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EXCUSING NONOCCURRENCE OF INSURANCE POLICY CONDITIONS IN ORDER TO AVOID DISPROPORTIONATE FORFEITURE: CLAIMS-MADE FORMATS AS A TEST CASE

*Bob Works**

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INTRODUCTION

Claims–made liability insurance coverage, the New York State Insurance Department told us more than a decade ago, "is generally inferior to occurrence coverage."[1] For a time developments regularly chronicled in the trade press seemed to confirm that judgment. Industry efforts to introduce a claims–made format for commercial general liability policies were flatly rejected by most sophisticated buyers.[2] Some jurisdictions instituted

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1. *New York State Insurance Department Opinion and Decision on Issues Raised by Insurance Services Office on Commercial General Liability Claims–Made Form*, 4 J. INS. REG. 39, 41 (1986). *See also* Reg. No. 121, N.Y. COMP. CODES R. & REGS. tit. 11, § 73 (1993) (minimum standards for approval of claims–made forms).

In a "pure" occurrence format, the trigger that activates liability insurance coverage usually is bodily injury or property damage allegedly caused by a tortious act; less frequently, in professional liability and other settings where determining the time of the injury may be difficult, the occurrence trigger may be the negligent act or omission itself. In a "pure" claims–made format, the trigger that activates liability insurance coverage is a claim for damages made by an injured party against the insured during the policy period. As we shall see, such generalizations often obscure more than they reveal.

2. *See, e.g., In re* Insurance Antitrust Litig., 938 F.2d 919, 923 (9th Cir. 1991) (policyholder resistance to claims–made formats), *aff'd in part, rev'd in part by* Hartford Fire Ins. Co. v. California, 509 U.S. 764 (1993). *Compare* INSURANCE SERVICES OFFICE, COMMERCIAL GENERAL LIABILITY INSURANCE: ISO MAKES THE CASE FOR THE CGL (1985) (reciting advantages of claims–made formats) *with* John F. Fitzgerald, *Claims–Made and the Agent*, BESTS REV. — PROP. & CASUALTY INS. ED., Jan, 1988, p. 48 ("Claims–made is a bust, an overreaction, a dead issue."). *See*

regulatory restrictions on the use of claims–made formats.[3] Defense lawyers complained that courts both in this country[4] and abroad[5] improperly were converting claims–made policies into occurrence policies, and were in turn denounced as having mounted a crusade to "rig the common law" to prevent such heresies from taking root.[6] And, perhaps most visibly to the casual observer, major players in the insurance industry found themselves defending high profile antitrust litigation alleging that they had employed illegal boycotts in an effort to force an unwanted format on unwilling buyers.[7]

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also Alison Kittrell, *Risk Managers Accept Claims–Made Reluctantly*, BUS. INS., Oct. 13, 1986, at 1, col. 2 (survey indicates more than 50% forced to use claims–made policies); Robert A. Finlayson, *Insurers Restricting Use of Claims–Made CGL Form*, BUS. INS., Feb. 9, 1987, at 1, col. 2 (insurers insisting on claims–made format only for long tail exposures). The best generally accessible guides to the current use of claims–made formats are the publications of the International Risk Management Association. *See* INTERNATIONAL RISK MANAGEMENT INSTITUTE, INC., PROFESSIONAL LIABILITY INSURANCE VIII.C.3 (1995) (hereinafter "IRMI, PROFESSIONAL LIABILITY INSURANCE"); INTERNATIONAL RISK MANAGEMENT INSTITUTE, INC., COMMERCIAL LIABILITY INSURANCE II.C.5 (1995) (hereinafter "IRMI, COMMERCIAL LIABILITY INSURANCE").

3. *See, e.g.*, ARK. CODE ANN. §§ 23–79–306 to 307 (Michie 1992); COLO. REV. STAT. § 10–4–419 (1998); CONN. ADMIN. CODE Title 38a §§ 327–1 to 327–6 (1990); N.Y. COMP. CODES R. & REGS. title 11, § 73 (1993); N.C. GEN. STAT. § 58–40–140 (1994).

4. *See infra* notes 50–68, 88 and accompanying text.

