policyholders themselves knew. Thus, whether or not these methods yield good predictions in some absolute sense, they could still profoundly shape equilibria, even if all they do is improve insurers' predictions *relative* to what insureds know.⁴¹

What follows is an attempt to illustrate this relatively simple observation.

A. CHARACTERIZING INFORMATION: WHO KNOWS WHAT

Consider a very simple description of possible information stocks. Policyholders face a known loss, L , which is the same for everyone. Each policyholder j has a unique probability of experiencing this loss, p_j . The actuarially fair premium for policyholder j is equal to j 's expected loss:

$$E(L) = p_j \times L.$$

In turn, the probability of loss depends on facts about the policyholder, which we can describe as a vector of characteristics, X_j . We can thus write

$$p_j = f(X_j),$$

which says nothing more than that the probability that individual j will experience a loss is a function of the value of the various explanatory variables for that individual, X_j .

We can go further and partition the variables that make up X_j into two possibly-overlapping parts. $X_{j,P}$ represents all the information the policyholder knows about himself—for example, how recklessly he drives. $X_{j,I}$ represents the insurer's information about j (for example, the riskiness of j 's car, or of the area where he typically drives). Some information will, of course, be uniquely held by one party, while some will be common to both (j 's sex or age). In addition, we should allow for information that is known to nobody, which we can denote as random error, ε . Thus, the expected loss (and fair premium) for policyholder j can be written as:

$$E(L) = f(X_{j,P}, X_{j,I}, \varepsilon)L.$$

⁴¹ Two hikers spot a bear getting ready to charge them. The first hiker drops his pack, takes off his hiking boots, and begins to put on running shoes. The second hiker asks, "What's the point? You're never going to outrun that bear." The first replies: "You're right, I won't; but all I need is to outrun *you*."

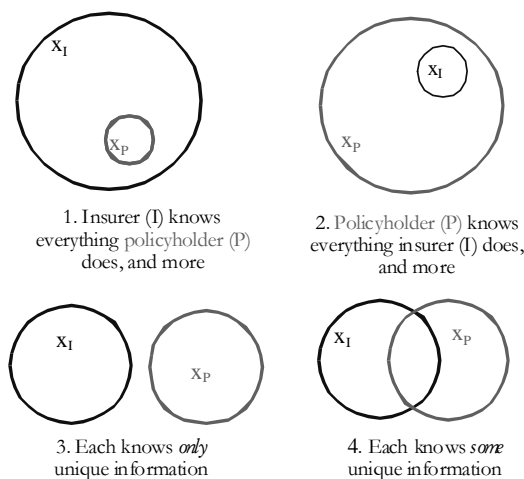


Figure 1

Figure 1 presents some possible configurations of information sets. For example, in panel 1, the insurer knows everything the policyholder knows, as well as some information in addition. In panel 2, the situation is reversed; the policyholder knows everything the insurer knows, and more.

It has generally been assumed by economists that (2) is the best description of how the world works. For example, all models of adverse selection and moral hazard are based on this characterization. While it may seem implausible, there is actually a sophisticated justification for this assumption. When the insurer quotes a price for insurance coverage for individual j , j 's premium, it will presumably make an optimal computation of j 's riskiness, based on all the information it has at its disposal. So the insurer's estimated fair premium for j will be $f(X_{ji}) \times L$. But that's just the expected loss for policyholder j , given the information available to the insurer, X_{ji} . And since the premium is actuarially fair,⁴² policyholder j can easily deduce what the insurer thinks his risk of loss must be. For example,

⁴² This is required in a competitive equilibrium. A premium that is less than actuarially fair can be expected to earn losses, and the insurer will prefer not to offer any policy at all than to offer one that loses money. A premium priced *above* the actuarially fair level will attract competitors who can offer a slightly lower price and lure away all customers. So the only sustainable price in a competitive market is the fair premium.

suppose the loss is known to be 100. Then a quoted premium of 2 implies that the insurer must believe there is a 2% chance it will have to pay out 100. That, in turn, suggests that even if the policyholder does not know exactly what the insurer knows, he can infer all he *needs* to know about the insurer's information *via* the premium he is quoted, which will necessarily reveal exactly what the insurer believes about the policyholder's expected loss. So the insurer effectively ends up having to surrender all its private information in a competitive equilibrium, while the policyholder doesn't.⁴³ That situation resembles panel (2) of Figure 1.

But this simple story, appealing as it is, need not be correct. It is possible to have equilibria in which the insurer knows less about insureds than they know about themselves, even with completely rational consumers, a competitive market, zero-cost (no load factor) insurance, and no uncertainty about the size of the loss.⁴⁴ The next section explains, by way of an example.

B. EQUILIBRIUM WHEN POLICYHOLDERS ARE BETTER INFORMED THAN INSURERS⁴⁵

Suppose that the population consists of equal numbers of two types of insureds, high-risk and low-risk. The first group has a risk of loss equal to 0.4 ($p_H = 40\%$); the second has a risk of loss equal to 0.3 ($p_L = 30\%$). The loss is known to be 100 for all individuals who experience a loss. The fair premium *for the group as a whole* is just the average loss:

⁴³ The policyholder reveals *some* information when he decides to accept or reject the insurer's offer, but it should be clear that this decision does not give away everything the policyholder knows about his own riskiness.

⁴⁴ If consumers are unable to make rational inferences—and the evidence cited suggests this is indeed the case—their ability to extract the insurer's estimate of their own riskiness from the premium quotation they receive is obviously diminished. The ability to extract this information is further diminished by any markup over the fair premium to cover the insurer's cost and by failures of competition to drive prices down to the zero-profit level. KUNREUTHER ET AL., *supra* note 16.

⁴⁵ Bertrand Villeneuve, *Competition Between Insurers with Superior Information*, 49 EUR. ECON. REV. 321 (2005), provides the careful analysis on which this loose paraphrase is based. There are important background conditions (e.g., that all policyholders are risk averse enough so that they will demand insurance at each of the possible premiums) which are too technical to consider here.

$$\pi = \left(\frac{1}{2}p_H + \frac{1}{2}p_L \right) \times 100 = 35.$$

Assume further that for any individual j , the insurer knows exactly which group j is in, while j knows only the *average* risk of the population as a whole, but not his own individual risk. The industry contains N competitive firms, so that premiums are driven down to the actuarially fair level (given that there are no operating or other costs). Thus, all firms earn zero profit.

Suppose the insurer makes an offer to sell insurance to individual j by quoting her a premium.⁴⁶ Consider first the possibility that the insurer quotes the group-wide average premium of 35. How would a policyholder react to this offer? If she *knew* she were a low-risk individual, she should reject the offer, because in a competitive market, she would be able to attract a better one from another insurer until the premium was actuarially fair *for a known low-risk individual*. (Conversely, a known high-risk individual would be delighted to be quoted a premium that was less than his actuarially fair value.) But the whole point is that the policyholder does *not* know her own risk type, so the premium of 35 is the best she can expect, given her ignorance of her own riskiness. Thus, both high and low-risk individuals would be content to stick with the average or “pooled” premium, if they were offered it.

But for this to be an equilibrium, we have to establish that the insurer would want to quote the average price in the first place. Consider first what happens when the insurer knows that j is low-risk (but remember, j herself does not). A premium of 35 implies that the insurer would earn profits of $35 - 30 = 5$ for this customer, if she accepts the offer. But if the insurer offers a premium appropriate for the population average risk of 35, it will then be competing with every one of the other N insurers in the market who also offer this price. That in turn means that the insurer faces a $1/N$ chance of landing this consumer, for an expected profit of $5/N$. Alternatively, the insurer might consider quoting a slightly lower premium, say 34, and having a 100% chance of attracting this policyholder given that all its competitors are quoting a price of 35. That would yield a profit of $100\% \times (34 - 30) = 4$. As long as the number

⁴⁶ Significantly, this is what is known as a “signaling” equilibrium because the informed party—here, the insurer—makes the offer. In standard models of insurance market equilibrium, it is the *uninformed* party (still the insurer, but the policyholder knows everything that the insurer does and more, so the insurer is *uninformed*) who makes the offer, which leads to a “screening” equilibrium.

of rivals is greater than 2, the insurer would prefer to offer the lower price and land the customer with certainty.

Thus, it might look as if quoting the blended premium (35) cannot be an equilibrium, because an insurer would prefer to do something else. But that intuition turns out to be wrong. Once an uninformed customer receives a quote of 34 from an insurer—who is known to be better informed than she is—she will instantly know that the *insurer* knows she is low-risk.⁴⁷ With this knowledge, she is then in a position to demand a reduction in premium to 30 (befitting a known low-risk customer); in a competitive equilibrium with full information on all sides, the zero-profit price is the only one that can prevail.

The point is that by quoting an even slightly more-appropriate price, the insurer ends up telling the consumer exactly what her risk is, and the consumer is then in a position to use that information against the insurer, by insisting on an even lower premium. And in a competitive market, she will, in fact, receive that lower premium. Thus, a small deviation from the blended (average) premium will not be profitable for the insurer. Sticking with the “pooled” rate will be the best the insurer can hope to do.

C. POOLING VS SEPARATION

The careful reader—if he or she has gotten this far—might find something surprising here. A world in which insurers know more about each policyholder than the policyholder does about herself is actually supportive of a *pooling* equilibrium, one in which all consumers pay the same “bundled” or average premium. The *non*-existence of a pooling equilibrium in the presence of adverse selection is one of the key insights of the pioneering Rothschild/Stiglitz model of insurance markets: when consumers know more than insurers do, policyholders’ ability to select a policy based on their “inside” information makes a pooling equilibrium unsustainable in a competitive market.⁴⁸

You might think that as insurers learn more and more about their customers, premiums would become more and more individualized and the possibility of pooling would only be diminished. But the weird economics of insurance markets demonstrates that this need not be true. The example above illustrates that when the insurer knows each customer’s risk exactly,

⁴⁷ An offer of 34 is only profitable if made to a known low-risk consumer.

⁴⁸ Rothschild & Stiglitz, *supra* note 9, at 639.

while customers know only the group average risk, pooling equilibria *are* possible. Unfortunately, theory predicts that separating equilibria (in which each type pays a premium appropriate to its riskiness) are also possible.⁴⁹ So, in the end, the lesson is cautionary. Theory does not support the idea that as insurers learn more about their customers, pricing will necessarily become more individualized and pooling and attendant risk-spreading will necessarily decrease. Instead, a world in which insurers know more about policyholders than the latter know about themselves might actually give rise to *more* pooling.

V. BIG DATA, BIG INSURANCE

In this section, I want to very briefly discuss 2013 Nobel Laureate Robert Shiller's⁵⁰ visionary⁵¹ ideas for using Big (or at least More) Data to dramatically increase risk-spreading by allowing consumers to insure (pool) risks that they are currently forced to bear themselves. Shiller's insight is that new kinds of data, aggregated in new ways, could lead to radically new forms of insurance against risks that consumers are currently forced to bear themselves. (This is a somewhat different take on what "Big Data" means, since we are no longer talking about data-mining techniques to extract predictive information from high-dimensional data. Rather, as I explain below, we are concerned with the prospect of creating new *kinds* of information beyond that which is currently available.)