5. *See generally* Jorge Angell, *Claims Made Policies or Occurrence Policies in Civil Liability Insurance: A Spanish Judicial Perspective*, INT'L J. INS. L. 112 (1994); Jorge Angell, *Claims Made Policies or Occurrence Policies in Civil Liability Insurance in Spain: Announced Legislative Changes*, INT'L J. INS. L. 191 (1994); Marcel Fontaine, *Claims Made Policies Under Belgian Law*, INT'L J. INS. L. 128 (1994); Tim Griffiths, *Time–Limits in Claims Made Insurance in Australia and New Zealand*, 5 INT'L INS. L. REV. 85 (1997); Mikaël Hagopian, *France: The Supreme Court Rules that "Claims–Made" Coverage Is a Nullity*, INT'L J. INS. L. 52 (1994); Susan Hankey, *Claims Made Policies and Choice of Law in the European Union*, 2 INT'L INS. L. REV. 267 (1994); Mark Sheller, *"Claims Made": The Australian Experience*, INT'L J. INS. L. 188 (1994). For more accessible summary treatment of the European developments, see Sarah Goddard, *Directives Command Change in Europe: Claims Made Policies Under Fire*, BUS. INS., Oct. 9, 1995, at 75.

6. *See infra* notes 50–71 and accompanying text.

7. *See generally* ABA SECTION OF ANTITRUST LAW, THE INSURANCE ANTITRUST HANDBOOK 28–30 (1995); Ian Ayres & Peter Siegelman, *The Economics of the Insurance Antitrust Suits: Toward an Exclusionary Theory*, 63 TUL. L REV. 971

But in recent years that apparently settled history has required some rewriting. Claims–made policies constitute a growing presence in the liability insurance marketplace. University finance departments assure us that "the claims–made form represents a preferred form of contracting under conditions of non independence between insurable risks."[8] Judicial unease

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(1989); George L. Priest, *The Antitrust Suits and the Public Understanding of Insurance*, 63 TUL. L. REV. 999 (1989). In 1988, nineteen states and a number of private plaintiffs filed complaints in federal district court alleging that some domestic primary and reinsurance companies, a reinsurance broker, and London–based reinsurers had conspired to force the Insurance Services Office to make changes in its CGL program, to include, especially, claims–made policy triggers. Later that year ten other states joined the litigation, and a similar action was filed in Texas state court. In 1991, the Texas suit was settled for $6.6 million. *See* Michael Bradford, *Final Defendants Settle Texas Antitrust Litigation,* BUS. INS., Apr. 1, 1991, at 2.

The federal suit was dismissed on summary judgment in September, 1989, but the United States Court of Appeals for the Ninth Circuit reversed in a decision that defined boycott to mean a "use of economic power of a third party to force the boycott victim to agree to the boycott beneficiary's terms." *In re* Insurance Antitrust Litigation, 938 F.2d 919, 930 (9th Cir. 1991). The United States Supreme Court reversed; the five to four decision held that allegations that the defendants tried to limit liability coverage to claims–made fell within the boycott exception to the McCarran–Ferguson exemption, but in the process defined boycott much more narrowly than had the Ninth Circuit. *See* Hartford Fire Ins. Co. v. California, 509 U.S. 764 (1993). The suit was finally settled in 1994 by an agreement that industry dominance of the ISO board of directors would be ended, and that the defendants would pay the plaintiffs' legal fees and contribute more than $26 million to establish a public entity data base and a "Public Entity Risk Institute." *See generally* Judy Greenwald, *Antitrust Settlement to Alter ISO, Industry*, BUS. INS., Oct. 10, 1994, at 1.

The suits by the attorneys general were preceded by *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531 (1978), in which the only four insurers selling medical malpractice insurance in the market were accused of conspiring to boycott prospective purchasers of medical malpractice insurance in order to force them to accede to a change from occurrence formats to claims–made formats; the complaint alleged that St. Paul and the other three insurers agreed that St. Paul would offer only claims–made coverage, and that the other three would refuse to write medical malpractice insurance on any terms. The Supreme Court held that the boycott exception to the McCarran–Ferguson exemption from antitrust laws included boycotts that were not aimed at harming competitors.

8. Neil A. Doherty, *The Design of Insurance Contracts when Liability Rules are Unstable*, 58 J. RISK & INS. 227, 243 (1991). In Doherty's view, the emergence of claims–made forms "helped to revive a flagging market" and "challenges the basis of recent antitrust suits brought against the industry which suggests that introduction

about claims–made coverage seems on the wane, and a variety of legal voices can be heard confirming that "the advantages of the claims–made form over occurrence policies for professional and commercial liability risks are now well documented."[9]

So which is it? Are claims–made formats "generally inferior," or a "preferred form of contracting" whose "advantages . . . [are] well

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of the claims made policy is harmful to consumers"). *Id.* at 243, 244. *See also infra* notes 302–304 and accompanying text.

9. Harry W.R. Chamberlain II, *Claims–Made Policies Are Enforceable in California: Trends after Burns v. International Insurance Company*, 28 TORT & INS. L.J. 90, 92 (1992). *See also* W.F. Young, *Is Insurance A Niche Business? Reflections on Information as an Insurance Product*, 1 CONN. INS. L.J. 1, 29 (1995) (seeing no sharp dichotomy between "occurrence" and "claims–made" coverages: "The two are roughly equivalent, so long as the enterprise insured throws off claims that are even over time in frequency and magnitude."); Kathleen E. Wherthey, *New Life for The Claims–Made Liability Policy in Maryland*, 53 MD. L. REV. 948, 949 (1994) (celebrating Maryland's joining "the national trend toward continuing the viability of the claims–made form of coverage, a cost–effective innovation, which, if drafted with reasonable clarity, benefits both insurers and policyholders"). Not all agree that the systemic effects are so benign. *See, e.g.*, KENNETH S. ABRAHAM, DISTRIBUTING RISK 49–51, 58–59 (1986) (claims–made coverages make cost–internalization more difficult).

> A claims–made pricing system forces insured enterprises to internalize some costs. But they are mainly not the future costs of today's activities; they are the costs incurred this year as a result of activities that took place in the past. In effect, claims–made premiums are installment payments for coverage against losses caused by past activities.

Id. at 50. Others recognize some of the greater risks individual insureds are forced to bear. *See, e.g.*, ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW § 5.10(d)(1) & (3) at 599 (1988) (" [O]ne of the principal disadvantages . . . is that the policyholder is left to bear much of the burden of uncertainty about future claims costs and the premiums which will have to be paid to cover the continuing risk that new claims may be asserted for activities that occurred years earlier"); Eugene R. Anderson, *Current Issues in Claims–Made Insurance Policies*, ALI–ABA COURSE MATERIALS J., Oct. 1989, at 57; Jeanine Dumont, *What Every Professional Should Know before Buying Claims–Made Liability Insurance*, 35 FED. INS. COUNSEL Q. 363 (1985); Lee Roy Pierce Jr., *Professional Liability Insurance: The Claims Made and Reported Trap*, 19 W. ST. U. L. REV. 165 (1991).

documented?" And why has that question provoked so much explicit attention from lawyers and judges whose conceptions of their professional roles rarely permit any overt examination of the adequacy of contractual exchanges? Most observers agree that liability insurance markets seem to have settled into a relatively stable pattern in which most coverage is written on an "occurrence" basis and "claims–made" coverage is employed chiefly for the more troublesome long–tail exposures. Why not conclude that with liability insurance formats, as with apples and oranges, such questions of relative value may best be left to individual consumers, some of whom may have chosen to purchase a less comprehensive and thus less costly product? After all, as Judge Richard Posner recently reassured us, with claims–made formats "the coverage is less, but so, therefore, is the cost."[10]

But is rolling out the standard Rosetta Stone of applied price theory really a useful way to decipher the Babel that continues to infect the law and literature of claims–made insurance? Is the coverage provided by a claims–made policy less in the same sense that an insured under a personal auto policy has less coverage than if she had purchased collision coverage to go with the other coverages she did buy, or in the sense that the coverage provided by a homeowner's policy is less because the policy excludes liabilities arising out of business activities, or requires that notice of accidents be given within a reasonable time? Of course, in some formal and ultimately trivial sense these limitations on coverage are all the same. In the simple black letter law of contracts, they are all conditions, and the insurer has no obligation to perform unless all conditions are fully satisfied. And in the simple analytics of applied price theory, they are all reductions in coverage that operate to reduce the cost of insurance to insureds, and thus redound to the benefit of all insureds except the unfortunate few who actually get caught by the limitations. But in this article I will argue that there is more to concerns about claims–made formats, and more, both to law and to economics, than that.