Consider, for example, the risk that one's house might decline in value (something few people did in fact consider in 2003, when Shiller's book was published), or the risk that one's chosen line of work might

⁴⁹ Villeneuve, *supra* note 45. The existence of separating equilibria depends on the degree of consumers' risk aversion and the difference in riskiness between the two types. Note that despite its complexity, the model admits only an extremely limited degree of consumer heterogeneity. Policyholders differ *only* in their riskiness and not, for example, in their degree of risk aversion. Nor are consumers subject to any behavioral "flaws" or deviations from rationality. For an attempt to incorporate such heterogeneity into a theoretical (simulation) model of insurance markets, see Tsvetanka Karagyozyova & Peter Siegelman, *Can Propitious Selection Stabilize Insurance Markets?*, 35 J. INS. ISSUES 121 (2012).

⁵⁰ ROBERT J. SHILLER, *THE NEW FINANCIAL ORDER: RISK IN THE 21ST CENTURY* (2003).

⁵¹ Some have almost gone so far as to suggest that "hallucinatory" would be a better description. See Stephen A. Ross, *Review of The New Financial Order by Shiller*, 42 J. ECON. LIT. 1098 (2004).

experience a drop in demand, causing a fall in one's earnings. Risk-averse individuals should want these products, which protect against important risks that they would prefer not to fact.

But individualized insurance against these risks cannot work, Shiller points out, because of Moral Hazard.⁵² If the value of my home is fully insured, I have an incentive to under-maintain it: maintenance is costly, after all, and my home value insurance policy will cover any drop in price when it comes time to sell the property.⁵³ Similarly, if my livelihood (earnings) is fully insured, I may slough off because hard work is costly and my livelihood insurance will pick up any shortfall in my paycheck that results from my shirking.⁵⁴

Shiller's brilliant insight is that even if some component of these risks is uninsurable at an individual level, it is possible to create a viable insurance product that covers aggregate-level risks without any moral hazard risks. Thus, instead of insuring against a fall in the value of *my* house, I would buy coverage against a drop in the value of *all* houses in my city or neighborhood. Instead of insuring against a fall in *my own* earnings, I would buy coverage against a drop in the earnings of all persons in my profession (law professor) or perhaps some narrower aggregate (all law and economics professors).

Under Shiller's solution, some risks remains with the consumer, as they must to preserve incentives, but at least medium- to large-scale risks can be insured against. If the largest employer in town closes its factory and all local house prices plummet, I am covered. If nobody wants to go to law school any more, and law professor salaries plunge, I am covered there as well.

The genius of this approach is that it offers maximal insurance with no potential for Moral Hazard, since insurance is offered only against drops in an aggregate (price index), over which no individual exerts any control. If I under-maintain my house, I bear 100% of the marginal loss in value, relative to the average house in my neighborhood. If I slack off rather than working hard, I do less well than the average law professor (even if all salaries drop), and

⁵² And possibly Adverse Selection as well, although Shiller scarcely mentions adverse selection in his book.

⁵³ Of course, if it were possible to write an insurance contract that covered exactly what kind of maintenance I was required to do, this problem could be solved. But, it seems clear that maintenance is simply too complicated, heterogeneous and subjective to be captured by an ex ante contract.

⁵⁴ See, e.g., Soviet-era Russia. There are possible selection issues as well if homeowners know better than their insurers whether their house needs repairs or what their own future work plans entail.

those losses are not covered by my insurer. Shillerian insurance thus preserves maximal incentives for me to work hard and to maintain my home, while permitting me to pool risks that I would like to avoid.⁵⁵

But in order for this kind of insurance to work, we need “Big” data on aggregates (neighborhood home values, earnings by occupation or sub-specialty). This information would need to be built up from detailed data collected at an individual level. For each house, we have to know its age, its square footage, its condition, and of course its price. This data could then be aggregated to provide quality-weighted neighborhood-level information that could then be used to set premiums and payouts. Shiller and his collaborator Karl Case actually created such a dataset, which is now maintained (for several cities) by the rating agency Standard and Poors.⁵⁶

VI. CONCLUSION

Equilibrium in insurance markets is highly sensitive to seemingly-innocuous details about how offers are made and received, by whom, and under what conditions. Robust predictions about how markets will respond to any exogenous change are very difficult. It would therefore be silly to claim, at least as a theoretical matter, that Big Data will have little or no effect on insurance market equilibria. But at least the notion that Big Data techniques will enable some sort of perfect prediction seems pretty far-fetched.

And while the collection and analysis of additional information may pose some significant privacy concerns, it may also make possible the creation of new markets for spreading risks that rational individuals should greet with approval.

⁵⁵ There is a structural similarity between this kind of insurance and Robert Cooter’s theory of the law and economics of “precaution.” See Robert Cooter, *Unity in Tort, Contract, and Property: the Model of Precaution*, 73 CAL. L. REV. 1 (1985). In both models, one party (the insurer or the injurer) bears responsibility for the inframarginal precautions, while the other party (the insured or the tort victim) bears responsibility for the marginal precautions, thereby providing simultaneous incentives for both parties to take efficient levels of care.

⁵⁶ See *S&P/Case-Shiller Home Price Indices*, S&P DOW JONES, <http://us.spindices.com/index-family/real-estate/sp-case-shiller> (last visited Aug. 11, 2014).

RISK CLASSIFICATION'S BIG DATA (R)EVOLUTION

RICK SWEDLOFF[†]

Insurers can no longer ignore the promise that the algorithms driving big data will offer greater predictive accuracy than traditional statistical analysis alone. Big data represents a natural evolutionary advancement of insurers trying to price their products to increase their profits, mitigate additional moral hazard, and better combat adverse selection. But these big data promises are not free. Using big data could lead to inefficient social and private investments, undermine important risk-spreading goals of insurance, and invade policyholder privacy. These dangers are present in any change to risk classification. Using algorithms to classify risk by parsing new and complex data sets raises two additional, unique problems.

First, this machine-driven classification may yield unexpected correlations with risk that unintentionally burden suspect or vulnerable groups with higher prices. The higher rates may not reinforce negative stereotypes and cause dignitary harms, because the algorithms obscure who is being charged more for coverage and for what reason. Nonetheless, there may be reasons to be concerned about which groups are burdened by having to pay more for coverage.

Second, big data raises novel privacy concerns. Insurers classifying risk with big data will harvest and use personal information indirectly, without asking the policyholders for permission. This may cause certain privacy invasions unanticipated by current regulatory regimes. Further, the predictive power of big data may allow insurers to determine personally identifiable information about policyholders without asking them directly.

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Thus, while big data may be a natural next step in risk classification, it may require a revolutionary approach to regulation. Regulators are going to have to be more thoughtful about when price discrimination matters and what information can be kept private. The former, in particular, will require regulators to determine whether it will be acceptable to charge risky groups more for coverage regardless of the social context in which those risks materialize. Further, for both price discrimination and privacy issues, regulators will have to increase their capacity to analyze the data inputs, algorithms, and outputs of the classification schemes.

I. INTRODUCTION

Big data is at the insurance industry's door. It is frequently in the business, popular,¹ and academic² press. The predictive power of big data

¹ As proof of this claim, just consider the focus and coverage of three of the leading popular/business news sources. The *New York Times* has a blog dedicated just to technology issues: *Bits: The Business of Technology*, N.Y. TIMES, <http://bits.blogs.nytimes.com/> (last visited Dec. 26, 2014). The blog is littered with entries about big data. See, e.g., Steve Lohr, *Google Flu Trends: The Limits of Big Data*, N.Y. TIMES (Mar. 28, 2014), <http://bits.blogs.nytimes.com/2014/03/28/google-flu-trends-the-limits-of-big-data/>. Likewise, the Wall Street Journal has a technology blog, *Digits: Tech News & Analysis from the WSJ*, WALL ST. J., <http://blogs.wsj.com/digits/> (last visited Dec. 26, 2014), and regularly has articles on big data. See, e.g., Elizabeth Dwoskin, *'Big Data' Doesn't Yield Better Loans*, WALL ST. J. (Mar. 17, 2014, 11:19 PM), <http://online.wsj.com/news/articles/SB10001424052702304732804579425631517880424>; Ben DiPietro, *Survey Roundup: Money Laundering Moves Up Agenda, Big Data Potential*, WALL ST. J. (Mar. 28, 2014, 2:05 PM), <http://blogs.wsj.com/riskandcompliance/2014/03/28/survey-roundup-money-laundering-moves-up-agenda-big-data-potential/>. Forbes also has regular features and blog posts about the impact of big data in the financial sector. See, e.g., Adam Tanner, *Different Customers, Different Prices, Thanks to Big Data*, FORBES, Apr. 14, 2014, available at <http://www.forbes.com/sites/adamtanner/2014/03/26/different-customers-different-prices-thanks-to-big-data/>.

² For a small smattering of just the legal academic articles about big data, consider the following titles: Danielle Keats Citron, *Technological Due Process*, 85 WASH. U. L. REV. 1249 (2008); Danielle Keats Citron & Frank Pasquale, *The Scored Society: Due Process for Automated Predictions*, 89 WASH. L. REV. 1 (2014); Kate Crawford & Jason Schultz, *Big Data and Due Process: Toward a Framework to Redress Predictive Privacy Harms*, 55 B.C. L. REV. 93 (2014);

analytics has been touted as game changing for goals as diverse as ending poverty,³ stopping terrorism,⁴ and transforming business practices.⁵ Its evangelists see big data as the most important development since the advent of the Internet. However hyperbolic these claims, there is no doubt that this press has had some effect as a wide variety of businesses are using or considering how to use big data analytics.

Despite this, insurers have been slow to adopt big data analytics.⁶ There are, however, few industries with as voracious an appetite for data, in any form, as the insurance industry. Carriers likely can no longer ignore the possibility that the algorithms driving big data will offer greater predictive accuracy than traditional statistical analysis alone. And, if realized, this additional accuracy could potentially benefit insurers in at least three ways.⁷ First, by analyzing purchasing patterns, carriers could better target those individuals most likely to buy new coverage and retain those insureds most likely to switch to a different carrier.⁸ Second, insurers may be able to use claims and settlement patterns to better distinguish

Jeffrey Alan Johnson, Senior Research Analyst, Inst'l Research & Info., Utah Valley Univ., Address at the Annual Conference of the Midwest Political Science Association: From Open Data to Information Justice (Apr. 13, 2013) (transcript available at <http://ssrn.com/abstract=2241092>); Frank Pasquale, *Restoring Transparency to Automated Justice*, 9 J. ON TELECOMM. & HIGH TECH. L. 235 (2011); Omer Tene & Jules Polonetsky, *Big Data for All: Privacy and User Control in the Age of Analytics*, 11 NW. J. TECH. & INTELL. PROP. 239 (2013).