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10. National Union Fire Ins. Co. v. Baker & McKenzie, 997 F.2d 305, 306 (7th Cir. 1993). The refrain is a familiar one. *See, e.g.*, Livingston Parish Sch. Bd. v. Fireman's Fund Am. Ins. Co., 282 So.2d 478, 483 (La. 1973) ("[T]he insured received what [it] paid for by the present policy, with premiums presumably reduced to reflect the limited coverage."); Ferguson v. Phoenix Assur. Co., 370 P.2d 379, 481(Kan. 1962) (dissenting opinion) ("In this day and age a person gets just about what he pays for—whether it be insurance protection or anything else—and that is what happened here.").

Put simply, claims–made triggers sometimes operate to allocate to insureds risks that are different in kind from those assigned by more familiar insurance policy coverage restrictions. Because many "claims–made" policies are structured and interpreted to include "claims–made–and–reported" triggers or "potential–claim–discovered–and–reported" triggers, they create the potential that in some circumstances even an insured who maintains continuous unaltered coverage with the same insurer may find that fortuities of timing of some of the events in the tort liability sequence mean that none of those policies has been triggered even when those same fortuities of timing do not affect the burdens borne by the insurer. And, even more fundamentally, because they make the triggers for determining whether a particular insurer is potentially obligated operate late in the liability claim sequence, claims–made policies create the potential that "preexisting circumstances" will become known and render the insured effectively uninsurable in a way not usually encountered outside of medical expense insurance.

Unfortunately, these characteristics of claims–made policies—what I will call the "forfeiture risk" and the "classification risk"—though familiar to the professional risk managers who led the resistance to adopting claims–made triggers for commercial general liability policies, have not received the attention they deserve. There are several reasons. First, these particular devils are in the details, and the details of claims–made policies are far from standardized and often devilishly complicated. Rather than fight through these complexities, too many discussions settle for stylized characterizations of the differences between idealized "pure" versions of occurrence and claims–made formats, and thus fail to train scrutiny on the ways claims–made formats can create occasions for insurer opportunism and encourage forfeitures. Second, though the failure of claims–made triggers to take root in commercial general liability insurance may be an especially useful example of how even a thin margin of informed buyers can protect a larger group of unsophisticated, not all parts of the liability insurance buying market seem to have produced such leaders, and only sometimes are both claims–made and occurrence formats available in the same markets for the same risks. In medical malpractice, legal malpractice, products liability, environmental impairment and a host of specialty product lines, occurrence coverage simply is not an available option for most buyers, and the separation of buyer from insurer by intermediaries like bar and medical associations, managing partners, and brokers may prevent many of those most affected from appreciating the differences. Third, the last decade has been a period of

extraordinarily soft markets in which renewals come easily; we simply have not yet seen the hard markets that would push these concerns to the forefront. But there is another reason as well. Even when the multiple–event trigger and preexisting circumstances problems are squarely presented, the neo–classical habits of thought still dominant in both the law and the economics of insurance provide few tools to help lawyers to understand the problems posed by "forfeiture risk" and "classification risk" and to construct ways to ameliorate them.

Thus, this article has two principal ambitions. The first is to rescue understanding of the operation of claims–made liability formats from the stylized and often misleading descriptions found in the insurance decisions and much of the professional commentary. In this, my effort is not to root out all errors nor to provide a complete systematics of claims–made formats, but rather to suggest a conceptual structure and vocabulary that will permit a more nuanced examination of the very real issues posed by various claims–made formats. The second is to suggest that our understanding of the problems posed by claims–made policies and of the legal responses that may be possible will be enhanced by drawing on the literatures of neo–institutional economics and relational contracting. Neo–classical economic and legal models that use spot market transactions as their paradigm, and that regard each insurance policy as a fully–presentiated contract that speaks clearly to dictate a specific allocation of risks for a specific term, operate from much different premises than the new institutional models grounded in behavioral assumptions concerning "bounded rationality" and "opportunism" and informed by a methodological sensitivity to the vulnerabilities that sequential performances and transaction–specific investments can create. In the neo–classical tradition, a condition is a condition, and there is no reason to inquire why it was included in a contract, why one party failed to satisfy it, or whether the other party was adversely affected by the failure. In this world, defense lawyers understandably regard any unhappy judicial decision as a "refusal to enforce" the policy by a court that has strayed into efforts to "rewrite the contract," and lawyers representing insureds, struggling to find an explanation for why failure to satisfy a policy condition should not be fatal to their client's claim, end up casting their challenges as broad–gauge assertions that claims–made forms contravene public policy or violate the reasonable expectations of insureds. By contrast, neo–institutional economics and its legal analogs permit the focus to move from whether claims–made forms on balance are a good thing or a bad thing to how they operate in a particular context, and offer a conceptually coherent explanation for judicial

policing of the application of claims–made formats that the neo–classical tradition simply cannot provide.

The organization of this essay mirrors this agenda. Part I begins with a brief field guide to insurance policy triggers, the variety of triggers to be found in nominally "claims–made" policy formats, and recent claims–made litigation; here we encounter insurance policy exotica so dense that legal taxonomy using traditional classification tools can only hint at the problems claims–made insureds encounter with their claims–made formats and the problems their attorneys encounter with the inadequate doctrinal tools insurance law puts at their disposal. Part II follows with a primer on the law of insurance policy conditions, with particular attention to differences between dominant ex ante perspectives summarized by traditional insurance law efforts to vindicate the hypothetical objective reasonable expectations of insureds and subterranean ex post policing designed to excuse nonoccurrence of conditions to avoid disproportionate forfeitures; here we seek to identify a fuller array of tools than usually will be found in the insurance lawyer's kitbag. Part III then offers a preliminary exploration of how these doctrinal tools might operate if applied to some of the peculiar challenges of claims–made formats.

The result is an academic's exercise, part polemic decrying continued debasements of insurance law by uncritical application of the acontextual formalisms of neo–classical economics and contracts, part homiletic preaching that contextualization requires us to acknowledge that both bounded rationality and opportunism contribute to the special challenges of insurance law, and part speculative meditation about what the problems posed by claims–made formats might tell us about how such an enriched version of insurance law might work in practice. Thus it should not surprise that the focus throughout is less about who should prevail in specific disputes in this small slice of the insurance market than about the different habits of mind that constrain and channel the rhetorical resources that can be brought to bear in controversies throughout insurance.

I. A SHORT FIELD GUIDE TO CLAIMS–MADE POLICY TRIGGERS AND CLAIMS–MADE TRIGGER LITIGATION

We seldom worry about insurance policy triggers. If my teenage daughter negligently backs our insured automobile into my neighbors' recreational vehicle, the insurer that issued our family automobile policy quickly will see that the damaged vehicle is repaired. What "triggered" that obligation? In a fundamental legal sense, the insurer's present active duty to

pay rests on satisfaction of all of the conditions precedent to that duty: my daughter was an "insured" within the policy definitions, the premiums had been paid, the damage was not something my daughter "expected or intended," she was not engaged in business activities, she gave timely notice to the insurer and cooperated in its investigation of the accident, and so on throughout the multi–page litany of conditions that establish the limitations of the family auto insurer's obligations. But that is not what insurance lawyers mean when they speak of policy triggers. They mean that before we can set about determining whether all a policy's conditions have been satisfied, we first must determine which policy is applicable to the particular insurance story.[11]

Of course, there is no mystery about what insurance policy was triggered by my daughter's accident. Family automobile policies are "occurrence" policies, and so the policy triggered was the one in effect at the time the RV suffered physical damage. Do we care? In this case we do not, because everything that we are likely to consider an element of my daughter's accident, from her initial inadvertence to the insurer's payments to the neighbors, seems likely to be conveniently packed within a single policy period. But what if the sequence takes longer? What if we decompose a liability insurance story into constituent elements and stretch that story over several policy periods? If my 1990 landscaping efforts include negligently leaving a large rock perched on the precipice at the edge of my property, but the rock does not actually crush my neighbor's perambulator until 1991, and the neighbor's claim is not settled until 1992, do we care whether my homeowner's insurer regards the problem as attributable to the 1990, 1991, or 1992 policy years? Usually we do not, so long as I maintained the same homeowner's coverage with the same insurer for each of the years in question. But what if a renewal policy differs in some material way from the policy it replaced, or I changed insurers part way through the sequence, or other claims have exhausted some or all of the policy limits for a particular year? Then we would care, for knowing that the physical damage is the policy trigger tells us which insurer will be obligated to perform if all of its policy conditions are satisfied.

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11. In Professor Fischer's felicitous metaphor, "the trigger concept . . . acts as a gatekeeper, matching particular claims with particular periods of time and hence particular insurance policies." James M. Fischer, *Insurance Coverage for Mass Exposure Tort Claims: The Debate over the Appropriate Trigger Rule*, 45 DRAKE L. REV. 625, 631 (1997).