³ WORLD ECON. FORUM, BIG DATA, BIG IMPACT: NEW POSSIBILITIES FOR ECONOMIC DEVELOPMENT (2012), available at <http://www.weforum.org/reports/big-data-big-impact-new-possibilities-international-development>.

⁴ John Arquilla, *Small Cells vs. Big Data: Can information Dominance Crush Terrorism?*, FOREIGN POL'Y (Apr. 22, 2013), http://www.foreignpolicy.com/articles/2013/04/22/small_cells_vs_big_data.

⁵ Kenneth Neil Cukier & Viktor Mayer-Schoenberger, *The Rise of Big Data: How It's Changing the Way We Think About the World*, FOREIGN AFF., May/June 2013, at 28, available at www.foreignaffairs.com/articles/139104/kenneth-neil-cukier-and-viktor-mayer-schoenberger/the-rise-of-big-data.

⁶ See Eric Brat, Bos. Consulting Grp., Big Data and Paradigm of Insurance: Summary of BCG Recent Research, Presentation at the University of Connecticut School of Law Big Data and Insurance Symposium (Apr. 3, 2014).

⁷ CHARLES NYCE, PREDICTIVE ANALYTICS WHITE PAPER 4 (Am. Inst. for CPCU/Ins. Inst. of Am. 2007), available at <http://www.theinstitutes.org/doc/predictivemodelingwhitepaper.pdf>.

⁸ *Id.* at 4–5.

between real and fraudulent claims.⁹ Third, again, to the extent greater predictive power is realized, carriers could use big data analytics to price their products more accurately.¹⁰ This Article focuses on the implications of this third category. While big data analytics are a natural evolutionary step for insurers trying to price their products, the regulatory ramifications of this move are potentially revolutionary.

Insurers set prices by predicting the probability that any group of observationally identical individuals will suffer a loss and predicting the magnitude of that loss in the insurance period. Insurers individuate those prices by determining whether the particular observable characteristics of a particular insured correlate with particular harms.¹¹ For example, based on auto claim data, insurers believe that young men are more likely to be in auto accidents and cause more damage than other demographic groups.¹² Therefore, when a twenty-two year-old man purchases auto insurance, he pays more than a twenty-two year-old woman for the same coverage. Big data promises new opportunities to fine tune risk classification by using algorithms to mine new and complex sets of data to find new correlations and make predictions about behavior. Carriers can gather information about insureds from a variety of new sources, including phone records; the Internet; health records; sensors in cars and clothing, electrical grids, or communication devices.¹³ In this way, carriers' use of big data may be a natural evolution in risk classification.¹⁴

Insurers are already doing some of this. For example, carriers have asked some drivers to equip their cars with electronic devices that monitor their driving patterns.¹⁵ Carriers know that drivers who break harder, drive

⁹ *Id.* at 5–7.

¹⁰ *Id.* at 5.

¹¹ Kenneth S. Abraham, *Efficiency and Fairness in Insurance Risk Classification*, 71 VA. L. REV. 403, 408 (1985).

¹² See Jessica Bosari, *What Really Goes Into Determining Your Insurance Rates?*, FORBES (Jan. 1, 2013), <http://www.forbes.com/sites/moneywisewomen/2013/01/08/what-really-goes-into-determining-your-insurance-rates/>; see also JJ Arnett, *Developmental Sources of Crash Risk in Young Drivers*, 8 INJ. PREVENTION ii17, ii19 (2002).

¹³ See *infra* notes 55–56 and accompanying text.

¹⁴ NYCE, *supra* note 7, at 5.

¹⁵ Allstate explains how this works on its website: “A telematics device is generally a system that you install in your car that records information about your driving habits, such as the number of miles you drive, your speed, and how quickly you brake. These systems sometimes analyze the time of day when you drive, as

faster, or drive during particular times of day are more likely to get into accidents and/or have more severe accidents. Using the data gathered from the devices, carriers can price auto insurance to better reflect the risks posed by the drivers. In the future, carriers could gather this same information from other sources, including communications devices, E-ZPass records, or sensors in the road. It is not a stretch to imagine harnessing more and different information to price different types of policies. For example, carriers could determine whether people who use cell phones at certain times of day, post revealing pictures on social media, or have certain search habits on the Internet are more likely to have liability claims, live shorter lives, or suffer more unemployment claims.

But the potential benefits of big data (to the extent carriers can recognize them) will not be free. Like any improvement in risk classification, additional expenditures on big data analytics could be socially wasteful and privately inefficient. Further, like all risk classification refinements, to the extent that the promised gains in predictive accuracy materialize, classifying risks with big data analytics may undermine important risk spreading goals of insurance. Lastly, mining individual data to build the data sets or to identify whether a potential insured falls into a particular risk category could invade policyholder privacy.

Algorithmic parsing of new and complex data sets may also raise problems unseen in the past. First, machine driven risk classification could yield unexpected correlations with risk. For example, it may be that people from a particular racial or ethnic group have certain Internet search patterns: for example, Jews may search for the time of sundown more often than other groups. Insurers may find those search results yield correlations to particular risks (like Tay Sachs). Carriers focusing on strange algorithmic correlations, like Internet searches to risk of disease, may inadvertently burden these groups with higher prices.¹⁶ Second, insurers classifying risk with big data will harvest and use personal information

well. If you use a telematics device from your insurer, you agree to allow the device to send this information to your insurance company.” *Tools & Resources: What Is a Telematics Device?*, ALLSTATE, <http://www.allstate.com/tools-and-resources/car-insurance/telematics-device.aspx> (last visited Dec. 26, 2014).

¹⁶ Of course, it is likely that insurers can already identify individuals by race, gender, ethnic group, etc. without asking these questions. What is different about big data is that the algorithms identifying the correlations may mask the fact that particular groups are being charged higher prices.

indirectly, without asking the policyholders for permission. This may cause certain privacy invasions unanticipated by current regulatory regimes. Further, the predictive power of big data may allow insurers to determine personally identifiable information about policyholders without asking them directly. This means that insurers could be invading new zones of privacy or finding ways to invade zones of privacy once thought protected.

Thus, while it may be a natural evolution for carriers to use big data to classify risk, there may be significant financial and social costs to doing so. These costs may require a revolutionary approach to regulating risk classification. Regulators can no longer rely, to the extent they ever could, on discriminatory intent to protect certain groups from higher prices. To the contrary, regulators must recognize that big data may make it even more likely that certain groups will be burdened with higher prices without any evidence of intentional discrimination. Whether this matters depends on whether a jurisdiction views a particular line of insurance as a means to spread risk generally across society or whether the jurisdiction is comfortable charging risky groups more for coverage regardless of the social context in which those risks materialize. Thus, as will be discussed, big data requires a move from regulating based on discriminatory intent to disparate impact. Further, regulators must determine what information, if any, policyholders may keep private. To protect those privacy matters, regulators will have to increase their computing capacity to analyze the data inputs, algorithms, and outputs of insurers' classification schemes.

This Article looks at the impact of the opaque proxies created by big data and offers some regulatory suggestions to control the risk that individuals or groups will be unfairly burdened by the classification scheme and minimize the risk that insurers will invade individual privacy in new or more nuanced ways.

A. THE RISK CLASSIFICATION FRAMEWORK

Insurers classify risks by trying to predict the probability that a potential insured will suffer a loss and the magnitude of that loss should it come to pass. To make that prediction, underwriters have traditionally looked at the features and the experience of a potential insured to determine whether and how those features and experiences correlate to insurable losses.¹⁷ Feature rating bases prices on the observable traits of an insured.

¹⁷ Abraham, *supra* note 11, at 413–14.

These traits could be inherent, like age, race, gender, or national origin. Feature rating could also look to certain systems that insureds have in place to prevent loss, like smoke detectors, risk management protocols, or whether the insured has taken a particular kind of risk management class (e.g., drivers education).¹⁸ Some of these characteristics are malleable; others are not. That is, an insurer can only control some of these features. In contrast to feature rating, experience rating prices risk based on the loss history of the individual policyholder.¹⁹

Some individuals have a vector of characteristics that has a low probability of loss conditional on the observables. These individuals represent a low risk and are charged relatively low prices for their insurance. Others have characteristics that correlate more strongly with loss. These individuals represent a higher risk and are charged higher prices.

Insurers have a significant financial incentive to classify insureds properly on the basis of risk. Accurate risk classification can impact the company's bottom line in two ways. An insurer who offers lower prices for good risks could add low risk insureds into its risk pool and thus lower its own risk of paying out. And, if multiple insurers are in the market, accurate risk pricing could allow an insurer to skim good risks away from competitors, leaving the competitor with a comparatively worse risk pool, thus raising its competitor's risk of paying out.²⁰

There are well-rehearsed benefits to and concerns with risk classification. On the positive side, accurate risk classification can help mitigate adverse selection and moral hazard. On the negative side, risk classification can be socially costly, may create unfair burdens on certain groups, and may implicate socially suspect categorizations such as race, national origin, or gender.

1. Benefits of Risk Classification

In addition to the profit motives listed above, carriers may give three justifications for classifying and charging higher premiums on the

¹⁸ See Ronen Avraham et al., *Understanding Insurance Antidiscrimination Laws*, 87 S. CAL. L. REV. 195, 202 (2014).

¹⁹ See *id.*

²⁰ KENNETH S. ABRAHAM, *DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY* 67 (1986); Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371, 377 (2003).

basis of perceived risk. These reasons are tied directly to the classic twin insurance dilemmas: adverse selection and moral hazard.

First, pricing based on risk allows insurers to combat adverse selection by marketing to low risks.²¹ Potential insureds who are less likely to suffer harm may not want to pay a price that reflects the likely harm of the entire population, including high, medium, and low risks. Low risks (theoretically) may go without insurance rather than pay the premiums that reflect a mix of high and low risk insureds.²² Thus, risk classification can help alleviate some of the consequences of adverse selection by allowing insurers to price products to entice low risks to enter the insurance pool.²³

Second, and relatedly, pricing based on risk may be more fair to low risk insureds. All insurance pools are somewhat heterogeneous with low risks subsidizing higher risk policyholders. Risk classification can remove some of the heterogeneity by putting like risks together. The more refined the classification scheme, the more homogenous the resulting pools will be, which will then require less subsidization from low risks to high risks.

Third, risk classification is also a form of moral hazard mitigation.²⁴ Pricing based on risk provides a signal to insureds about their riskiness.²⁵ To the extent that insureds have control over the characteristic

²¹ ABRAHAM, *supra* note 20, at 67.

²² As Ken Abraham explained, “insurance is only one of a number of ways of satisfying the demand for protection against risk. With few exceptions, insurance need not be purchased; people can forgo it if insurance is too expensive.” Abraham, *supra* note 11, at 407.

²³ ABRAHAM, *supra* note 20, at 67. The likelihood of this adverse selection is unclear. There is some evidence that low risk individuals are risk adverse and tend to buy insurance as well as take added precautions. *See, e.g.*, David Hemenway, *Propitious Selection*, 105 Q.J. ECON. 1063 (1990); *see also* Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223 (2004) (reviewing the literature on propitious selection). The impact of this propitious selection in various insurance markets is unclear and, even if there is some form of propitious selection, pricing based on risk remains a potential marketing opportunity to low risk groups that typically go without insurance.

²⁴ Tom Baker & Rick Swedloff, *Regulation by Liability Insurance: From Auto to Lawyers Professional Liability*, 60 UCLA L. REV. 1412, 1419 (2013).

²⁵ *See* Abraham, *supra* note 11, at 413 (“Risk classifications should reflect differences in expected losses between classes of insureds; ideally, they should also create loss prevention incentives based on variables within each insured’s control.”).

upon which they are being classified, the signal of a higher price may encourage potential insureds to change their behavior—either to take more precaution or to reduce the frequency of the risk creating activity. To provide policyholders such incentives to change extant behaviors, insurers must reevaluate and reclassify policyholders periodically.²⁶

2. Dangers of Risk Classification

Even assuming that the classification accurately predicts risk, properly mitigates adverse selection and moral hazard, and allows insurers to increase their profits, allowing insurers to make these kind of distinctions among potential insureds raises three distinct types of concerns: efficiency, fairness, and privacy.²⁷

a. Efficiency

Risk classification may be inefficient in several ways. First, it may be socially wasteful. Risk classification is socially beneficial to the extent that insurers succeed in bringing new, low risk entities or individuals into the overall risk pool. To the extent that insurers only succeed in moving low risks from one carrier to another, the money spent on risk classification is socially wasteful.²⁸ This is especially problematic when it is particularly costly for the insurer to acquire the information it needs to segregate risk classes.

Second, risk classification may be inefficient if the higher prices inhibit high-risk, but socially beneficial behaviors.²⁹ For example, if high medical malpractice insurance premiums for obstetricians drive physicians out of that field and into others, risk classification may create inefficiencies.³⁰

²⁶ *Id.*

²⁷ Ronen Avraham et al., *supra* note 18, at 204-20; Abraham, *supra* note 11, at 419-420.

²⁸ Avraham et al., *supra* note 18, at 208-09.

²⁹ *Id.* at 205.

³⁰ If it is inefficient to classify on the basis of risk in this type of situation, then there are still questions about who should subsidize the behavior. For example, should the entire insurance pool (in the example above, all physicians) pay a higher premium so as not to disincentivize the behavior? Or should the public at large subsidize the behavior through tax subsidies or caps on damages?

Third, risk classification may be inefficient because it may inhibit private acquisition of socially useful information. If risk classification is based, in part, on the knowledge of the insured (e.g., in the case of genetic diseases known only through testing), insureds may choose not to obtain that information.³¹

b. Unfair burdens

Beyond these concerns, risk classification may unfairly burden particular groups. Some view insurance as a means of spreading risks throughout an entire population.³² Risk classification undermines these risk spreading ideals. If all of society is (or all policyholders are) included in the pool, each individual can use insurance to maintain the status quo. But if insurers classify on the basis of risk, or deny insurance based on the amount of risk a potential insured presents, some individuals may be significantly burdened or even locked out of the safety net provided by insurance.³³ Said differently, if insurance is a means to promote social solidarity, the economic costs of risk factors should be distributed evenly across society. Classifying on individual characteristics “undermine[s] this feature of insurance by ‘fragmenting communities into ever-smaller, more homogenous groups.’”³⁴

This ideal is particularly undermined if insurers classify risk based on a suspect category.³⁵ Obviously, some groups are more likely to incur certain types of expenses than others. Women are more likely to incur medical costs associated with pregnancy and breast cancer. Men may have

³¹ Cf. Alexander Tabarrok, *Genetic Testing: An Economic and Contractarian Analysis*, 13 J. HEALTH ECON. 75, 80 (1994) (explaining why people may choose not to get genetic testing even if there is a possibility that the information gained could help minimize the risk of future harm).

³² See Baker, *supra* note 20, at 392–96 (arguing that those who believe risk classification is a fair mutual aid fail to see that the fairness justification for classification lacks the moral force its proponents believe it has).

³³ See *id.* at 392 (explaining how in the late 1980s insurance companies tried to exclude battered women from the insurance pool).

³⁴ Avraham et al., *supra* note 18, at 215.

³⁵ Indeed, the most obvious classifications will be based on just such distinctions. Age, sex, race, etc. have been traditional underwriting criteria. See, e.g., Regina Austin, *The Insurance Classification Controversy*, 131 U. PA. L. REV. 517, 517 (1983).

lower life expectancies than women.³⁶ African Americans are more likely to have medical costs associated with sickle cell anemia; Jews are more likely to have medical costs associated with Tay-Sachs. The elderly are more likely to die than the young. The young are more likely to get in car accidents than the middle aged. The list could go on and on. And, in some sense it may make sense to charge members of these groups more for different types of insurance because of their higher risk status. But there may be significant social and other reasons to ignore the additional risk factors.

First, to the extent that these groups are constitutionally protected based on race, religion, or national origin, there might be concerns that the classification system “reinforces or perpetuates broader social inequalities or . . . causes some sort of expressive harm by acknowledging and legitimating that prior unfair treatment.”³⁷ Said differently, even if it is true that a particular group is more likely to suffer a particular kind of loss, one might be concerned that by being charged more, the extra charge reinforces negative stereotypes, the group suffers certain dignitary harms, and/or the group is unfairly burdened.

Even if the classification is not based on a constitutionally protected class, risk classification may still be viewed as unfair if the rate is based upon a characteristic that is undeserved or when the potential insured does not have control over the characteristic.³⁸ For example, even if it is true that women who have suffered domestic abuse tend to require additional health care services over the course of their lives, it may be unfair to charge these women higher premiums, because the victims do not deserve their high-risk status.³⁹ It is, of course, difficult to determine

³⁶ *World Health Statistics 2014*, WORLD HEALTH ORG. (May 15, 2014), <http://www.who.int/mediacentre/news/releases/2014/world-health-statistics-2014/en/>.

³⁷ Avraham et al., *supra* note 18, at 217.

³⁸ See Deborah S. Hellman, *Is Actuarially Fair Insurance Pricing Actually Fair?: A Case Study in Insuring Battered Women*, 32 HARV. C.R.-C.L. L. REV. 355, 384–85 (1997); Austin, *supra* note 35, at 559–60.

³⁹ See Hellman, *supra* note 38, at 356–57, 369, 384. This intuition is doubly true when the characteristic is both undeserved and uncontrollable. As Alexander Tabarrok notes in the context of pricing based on health risks:

First, the intuition that those with higher risks should bear the costs seems less justifiable when the higher risk is not a matter of choice. Is it right that someone with the Huntington's gene should have to pay potentially staggering insurance bills or

whether an insured deserves or can control a characteristic,⁴⁰ but these are debates into which I need not wade for purposes of this Article. It is merely important to note that even if certain characteristics predict risk accurately there may be reasons that insurers should not classify their insured on that basis. Likewise it may be unfair to burden individuals with higher rates for socially valuable activity. For example, women in their twenties and thirties are more likely to incur medical expenses related to child birth. But it may not be fair to charge them higher premiums based on those expected medical expenses.

Further, and relatedly, some may view as unfair risk classifications based on characteristics that do not seem to cause the particular harm predicted. Of course, all risk classifications are based on correlation, not causation. But some correlations have a strong causal backbone. For example, the link between Huntington's disease and death is more than just correlative, and, for example, insurers can tell strong causal stories about the links between obesity and health. Other correlations may seem random, or even discriminatory, but actually have certain causal links. For example, facially there does not appear to be a link between credit scores and automobile accidents. There may, however, be common psychological and biological roots to financial risk-taking and risky driving.⁴¹ But, where the

even [be] denied health insurance altogether? Second, charging higher premiums will not reduce the number of people with Huntington's. Thus, in this case, there is no efficiency gain from charging high risk elements larger premiums (only a wealth transfer).

Tabarrok, *supra* note 31, at 80.

⁴⁰ Take health status, for example: in some respects, insureds can control their risk factors: they can stay fit, eat right, and abstain from smoking or drinking too much. But, of course, fit people can get sick, many obese people live until old age, and smokers may not get cancer. So what does it mean to control one's health status? See Avraham et al., *supra* note 18, at 215.

⁴¹ See Patrick L. Brockett & Linda L. Golden, *Biological and Psychobehavioral Correlates of Credit Scores and Automobile Insurance Losses: Toward an Explication of Why Credit Scoring Works*, 74 J. OF RISK & INS. 23, 26 (2007). Further, to the extent that bad credit scores significantly correlate with suspect or vulnerable characteristics, there may be statistical methods to isolate and eliminate these proxy effects while maintaining the predictive accuracy of the variables. See generally Devin G. Pope & Justin R. Sydnor, *Implementing Anti-Discrimination Policies in Statistical Profiling Models*, 3 AM. ECON. J.: ECON. POL'Y 206 (2011).

characteristic is causally remote from the predicted loss and is thus perceived to be non-causal (perhaps in a but-for sense of the word), the use of the characteristic may be challenged on the ground that the classification is unfair.⁴² For example, there is near perfect correlation between the per capita consumption of cheese and the number of people who die by becoming entangled in their own bed sheets.⁴³ But there is little argument that the amount of cheese consumed in the United States says anything interesting about death by entanglement. If there is no causal connection, it is unclear that it is reasonable for insurers to base rates on spurious correlations.

Lastly, there are fairness concerns based on the fact that risk classification is expensive and imperfect.⁴⁴ Despite the benefits of risk classification, carriers do not have an incentive to make risk classes completely homogenous (nor could they necessarily do so). Risk classification is expensive, and at some point the marginal increase in homogeneity may cost more than the marginal benefit to the insurer.⁴⁵ Thus, some members of the group will always be a higher risk than other members of the same risk class. To the extent that the burden of the imperfections and inaccuracies in the classification scheme falls disproportionately on one group over another, risk classification may implicate additional fairness concerns.⁴⁶

c. Privacy

Risk classification raises a number of privacy concerns. To classify risks, insurers may have to ask about or otherwise discern particularly intimate information about an insured, such as credit score, HIV status, genetic information, or sexual orientation.⁴⁷ Insurers could also

⁴² See Avraham et al., *supra* note 18, at 218–20.