A. Choosing a Policy Trigger

Why would a liability insurer choose one trigger over another? Ease of application is one major factor. We know when the rock crushed the perambulator, but can we confidently locate in one and only one policy year my failure to use reasonable care in planning, executing, and maintaining my landscaping? In that setting an occurrence trigger has obvious advantages over a negligence trigger.[12] But though occurrence triggers often will be satisfied by unambiguous scenes of crumpled metal and bleeding bodies, sometimes they too prove difficult in ways that over the last decades have kept legions of lawyers fully employed. If the perambulator was full of triplets, all of whom were injured, has there been one occurrence, or three (or four)?[13] Does it matter if the triplets were old enough to be walking single file down the sidewalk, and were hit seriatim by the negligently driven car? Because liability insurance usually is written with limits per occurrence, the answer to that question can matter a great deal. If an insured sells livestock feed contaminated with polybrominated biphenyl so that 28,679 cattle, 4,612 swine, 1,399 sheep, and over 6,000 chickens and other farm animals must be destroyed, do we count the mistakes, or count the injuries, or count the farmers bringing suit?[14] If an asbestos manufacturer in operation since the 1940's should have foreseen an unreasonable danger of asbestosis to both its workers and users of its products, should we treat the resulting injuries as having occurred when the victims first inhaled the asbestos fibers, when the fibers became resident in the victims' lungs, when scarring of the lungs could

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12. Of course, the ease–of–application factor can cut the other way. Before the advent of claims–made policies made them obsolete, "occurrence" professional liability policies often were triggered when the professional services were rendered —and the negligent act or omission allegedly occurred—rather than when the client was injured. For a discussion of the difficulties encountered in trying to locate the time of injury in lawyer's malpractice litigation, see RONALD E. MALLEN & JEFFREY M. SMITH, 4 LEGAL MALPRACTICE § 33.9–33.11 (4th ed. 1996).

13. Don't forget the perambulator.

14. *See* Michigan Chem. Corp. v. American Home Assur. Co., 728 F.2d 374 (6th Cir. 1984). Probably most courts agree that "[t]he general rule is that an occurrence is determined by the cause or causes of the resulting injury. . . . [T]he court asks if there was but one proximate, uninterrupted, and continuing cause which resulted in all of the injuries and damages." *Id.* at 379, n.5. *See also* Bartholomew v. Appalachian Ins. Co., 655 F.2d 27 (1st Cir. 1981).

have been discovered, when the scarring actually was discovered, when medical treatment was required, or all of the above?[15]

Of course, such familiar lawyers' concerns about ease of application are not the only important criteria for selecting a policy trigger. Other things being equal, the insurer's financial people will want to employ a policy trigger that falls later in the sequence rather than earlier, in order to shorten the time between when a policy obligation is priced and when the extent of that obligation is determined. Statistical models of insurance pools that help inform insurance underwriting and pricing decisions depend in part on the quality of the loss frequency and severity estimations they employ.[16] Consequently, the longer the period for which one must "develop" immature historical loss data in order to estimate ultimate loss costs for policies written in the past, and the longer into the future one must peer in an effort to trend those estimates of past loss costs in order to make predictions about future loss costs for new policies, the greater the likelihood for error. In the 1970's and 1980's, as insurers wrestled with newly reported claims implicating occurrence policies priced and underwritten (and triggered) decades earlier,[17] many became convinced that the best way to shorten the "tail" on liability insurance policies was to choose a policy trigger that would operate later in the tort liability sequence. How much better, the argument ran, if a claim made against an insured in 1985 based upon a latent injury that "occurred" in 1945 could have been treated as triggering the 1985 policy rather than the 1945 policy; with the benefit of forty additional years of experience to reflect the correlated changes in inflation, loss frequency, legal doctrine, medical

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15. *See generally* John P. Arness & Randall D. Eliason, *Insurance Coverage for "Property Damage" in Asbestos and Other Toxic Tort Cases*, 72 VA. L. REV. 943 (1986); Stephen V. Gimigliano, Note, *The Calculus of Insurer Liability in Asbestos–Related Disease Litigation: Manifestation + Injurious Exposure = Continuous Trigger*, 23 B.C. L. REV. 1141 (1982). For more recent surveys of the field after attention moved from asbestos–related claims to other progressive injury and progressive damage claims, see Kenneth S. Abraham, *Environmental Liability and the Limits of Insurance*, 88 COLUM. L. REV. 942 (1988); Tung Yin, *Nailing Jello to a Wall: A Uniform Approach for Adjudicating Insurance Coverage Disputes in Products Liability Cases with Delayed Manifestation Injuries and Damages*, 83 CAL. L. REV. 1243 (1985).