⁴³ See Tyler Vigen, *Per Capita Consumption of Cheese (US) Correlates with Number of People Who Died by Becoming Tangled in Their Bedsheets*, SPURIOUS CORRELATIONS, http://www.tylervigen.com/view_correlation?id=7 (last visited Dec. 26, 2014).

⁴⁴ Ken Abraham refers to this problem as differential inaccuracy. See ABRAHAM, *supra* note 20, at 84–89; Abraham, *supra* note 11, at 429–36.

⁴⁵ Avraham et al., *supra* note 18, at 217 (“Efficient insurance regimes will only invest in improving classification to the extent that the resulting benefits are larger than [the cost of doing so].”).

⁴⁶ Abraham, *supra* note 11, at 429–36.

⁴⁷ Avraham et al., *supra* note 18, at 220.

ask questions about drug and alcohol use, lifestyle, exercise, etc. Of course, these are not just idle questions. Failure to answer or answer truthfully could have significant ramifications. Potential insureds refusing to answer could be denied coverage.⁴⁸ And policyholders who respond inaccurately could be denied coverage after suffering a loss.⁴⁹ These privacy concerns are redoubled when one considers that insurance is a de facto requirement for a number of important life activities like driving a car and owning a home.⁵⁰ Thus, many may be forced to divulge particularly intimate information about themselves to obtain insurance.

Which areas are off limits and which questions delve too deeply into private spheres depends on the product line and one's prior assumptions about the strength and meaning of privacy. For example, one's use of alcohol, tobacco, or illegal drugs might be relevant to life expectancy and thus some may not view questions about these topics on a life insurance applications as invasions of privacy. Others, however, may view those questions as intrusive of a personal sphere of privacy regardless of the relevance of the information to the line of insurance, because they represent inquiry into a particular type of personal activity. As with the issues related to control over a particular risk factor,⁵¹ it is not necessary to settle debates about which questions are appropriate in which policy lines and which questions invade a particularly private sphere. It is enough to note that risk classification may implicate privacy concerns even in the absence of the big data concerns to be raised later in this essay.

⁴⁸ See Philip R. Reilly, *Public Policy and Legal Issues Raised by Advances in Genetic Screening and Testing*, 27 SUFFOLK U. L. REV. 1327, 1356 (1993) (refusing to answer questions about genetic background can lead to denial of coverage); James Monroe Smith, *When Knowing the Law is Not Enough: Confronting Denial and Considering Sociocultural Issues Affecting HIV Positive People*, 17 HAMLINE J. PUB. L. & POL'Y 1, 34-35 (1995) (failing to disclose HIV diagnosis is a material misrepresentation justifying denial of coverage).

⁴⁹ Avraham et al., *supra* note 18, at 210.

⁵⁰ *Id.* at 220.

⁵¹ See *id.* at 215.

II. THINKING ABOUT BIG DATA

A. BIG DATA AND THE DATA DRIVING IT

Big data derives its name from the mountain of information created by daily activities and gathered by all types of commercial and governmental entities. The data includes such sources such as Internet “transactions, email, video, images, clickstream, logs, search queries, health records, and social networking interactions.”⁵² These online sources could include both the primary record (e.g., a tweet or Facebook post) and the metadata of the record (e.g., the time and date of posting, the type of media used in the post, the number of retweets, etc.). But big data is not limited just to information from the Internet. Big data can also include traditional data sets and it increasingly includes “sensors deployed in infrastructure such as communications networks, electric grids, global positioning satellites, roads and bridges, as well as in homes, clothing, and mobile phones.”⁵³

Given the vast reach and the variety of types of data, there is a tendency, especially among commercial entities, to define big data in terms of the amount of this information and the ability to manage that data. For instance, McKinsey Global Institute, an offshoot of McKinsey & Company, defines big data as “datasets whose size is beyond the ability of typical database software tools to capture, store, manage, and analyze.”⁵⁴ These quantity definitions often refer to the rapidly increasing amount of data created every year.⁵⁵ Other definitions point out that it is not just the amount, but also the type of data being gathered that matters. For example, Forbes, writing for a corporate clientele, defined big data as “a collection of data from traditional and digital sources inside and outside your company

⁵² Tene & Polonetsky, *supra* note 2, at 240.

⁵³ *Id.*

⁵⁴ JAMES MANYIKA ET AL., BIG DATA: THE NEXT FRONTIER FOR INNOVATION, COMPETITION, AND PRODUCTIVITY 1, (McKinsey Global Inst. ed., 2011), *available at* http://www.mckinsey.com/insights/business_technology/big_data_the_next_frontier_for_innovation (click download full report).

⁵⁵ Kenneth Cukier, *Data, Data Everywhere*, *ECONOMIST* (Feb. 25, 2010), <http://www.economist.com/node/15557443> (“[T]he world contains an unimaginably vast amount of digital information which is getting ever vaster ever more rapidly.”).

that represents a source for ongoing discovery and analysis.”⁵⁶ This collection of data, according to Forbes, includes structured and unstructured data. The former refers to data points that are easily placed into databases. The latter refers to inherently more messy data like text in tweets, video uploads, pictures, etc.⁵⁷

Simple size-and-kind definitions, however, tend to be driven by companies selling analytic products, marketers selling big data services, insurers trying to optimize offerings, and Wall Street traders interpreting and predicting the market.⁵⁸ These definitions overstate the importance of the amount of data and understate the way the data is analyzed and the sociological meaning of the term. “Big Data is less about data that is big than it is about a capacity to search, aggregate, and cross-reference large data sets.”⁵⁹ Big data analytics do not necessarily rely on large data sets—in fact, the set of data may be smaller than traditional (non big) data sets.⁶⁰ Rather than think of big data as different because it relies on *big* data sets, it is better to think of big data analytics as different because big data uses complex algorithms to mine messy and diverse data sets.⁶¹ What is unique about big data is that the algorithms driving the analytics are not like

⁵⁶ Lisa Arthur, *What is Big Data?*, FORBES (Aug. 15, 2013), <http://www.forbes.com/sites/lisaarthur/2013/08/15/what-is-big-data/>.

⁵⁷ *Id.*

⁵⁸ Nicole Wong, Twitter’s former legal director and the Obama administration’s Deputy U.S. Chief Technology Officer, tweeted, “Tweeps, can you point me to the best available definition of ‘big data’? A lot of marketing-speak out there, low on precision.” Nicole Wong, Twitter (Jan. 25 2014, 12:56 PM), <https://twitter.com/nicolewong/status/426413033200812033>. See also Tim Harford, *Big Data: Are We Making a Big Mistake?*, FIN. TIMES (March 28, 2014), <http://www.ft.com/cms/s/2/21a6e7d8-b479-11e3-a09a-00144feabdc0.html#axzz30tH6hAOd> (“As with so many buzzwords, ‘big data’ is a vague term, often thrown around by people with something to sell.”); Danah Boyd & Kate Crawford, *Critical Questions for Big Data: Provocations for a Cultural, Technological, and Scholarly Phenomenon*, 15 INFO. COMM. & SOC’Y 662, 663 (2012).

⁵⁹ See Boyd & Crawford, *supra* note 58, at 663.

⁶⁰ Size-based definitions are limiting in two respects. First, they are limited temporally given the ever-expanding computational power of computers. What once required so-called super computers can now be done on simple desktop machines. Second, the definition is over-inclusive. Some of the data “encompassed by Big Data (e.g. all Twitter messages about a particular topic) is not nearly as large as earlier data sets that were not considered Big data (e.g. census data).” *Id.*

⁶¹ See Crawford & Schultz, *supra* note 2, at 96.

traditional statistical techniques, and allow data scientists to look at data that was once thought unusable. These new techniques have also given rise to the sociological meaning of big data. As Crawford and Schultz argue, there is a growing and pervasive “belief that large data sets generate results with greater truth, objectivity, and accuracy.”⁶²

Despite this belief in the perfection of big data, there may be serious concerns about the data and the outputs. First, there are a number of errors that may exist in the data. As Boyd and Crawford explain, “[l]arge data sets from Internet sources are often unreliable, prone to outages and losses, and these errors and gaps are magnified when multiple data sets are used together.”⁶³ Moreover, some have expressed concerns about which data are collected and used. For example, “in case of social media data, there is a ‘data cleaning’ process: making decisions about what attributes and variables will be counted, and which will be ignored. This process is inherently subjective.”⁶⁴ Even choosing to use certain data can be misleading. Not everyone is on Twitter or Facebook, and those who are aren’t created equally. Some users post far more often than others.⁶⁵ And the data sets themselves are far from pure. Twitter, for example, doesn’t make available all tweets and any sampling will likely over-represent the present.⁶⁶ Moreover, even if the data were clean and unbiased, there is a problem of over fitting. Given the enormous number of data points considered, there is a risk that the algorithms will find correlations with statistical significance even if there is no meaningful connection between the variables.⁶⁷

That said, private actors have every incentive to find meaningful correlations and data analysts are well aware of the problems listed above. Thus, it is unsurprising that these concerns have not dampened either the demand for big data analytics or the belief in the power of the correlative and predictive outputs.⁶⁸ This demand has created a business of collecting

⁶² *Id.*

⁶³ Boyd & Crawford, *supra* note 58, at 668.

⁶⁴ *Id.* at 667.

⁶⁵ *Id.* at 669.

⁶⁶ *Id.*

⁶⁷ Gary Marcus & Ernest Davis, *Eight (No, Nine!) Problems With Big Data*, N.Y. TIMES (Apr. 6, 2014), <http://www.nyti.ms/1kgErs2>; Harford, *supra* note 58 (detailing the downfall of Google Flu Trends as a “theory-free, data-rich model”).

⁶⁸ In part this may be because data scientists managing big data analytics promise that they can massage the messy data and weed out correlations that have no real causal validity.

personal information either for use of the entity doing the collecting or for sale to third parties. The next section provides a brief taxonomy about how big data relates to personal information and the resulting privacy concerns.

B. USES OF PERSONAL INFORMATION

There are serious concerns about the way entities collect and use personal information.⁶⁹ These privacy concerns have driven much of the debate about the use of big data. There are a number of different ways that data brokers and other entities could interact with an individual's personal information. Many of those ways could implicate a number of privacy concerns. Rather than catalog various privacy concerns and the debate surrounding them⁷⁰—the contours of which are not directly relevant to this paper—what follows is a brief description of the ways in which big data could use personal information generally and a sense of the privacy implications.

First, personal information could be harvested to power the algorithms. As described above, companies obtain data from a diverse set of human activities, including online interactions such as ecommerce or social networking and other activities of daily living like using a cell phone or driving a car with E-ZPass.⁷¹ Data brokers collect and categorize each of these data sources to identify correlations and predictions about individuals and their habits. Data brokers cull and sift reams of this personal data without the knowledge of those who generate the data. Generally speaking this data need not be identified with a particular person. Or, at least, in this context, the data are not used in a personally identifiable way. Rather, the data are grist for the algorithm mill. It is the raw material out of which the big data analytics create their correlations and predictions. From a privacy standpoint, one might be concerned that the data are being harvested without consent and often without the knowledge of the content

⁶⁹ Neil M. Richards & Jonathan H. King, *Big Data Ethics*, 49 WAKE FOREST L. REV. 393, 408 (2014).

⁷⁰ For an example of the types of concerns, see *id.* For a flavor of the debate, see Jules Polonetsky & Omer Tene, *Privacy and Big Data: Making Ends Meet*, 66 STAN. L. REV. 25 (2013).

⁷¹ Tene & Polonetsky, *supra* note 2, at 240.

generators.⁷² Further, while the data is not necessarily used to identify specific individuals, personal identity is also not scrubbed from the data.⁷³

Second, companies run personally identifiable information through the algorithm. That is, companies use personal information from a particular individual to determine whether that individual's characteristics correlate to a particular set of outcomes. As above, there are significant concerns in this respect that individuals do not know what data is being harvested and used to determine correlations. For example, are banks using an individual's Facebook posts or pictures to modify his or her credit ratings? Or, in the context of this Article, are carriers gathering data about individual insureds to determine their riskiness? The data collected and used in this way are not anonymous, nor can they be. This raises, at a minimum, concerns about the access that corporations have to private data.

There may be second order concerns related to this algorithmic use of personal data. As Crawford and Schultz suggest, "[b]ig data processes can generate a model of what has a probability of being [personally identifiable information], essentially *imagining* your data for you."⁷⁴ For example, in 2012, Target used big data analytics to effectively predict which of its customers were pregnant and passed that information to its marketing arm.⁷⁵ That is, without asking any customers about their pregnancy status or harvesting that data in particular, Target was able to predict extremely sensitive and personal information about its customers.⁷⁶

Third, and relatedly, companies harvest and use data without respect to who generates the data for marketing purposes. For example, companies typically gather all sorts of information from Internet searches to target marketing. While few express concerns about this targeted marketing, it is nonetheless another way that companies use private information (individual searches) without permission.

⁷² Crawford & Schultz, *supra* note 2, at 94-95.

⁷³ Tene & Polonetsky, *supra* note 2, at 251-252.

⁷⁴ Crawford & Schultz, *supra* note 2, at 98.

⁷⁵ Charles Duhigg, *How Companies Learn Your Secrets*, N.Y. TIMES (Feb. 16, 2012), <http://www.nytimes.com/2012/02/19/magazine/shopping-habits.html>.

⁷⁶ This so-called predictive privacy invasion may result in a number of harms. For example, marketers could attempt to avoid anti-discrimination statutes by simply directing on-line marketing to groups segregated by certain demographics, including race, gender, age, credit worthiness, etc. Crawford & Schultz, *supra* note 2, at 99-100. Crawford and Schultz also raise concerns about predictive policing and health care privacy.

III. BIG DATA AND RISK CLASSIFICATION

When risk classification actually results in identifying better and worse risks and provides carriers the ability to price these differential risks correctly, the benefits of risk classification mostly redound to the insurer in the form of greater profits from a better risk pool and to low risks in the form of lower-cost insurance. The costs, on the other hand, manifest in the form of privacy invasions and higher prices on select groups. As such, it is easy to see why insurers would want to enhance their classification capabilities. Big data offers just such an opportunity.

There could, however, be a number of significant issues related to using big data to classify risk. This Article assumes away myriad potential problems with the data⁷⁷ by assuming that insurers only use good data—that is, data that represents a good statistical sample, has few biases in place, and no major errors. Further, this Article assumes that the data are providing correlations that represent actual differences between risk classes. That is, this Article assumes the data show that some set of people who have some set of characteristics is more risky than some other set. Even if all of this is true, there remain specific efficiency, fairness, and privacy concerns raised by insurer's use of big data to classify risks.

The social and private costs attached to using big data to classify risks may be significant and include inefficient investment of capital, unfair burdening of groups and individuals, and inappropriate invasions of personal privacy. These costs suggest potential regulatory responses. Whether and how regulators should respond, however, turns on a number of things including the incentives that private actors have in the marketplace to self-correct, the cost of any regulatory response, the costs created in the absence of a regulatory response, and views about the underlying purpose of insurance. Typically it is left to industry to fix problems stemming from inefficient investments. Carriers have significant incentives to determine for themselves whether investments in big data are profitable and adding new insureds to the pool. And it is not clear there is a role for regulators in solving whatever collective action problems might exist. On the other hand, regulators may have a reason to insert themselves into problems created by the disincentives created by big data, unfair burdens created by risk classification, and increased privacy concerns.

This part focuses on the costs created. Part IV addresses potential regulatory responses.

⁷⁷ See Boyd & Crawford, *supra* note 58, at 666-75.

A. EFFICIENCY

Most carrier expenditures implicate a number of efficiency concerns. Carriers' expenditures on marketing, information technology, or even policy drafting could be unprofitable, socially wasteful or otherwise inefficient. Investments in big data to classify risk are no different. For example, it might be extraordinarily expensive to harness big data and generate more refined risk classifications. Each carrier might have to spend significant sums to make marginal improvements to their risk classification scheme. These costs could be exacerbated because carriers may feel a pressure to follow popular trends. Given the press coverage on the wonders of big data, firm leaders may spend exorbitantly even if the new classification scheme costs more than it generates in revenue for two reasons. First, carriers may hope that classifying based on big data now will reap profits in the future. Second, carriers may fear that if other insurers get better at classifying risks, they will lose low risk insureds, thus making their pool worse and forcing them to pay out more. These investments may be inefficient in two ways. First, it is unclear whether the refinements based on big data (to the extent they can be made) will bring in new, low risk policyholders into the insurance pool. If not, the expenditures on risk classification through big data will be socially wasteful, perhaps significantly so if the associated costs are particularly high. Second, the investment in big data may not be profitable. Given the collective action problem, firms may continue to invest so that a competitor that is using big data does not undercut their prices.

Whether, in fact, the expenditures to classify risk using big data are worth it for either the individual firm or for the industry as a whole is an empirical question. In thinking through this analysis, one must determine the following: is the use of big data profitable? Are new insureds being added? Is there a collective action problem spurring socially wasteful investments?

Further, the fear of big data may have inefficient impacts on policyholders and potential insureds. Individuals may refuse to invest in socially useful activities or fail to acquire important information for fear of being charged higher premiums or excluded from insurance altogether. For example, genetic testing could be both a socially useful activity and provide privately important information. It could both inform public understanding of genetic disorders and private decisions about health and welfare. But individuals may forgo genetic testing because insurers can

use the information discovered by those tests to set rates for or exclude individuals from life, disability, and long-term care insurance.⁷⁸

B. FAIRNESS

Policyholders may argue that using big data to classify risk unfairly burdens some groups. Of course, all risk classification burdens some groups more than others—that is the nature of differential pricing. Big data, however, has the potential to change old debates about risk spreading versus pricing based on risk. As discussed below, the algorithms driving big data analytics may find correlations between risk and suspect or vulnerable classes or based on non-causal factors without the insurer being aware that particular groups are being financially burdened.

Whether these higher prices should be thought of as unfair depends, in no small part, on one's belief about the underlying nature of insurance.⁷⁹

1. Proxies for Suspect and Vulnerable Classes

Insurers have long gathered data about policyholders' race, gender, age, and income level for many different lines of insurance. Insurers could easily use traditional statistical techniques to determine whether these or other suspect or vulnerable characteristics correlate strongly with loss. Even if characteristics that receive heightened constitutional protection (such as race, religion, and national origin),⁸⁰ characteristics that identify individuals as members of vulnerable groups (such as income), or characteristics that are otherwise undeserved (such as victims of domestic violence)⁸¹ correlate more significantly with loss, there may be good policy reasons not to charge higher premiums on this basis alone. The cause of the higher risk rating may be bound tightly to sociological and historical

⁷⁸ See Kira Peikoff, *Fearing Punishment for Bad Genes*, N.Y. TIMES (Apr. 7, 2014), <http://nyti.ms/1mVTzYS>. The Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 100-233, 121 Stat. 881 (codified as amended in scattered sections of 42 U.S.C. and 29 U.S.C.), only covers the behavior of health insurers. It does not prohibit using information from genetic testing to price or exclude individuals from other insurance products.

⁷⁹ See *supra* notes 32–49 and accompanying text.

⁸⁰ Austin, *supra* note 35, at 517.

⁸¹ See Baker, *supra* note 20, at 392.

conditions, making the higher risk status *undeserved*. Charging higher premiums “saddles people with all the consequences of their high risk status, whether deserved or not . . . [and] entitles other people to all the benefits of their low risk status, also whether deserved or not.”⁸²

These consequences could include making it more difficult to access insurance as a social safety net, reinforcing negative stereotypes, and causing dignitary harms. The first of these is obvious. Making insurance more expensive may make it impossible for some individuals to purchase the financial security that insurance provides. But charging more could have other negative effects. If it is known that members of a group pay higher premiums because they are members of the group (even if there are actuarial reasons for the higher premiums), it may reinforce a belief that the members of the group deserve their high-risk status or are burdens on society. For example, people may believe that Jews deserve Tay Sachs, that the poor actively choose not to take care of their health or property, or that victims of domestic abuse are responsible for their additional medical costs. This could serve to further reinforce negative stereotypes and thereby cause dignitary harms.

But insurers need not base the higher premiums directly on the characteristics listed above. There could be non-suspect individual characteristics that correlate with both a suspect or vulnerable characteristic and high-risk status. For example, property insurers could base higher property insurance rates on crime statistics. If people of color primarily live in areas with higher crime rates, the higher premiums would be based on a factor—crime rates—that correlates with race. Carriers could justify additional premiums based on the higher rate of loss in high crime areas. Outside of any current regulatory regime that prohibits disparate impact,⁸³ would it be normatively defensible to allow insurers to charge higher rates

⁸² *Id.* at 394.

⁸³ The United States Department of Housing and Urban Development (“HUD”) recently promulgated a rule establishing that a plaintiff can establish a Fair Housing Act claim on the basis of discriminatory effects. HUD’s final rule declares that “[l]iability may be established under the Fair Housing Act based on a practice’s discriminatory effect . . . even if the practice was not motivated by a discriminatory intent.” 24 C.F.R. § 100.500 (2013). This regulation presumably prohibits charging higher rates for property insurance to people of color even if the rates are actuarially fair. That is, the rule would prohibit the disparate impact of the higher prices for property insurance. This rule is, of course, limited to those insurance types that lay within HUD’s ambit. Neither this rule nor any other prohibits higher prices for life or auto insurance.

to people of color? There are strong arguments on both sides of this debate. On one hand, as with all risk classification, price differentiation allows a carrier to control adverse selection and moral hazard. Further, some may view it as fairer to charge those who have less of a risk of loss less for their property insurance.⁸⁴ On the other hand, if one views insurance as a means of risk spreading, it may be unattractive to charge the high risk group higher premiums. This argument has additional weight in this example because there may be historical and sociological reasons for higher crime in particular areas. Further, insureds who live in high crime areas may not have the means to move. Under this view, society as a whole bears some responsibility for the high-risk status of the insureds. And, importantly, because insureds cannot move, they likely cannot mitigate the risk of living in a high crime neighborhood. Further, to the extent that areas of high crime are predominately made up of people of color, there may be a risk that the higher premiums reinforce negative stereotypes, and thereby impose dignitary harms on those affected.