16. *See generally* David Cummins, *Statistical and Financial Models of Insurance Pricing and the Insurance Firm*, 58 J. RISK & INS. 261 (1991).

17. *See, e.g.*, Boyce Thompson Inst. for Plant Research v. Insurance Co. of N. Am., 751 F. Supp. 1137 (S.D.N.Y. 1990) (in 1988, insurer tendered defense of claims based on activities that occurred between 1924 and 1969).

technology, and jury attitudes over that period, the best pricing guesses for 1985 must necessarily be superior to the best pricing guesses for 1945. Though it was too late to rewrite history to replace occurrence coverage with claims–made coverage for already triggered policies, a change to claims–made formats for future years would assure that future tails would not be so long, and that the uncertainties to which insurers would be exposed by future policies would not be so great.

Thus, claims–made formats could seem to offer a way for liability insurers to avoid at least some of the problems that have so occupied their recent pasts. If the policy trigger no longer must be the injury, but instead could be the claim, many of the nasty lawyer problems involved in determining when an occurrence occurred disappear, and the guesswork involved in determining a price for future liability coverage can be made less daunting. There is little reason to try to change my family auto and homeowners policies to a claims–made format, for the claim by my unhappy neighbors is likely to follow closely behind the sound of an unambiguous crash. But for other settings, where the potentials for multiple or progressive injuries and for long tails seem more threatening, making the policy trigger a claim against the insured could promise insurers an attractive way to avoid some of the problems posed by occurrence triggers.

However, for insureds, the move from an occurrence trigger to a claims–made trigger could prove much less attractive, for two principal reasons. First, claims–made triggers themselves present real lawyer problems. But, unlike the uncertainties of application associated with the "occurrence" trigger, where much of the litigation involved which among several insurers' policies should be deemed to have been triggered,[18] the burden of uncertainties associated with determining when a claims–made policy has been triggered fall most heavily on insureds. And second, the uncertainties the insurer avoids by pushing the trigger deeper into the tort claim sequence do not go away; they are shifted to insureds, and claims–made policies are structured in such a way that the insurer may be empowered to make those risks fall on an individual insured, rather than on the entire pool of insureds. These two ways in which claims–made policies can result in coverage gaps for insureds are at the core of the claims–made problems addressed in this article.

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18. *See generally* Kenneth S. Abraham, *Allocation of Settlements in Multi–Insurer Coverage Disputes,* 48 FED. INS. & CORP. COUNSEL Q. 427 (1998); Michael G. Doherty, *Allocating Progressive Injury Liability Among Successive Insurance Policies*, 64 U. CHI. L. REV. 257 (1997).

B. Beyond "Pure" Occurrence and "Pure" Claims–Made Policy Triggers

In the conventional telling, then, liability insurance comes in two flavors: occurrence, and claims–made. As explained by Gerald and Sol Kroll, the most influential of the early prophets of claims–made formats:

> At present two types of insurance policies are offered in the professional liability field: the "claims made" (or "discovery") policy and the "occurrence" policy. A "claims made" policy is one whereby the carrier agrees to assume liability for any errors, including those made prior to the inception of the policy, as long as a claim is made within the policy period. On the other hand, an "occurrence" policy provides coverage for any acts or omissions that arise during the policy period, regardless of when claims are made.[19]

Thus:

> The major distinction between the "occurrence" policy and the "claims made" policy constitutes the difference between the peril insured. In the "occurrence' policy, the peril insured is the "occurrence" itself. Once the "occurrence" takes place, coverage attaches even though the claim may not be made for some time thereafter. While in the "claims made" policy, it is the making of the claim which is the event and peril being insured and, subject to policy language, regardless of when the occurrence took place.[20]

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19. Gerald Kroll, *The "Claims–Made" Dilemma in Professional Liability Insurance,* 22 UCLA L. REV. 925, 925–26 (1975) (footnote omitted). Numerous courts and commentators have relied on Kroll's simple dichotomy in explaining "claims–made" policy formats, even where the characterization does not fit the policy format in question. *See, e.g.*, Hasbrouck v. St. Paul Fire & Marine Ins. Co., 511 N.W.2d 364, 366 (Iowa 1993). The two–kingdoms vision of the liability insurance world also holds sway from the other side of the divide. *See, e.g.,* Montrose Chem. Corp. v. Admiral Ins. Co., 913 P.2d 878, 904 (Cal. 1995) (to adopt "manifestation" interpretation of occurrence trigger would be same as "transforming the broader and more expensive occurrence–based CGL policy into a claims made policy").