Big data has the potential to change some of this analysis, although it depends, in part, on the type of proxies that carriers find for high-risk status. Insurers could find obvious correlations between non-suspect characteristics and both a suspect or vulnerable characteristic and high-risk status. It is easy to imagine the kind of data that may correlate more strongly with women than men; particular racial, religious, or ethnic groups; people from a particular country; or particularly vulnerable individuals. Women may “like” Oprah more often on Facebook, Jews may search more frequently for the precise timing of sundown on Google, people of Filipino decent may be more likely to follow @MannyPacquiao on Twitter, victims of domestic violence could search more frequently for women’s shelters or about restraining orders, and the poor may be more likely to look up information about social services.

It is unlikely that carriers would make it known why policyholders fall into high-risk groups—for example, by explaining which behaviors correlate with higher risk. But if they were to do so, these obvious proxies raise a similar set of normative arguments as described above. Carriers could justify the higher rates on both the adverse selection argument and the argument that it may be fairer to the low risk group to pay less for coverage. The moral hazard mitigation argument, however, holds little water in this context. There is little argument that the correlatives to risk identified above are, in fact, causal. As such, there is little benefit to

⁸⁴ Baker, *supra* note 20, at 375.

encouraging, for example, fewer “likes” on Facebook or fewer Google searches for sundown. Further, to the extent that the proxies are obviously coextensive with a suspect or vulnerable group, there may be a risk that the higher premiums reinforce negative stereotypes and impose dignitary harms on those affected.

The far more likely scenario is that it will not be readily apparent to anyone why some individuals are charged more. The algorithms driving big data will simply spit out higher prices for some policyholders than others. Carriers will not directly explain nor will it be obvious to insureds or third parties why some individuals are charged higher premiums. Insurers may treat the information as proprietary and thus have an incentive to conceal the reason for the pricing from the policyholders (especially given that there is likely no moral hazard mitigation to be done). This may mean that the algorithms driving risk classification will identify groups of risky individuals without anyone intending or even knowing that many of the identified individuals are members of a suspect or vulnerable group.⁸⁵ As discussed below, this opacity changes the arguments for and against risk classification. Importantly, if it is not clear who is charged more for insurance or why, there is little argument that insurers are reinforcing stereotypes or that policyholders are suffering dignitary harms.

As with obvious proxies, carriers could argue that the risk classification helps mitigate adverse selection and is fairer to low risk groups. And, like obvious proxies, carriers cannot argue that the pricing helps mitigate moral hazard. There is no risk-related reason to encourage people not to buy certain types of paper towels or place cell phone calls at a particular time of day.

What is different is that the reasons against classifying risk look very different. Here, even if a proxy is coextensive with a suspect class, the reasons for the increased rates are obscured. The algorithms are simply spitting out high-risk groups. The carriers may not even know that many or most of those charged higher rates are members of suspect or vulnerable

⁸⁵ There could be another possibility: the carriers reveal the correlations with risk, but those correlations are not obviously linked to a particular suspect or vulnerable class. Hypothetically, imagine that individuals who buy a particular kind or amount of paper towel, who call particular area codes at particular times of day, or who use social media in a particular way are more susceptible to a particular type of risk *and* are more likely to be members of a suspect or vulnerable group. There is nothing obvious to link those behaviors to particular groups. In that case, the same arguments about opacity discussed below apply.

groups. And given this, it is unlikely that policyholders or the public know either. Thus, it is difficult to see how the higher rates reinforce stereotypes or cause particular groups to suffer dignitary harms.

The remaining argument against using characteristics that correlate with both a risk factor and a suspect class is that the group will be burdened unfairly. Whether this disparate impact matters depends in large part on whether one views insurance as a vehicle for social solidarity through risk spreading or not. As above, if a particular group has a propensity for higher risk, then one may consider it fair to charge that group more for coverage. If one views insurance as a mechanism for society-wide risk spreading, then risk classification is rarely acceptable.

The table below summarizes these arguments. The three left columns represent the general arguments for risk classification. Where an “X” appears, carriers can reasonably make an argument in favor of classifying risk based on the type of proxy. As the chart makes clear, any time a characteristic correlates with risk—even if that characteristic also correlates with a suspect or vulnerable group—an insurer can argue that charging higher premiums helps fight adverse selection and is fairer to the low-risk group.⁸⁶ But, for most of these potential correlations, insurers have no reason to encourage their insureds to minimize the activity correlated with risk and thus do not mitigate moral hazard through pricing. Carriers can only mitigate moral hazard when the correlation to risk is known, is causal to the risk, and can be controlled by the policyholder.⁸⁷ For example, insurers can offer price breaks to install smoke detectors or take defensive driving classes. This helps mitigate the risk from materializing and controls moral hazard. On the other hand, if the price of auto insurance is based on age or sex, charging higher prices to young men does not encourage a different type of behavior. Policyholders are unlikely to be able to control most of the correlations found through big data. Even if the policyholder can control the characteristic upon which the carrier classified

⁸⁶ See Abraham, *supra* note 11. There are reasons to question the adverse selection story generally. It is, however, intuitively true that insurers can induce additional policyholders to pay for coverage by offering lower rates. In doing so, carriers may be mitigating some adverse selection, or at least enhancing their bottom line. This adverse selection argument is subject to a number of constraints. See e.g., Ronen Avraham et al., *Towards a Universal Framework for Insurance Anti-Discrimination Laws*, 21 CONN. INS. L.J. (forthcoming 2014).

⁸⁷ See generally Baker & Swedloff, *supra* note 24 (discussing risk-based pricing as a means of mitigating moral hazard).

the risk (e.g., by defriending Oprah), it is unlikely that the changed behavior will actually result in fewer losses.

The arguments *against* classifying risk based on suspect classifications are far more equivocal. One could argue that charging more simply based on an underlying suspect or vulnerable characteristic reinforces structural inequality, reinforces stereotypes, and creates dignitary harms. It may be that where a carrier uses a proxy (whether through big data or not) that is obvious and fairly coextensive with a suspect class, the higher premiums will create the same harms. But, as the reasons for the higher premiums become less clear, as the algorithms obscure who is paying more and for what reason, the arguments change. With no obvious connection to a particular group, the extra premiums neither cause dignitary harms nor reinforce negative stereotypes. Thus, the only argument left against classifying risk in this way is that the high-risk group is unfairly burdened by the high premiums. This puts one's view of insurance front and center in the debate.

Arguments For/Against Using Proxies For Suspect Classes in Risk Classification

| | Arguments for Risk Classification | | | Arguments Against Classifying Based on Suspect Class | | |
|--|-----------------------------------|-----------------------------------|----------------------|--|-----------------|---------------|
| | Adverse Selection | Moral Hazard | Fairness to Low Risk | Reinforce Stereotype | Dignitary Harms | Unfair burden |
| Suspect characteristic directly correlates to risk | X | | X | X | X | X |
| Non-suspect characteristic correlates to suspect characteristic and risk | X | If insured can control the factor | X | X | X | X |
| Obvious big data correlation with suspect characteristic and risk | X | | X | X | X | X |
| Nonobvious big data correlation with suspect characteristic and risk | X | | X | | | X |

2. Non-Causal Correlations

Even if insurers identify correlations with risk that do not disparately impact suspect or vulnerable groups, there may other concerns with correlations identified by big data. The algorithms may find correlations with risk for which carriers can tell no plausible story about the causal connection between the behavior and the loss. Big data is very good at finding subtle correlations, but these correlations may not be meaningful because the correlations are to activities that are unrelated to the underlying loss.⁸⁸ Of course, both traditional and big data risk classification are based on correlations. As discussed above, some correlations, such as the connection between smoking and illness or early death, have a significant causal backbone. For other correlations, such as a link between age and driving, carriers can tell a plausible story: young men act rashly and do not have fully developed control over their rapidly changing emotions, and are therefore more erratic drivers. But, there are certainly identifiable correlations with risk for which there is no plausible story—for example the link between consumption of cheese and death by entanglement in bed sheets.⁸⁹ If there is no causal connection, it is unclear that it is reasonable for insurers to base rates on spurious correlations.

Big data analytics exacerbate concerns that insurers will identify risks which have no causal relationship whatsoever to the insured loss. In part, this is due to the magic of big data. The Holy Grail for big data is finding subtle, yet undiscovered correlations. The problem, of course, is that finding such non-causally related correlations means that the policyholder cannot, and likely should not, try to minimize the activity, behavior, or characteristic. Imagine the following: using big data analytics, some carrier realizes that individuals who purchase vampire novels on

⁸⁸ “[A]lthough big data is very good at detecting correlations, especially subtle correlations that an analysis of smaller data sets might miss, it never tells us which correlations are meaningful. A big data analysis might reveal, for instance, that from 2006 to 2011 the United States murder rate was well correlated with the market share of Internet Explorer: Both went down sharply. But, it’s hard to imagine there is any causal relationship between the two. Likewise, from 1998 to 2007 the number of new cases of autism diagnosed was extremely well correlated with sales of organic food (both went up sharply), but identifying the correlation will not by itself tell us whether diet has anything to do with autism.” Marcus & Davis, *supra* note 67.

⁸⁹ See Vigen, *supra* note 43.

Amazon, "like" vampire related media on Facebook, or follow authors of vampire fiction on Twitter are more likely to engage in risky behavior. Reading vampire novels or being a fan of vampire fiction could be within the control of the policyholder, but should insurers be allowed to classify risks along these lines? There is likely little, if any, causal connection between being a fan of vampire fiction and an actual risk. Carriers have little reason to encourage the policyholder to be less of a fan of vampire fiction. So what is left to justify the higher prices? Carriers, of course, can still argue that prohibiting price discrimination—even for these non-causal characteristics—would create adverse selection problems and be unfair to low risk policy holders.⁹⁰

Again, this pits two different kinds of fairness arguments against each other. Big data has laid bare the essential nature of insurance. Should individuals who are higher risks have to bear the burden of that status even when no one can tell a reasonable story about why they have that high-risk status? Should low risks subsidize high risks even if they do not have any reason for being in the low-risk group?

3. Opacity in Correlation

As noted above, big data is unlikely to provide simple, easily explainable reasons for higher premiums. Rather, carriers classifying risk in this way will likely just charge some group of policyholders higher premiums without explanation based a number of factors, each of which is obscured by the underlying algorithmic analysis. This lack of transparency raises a number of issues.

On the one hand, as noted above, opacity undermines fears that higher rates will create a particular stigma or dignitary harm to the high-risk group. Policyholders likely will not know whether they or others are paying more for insurance or whether any particular groups are being singled out for higher rates. Thus, higher rates may not reinforce stereotypes, stigmatize a particular group, or create dignitary harms. But, the lack of transparency means that a policyholder may not be able to change his or her behavior even if he or she has characteristics that should and may be classified as high risk and can and should be controlled. In short, unless the carrier identifies which factors are leading to higher rates, there is little moral hazard mitigation to be done. All that is left to justify

⁹⁰ The likelihood of these claims depends in large part on the line of insurance. See Avraham et al., *supra* note 86.

the difference is a fear of adverse selection and a sense that it would be fairer to the low risks to charge them less.

Further, the opacity of the algorithm raises concerns about error. Imagine that the overall classification system works in that the insurer correctly identifies a certain set of characteristics that correlate with more risk, the carrier induces more insureds into the risk pool, and the classification system is otherwise efficient. There may still be individuals who are misclassified as high risk. The lack of transparency in the data collected and the algorithm deriving correlations means that these otherwise low risk individuals may not be able to determine why they were moved into the higher risk group or how to fix it.

C. PRIVACY

Interestingly, both big data and risk classification raise significant privacy concerns. First, as noted above, privacy issues are raised any time a carrier classifies risks (with or without big data) on intimate, personal information, like HIV status, marital status, sexual orientation, or genetic information.⁹¹ Likewise, privacy concerns are implicated any time a company obtains and uses personal information to augment its databases or any time a company feeds personal information through its big data algorithms for correlative or predictive purposes. Thus, it is natural that there would be significant privacy concerns when risk classification is combined with big data analytics.⁹² There are two principal ways that big data raises new privacy concerns for risk classification.

First, insurers now may be able to collect information about current or potential policyholders from public sources that the carriers are prohibited from asking a policyholder about directly. For example, it is reasonably easy to imagine that carriers could access information that policyholders share via social media about themselves, including for example, sexual orientation. While policyholders may want to share that information with friends and family, they may not want a carrier to have it. If, to follow through on this example, carriers cannot ask about sexual

⁹¹ See Avraham et al., *supra* note 18, at 220.

⁹² There is significant literature about whether these intrusions into personal space, or extrusions of personal information are privacy harms. It is beyond the scope of this Article to resolve any of these debates. Rather, at issue here is whether insurers using big data to classify risk implicate new or different privacy concerns.

orientation in classifying risk, they should not be able to use Facebook posts to identify the same information for classification purposes.

Second, and relatedly, carriers may be able to use predictive analytics to discern private information that they should not otherwise have or use as a basis for risk classification. For example, as described above, Target used shopping patterns to discern which of its customers were pregnant.⁹³ It is easy to imagine an insurer using the same or similar data to predict pregnancies or other personal information. Again, and without specifying where the boundaries are, if a carrier is prohibited from asking about the information in the first instance, the carrier should not be able to predict the same.

IV. REGULATORY RESPONSE

The financial and social costs listed above suggest a regulatory responsibility to actively consider the ways that big data could change risk classification. Big data has the potential to strip away certain reasons for and against risk classification. Possibly gone are credible claims to the benefits of managing moral hazard and concerns about explicit harm from being singled out as different as a result of being a member of a suspect or vulnerable group. Left are old debates. Are low risks entitled to the benefits of their low-risk status? Or, should society subsidize high-risks because it is, for some reason, inappropriate to saddle high-risks with the burdens of their status?

Similarly, gone are old ways of protecting privacy. Insurers may not need to explicitly ask questions that invade particularly private spheres. Instead, carriers can base decisions on a set of correlations and predictions that may burden particular groups more than others or may invade particular zones of privacy.

Big data thus implies a move from conscious discrimination and explicit privacy invasions to unconscious proxies.⁹⁴ Whether and how regulators respond will depend on jurisdictional priorities. Is there a will to protect groups impacted by higher premiums or to protect certain intimate information? The answer to these questions may depend on the line of

⁹³ See *supra* notes 75–76 and accompanying text.

⁹⁴ Cf. Solon Barocas & Andrew D. Selbst, *Big Data's Disparate Impact* 20–21 (Oct. 19, 2014) (unpublished article), available at <http://ssrn.com/abstract=2477899> (explaining that sorting using relevant criteria in making decisions also can serve as proxies for class).

coverage and the precise group burdened or information used. But, protecting these groups requires regulators to think actively about the harms and the remedies.

A. REGULATION OF DISCRIMINATORY IMPACT

To the extent that there is any legislative or regulatory will to engage with these discrimination or privacy issues, big data changes the conversation.⁹⁵ To monitor, curb, control, and eliminate these concerns, legislators and regulators must look at the outputs of, rather than the inputs to, the classification system. That is, they can no longer—to the extent that they ever did—worry about whether carriers are directly grouping suspect classes or basing rates on other socially vulnerable characteristics. Instead, in the age of big data, regulators must look at how particular classes and individuals are being charged and then determine whether those charges constitute an impermissible burden.

Regulators must first determine whether insurers are charging higher premiums to particular groups or individuals with particular characteristics (such as characteristics that are non-causal to the potential loss or represent socially vulnerable groups). This will require some additional legwork on the part of carriers and regulators, because insurers will have to determine not just who is being charged more but whether there are any patterns to the classes of risk. Are, for example, African Americans being charged more for a particular line of coverage? Or, are people without children being charged more for other lines of coverage?

Legislators and regulators must then compare these groups and individuals against internal calculations about whether and how insurance should spread risks and in which forms. Even if risk and loss correlate with suspect classes, actuarial science should not necessarily govern insurance rates; higher rates of loss may reflect socioeconomic realities that should

⁹⁵ It is not at all clear that there is legislative will to engage with this, or for that matter, any discrimination. There is little federal oversight of discrimination within the insurance industry. *See* Avraham et al., *supra* note 18, at 198 (listing the limited number of federal laws and regulations on point). State regulation of discrimination in insurance is highly variable across jurisdictions and across lines of insurance. *Id.* at 268. For the most part, states have not even prohibited explicit discrimination based on race, religion, or national origin. *See id.* at 267 (“[L]aws often have little to say about the most important divisive types of discrimination: distinctions based on race, national origin, or religion.”).

not burden one group over the population.⁹⁶ These calculations may differ across lines of insurance. There may be certain lines of insurance that require additional protection against discrimination. For example, given the semi-mandatory nature of homeowners insurance and the perceived importance of homeownership, there may be reasons to put more weight in the risk spreading rationale. This may be why federal regulators have instituted a very rare federal overlay of anti-discrimination regulation for homeowners' insurance.⁹⁷

If the state chooses to make a commitment, legislators should prohibit carriers from placing any extra burden on suspect classes. This analysis highlights one clear fact: the regulatory response to big data in the risk classification sphere is going to turn on the underlying normative framework of the state. When a state believes that a particular line of insurance is designed more to spread risk, it must be on the lookout for disparate impacts.⁹⁸ When a state does not, it need not worry.

B. REGULATION OF PRIVACY

The analysis for privacy intrusions is similar, but the prescriptions may be different. First, states must determine what, if anything, constitutes a privacy invasion in this context. Can carriers mine and use data anonymously? Can carriers use non-anonymous data about policyholders? Can carriers use predictive analytics to determine characteristic about the carrier that were otherwise private?

After determining what matters, regulators will face the same issues that others have flagged in a number of big data contexts: how to protect end consumers from privacy invasions and predictive analytics?⁹⁹ To resolve these issues, regulators need a two-pronged approach. First, regulators will have to audit insurers' classification systems looking at the "data sets mined" by the algorithms, as well as the "source codes and programmers' notes describing the variables, correlations, and inferences

⁹⁶ See *id.* at 267 ("Even when actuarial support can be found for these assumptions, that does not mean that they are not intimately tied up with socially suspect characteristics.").

⁹⁷ See 24 C.F.R. § 100.500 (2013); see also *supra* note 83.

⁹⁸ Cf. Citron & Pasquale, *supra* note 2, at 13–16 (describing how credit scores might have a disparate impact on racial minorities).

⁹⁹ See, e.g., Citron, *supra* note 2; Crawford & Schultz, *supra* note 2, at 95; Richards & King, *supra* note 69, at 408.

embedded” in the algorithm.¹⁰⁰ These audits should focus on whether personal data is appropriately scrubbed from the data used to create the predictions, whether carriers are gathering inappropriate individual data, and whether the data are suggesting inappropriate correlative predictions. Second, regulators may want to institute a hearing procedure for individuals who believe that inappropriate data are being gathered or used.¹⁰¹

V. CONCLUSION

Big data may be a natural evolution in risk classification. It makes sense for insurers to take advantage of new data sets and new algorithms to derive new correlations to risk. After all, insurers have a number of incentives to refine their pricing, including the possibility of higher profits and better management of adverse selection.¹⁰² But, these new correlations may yield price discrimination that disparately impacts some suspect or vulnerable groups of people. Further, the algorithms may use or divine information that has otherwise been entitled to some privacy protection.

These two costs suggest a somewhat revolutionary approach to regulation. First, regulators will have to actively consider whether it is acceptable for each line of insurance to have prices that burden suspect or vulnerable groups. This will put in stark relief important choices about whether insurance is about risk assessment or risk spreading.¹⁰³ Regulators will have to consider whether to protect certain groups of people from higher insurance prices, even if there are sound business reasons for carriers to charge the affected policyholders more. To the extent that

¹⁰⁰ See Citron & Pasquale, *supra* note 2 at 23.

¹⁰¹ See Crawford & Schultz, *supra* note 2, at 111; Richards & King, *supra* note 69, at 426.

¹⁰² Unless big data (a) yields correlations that make transparent the policyholders’ risky behavior and unless (b) that risk behavior is controllable and (c) has a causal relationship to the risk, there is no argument that the higher prices will control moral hazard.

¹⁰³ See generally ABRAHAM, *supra* note 20, at 65 (“In short, attitudes toward insurance always seem to be pulling in two directions—one that highlights the risk-assessment or efficiency promoting features of insurance classification and the other that stresses the risk-distributional function of insurance.”); Baker, *supra* note 20, at 25 (“Thus, debates over the legitimacy of particular forms of risk classification invoke classic debates over the nature of distributive justice.”).

regulators want to protect these groups, the regulatory regime will have to change from one based on prohibiting intentional discrimination to one based on prohibiting the disparate impact of business decisions.¹⁰⁴ Second, for both price discrimination and privacy issues, regulators will have to increase their capacity to analyze the data inputs, algorithms, and outputs of the classification schemes.

¹⁰⁴ As discussed above, HUD has already made that determination in the context of claims based on the Fair Housing Act. *See supra* note 83.

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