20. Sol Kroll, *The Professional Liability Policy "Claims Made,"* 13 FORUM 842, 843 (1978). For many courts this passage has become the short–hand description of

As described by the Krolls and most commentators, nothing could be simpler.[21] The reality is much more complex. If we decompose liability insurance stories into their constituent elements, beginning with the act or omission by the insured and running all the way through to the final payment by the insurer, we will generate a list likely to include at least the following potential stages in the evolution of liability insurance claims:

Exhibit 1: Potential Stages in the Evolution of Liability Insurance Claims

allegedly tortious act or omission by insured
exposure of potential victims
injury in fact
manifestation of victim's injury
insured should have discovered circumstances that may give rise to a claim
insured discovers circumstances that may give rise to a claim
insured discovers specific acts or omissions that may give rise to a claim
insured reports to insurer circumstances that may give rise to a claim insured
reports to insurer specific acts or omissions that may give rise to a claim
claim for compensation by victim against insured
insured reports claim to insurer
victim files suit against insured
investigation by insurer
defense and reserving decisions by insurer
negotiations between insurer and victim
judgment or settlement
payment to victim

the difference between occurrence and claims–made policies. *See, e.g.,* American Cas. Co. v. Continisio, 17 F.3d 62, 68 (3d Cir. 1994); Truck Ins. Exch. v. Ashland Oil, Inc., 951 F.2d 787, 790 (7th Cir. 1992); Insurance Corp. of America v. Dillon, Hardamon & Cohen, 725 F. Supp. 1461, 1469 (N.D. Ind. 1988); Sherlock v. Perry, 605 F. Supp. 1001, 1004 (E.D. Mich. 1985). *See also* Sol Kroll, *"Claims Made" — Industry's Alternative: "Pay As You Go" Products Liability Insurance,* 1976 INS. L.J. 63.

21. *See, e.g.*, JEAN LUCEY, INSURING AND MANAGING THE PROFESSIONAL RISK 32 (1993) ("How encouraging it is to find terms which accurately express intent and meaning: in this case, claims–made policies provide coverage for *claims which are made* during the policy period."); 1 ALLAN D. WINDT, INSURANCE CLAIMS & DISPUTES § 1.07, at 29 (3d ed. 1995) (discussing "the standard claims–made policy"); Fischer, *supra* note 11, at 636 ("Under an occurrence policy, the insured risk covered bodily injury or covered property damage *happening* within the policy period. Under a claims–made policy, the insured risk was a covered claim *being asserted* against the policyholder during the policy period.").

The exercise of exploding liability insurance stories into their constituent parts can serve to remind us of a number of things that will help us to understand the structure and operation of claims–made formats. First, and perhaps most obviously, there is the question of pace: sometimes, as in my daughter's simple auto accident, the entire sequence will play out in a few days; sometimes, as with some insidious disease, products liability, and professional malpractice exposures, the sequence—or even portions of it—can extend over many decades. Second, there is the question of order: though we can imagine liability insurance stories that follow the sequence outlined in Exhibit 1, we also can imagine stories that do not. Discovery by the insured of circumstances that may give rise to a claim, for example, may occur at various places in the sequence, and may not happen at all; if it occurs before a policy has been triggered, the insured may or may not report that information to the insurer. Third, there is the question of when to cut off the sequence: though insurers' rhetoric tends to focus on their desire to avoid uncertainties associated with liabilities that have been incurred but not reported by the end of the policy period (the "IBNR" tail), and academic models often assume that all claims are paid at the end of the policy year, in fact tail problems do not end with tender of the defense to the insurer; even after a claim has been reported to the insurer, the claims–adjustment process still may involve many continuing sources of uncertainty concerning the ultimate impact of the claim on the insurer's treasury.[22]

But the most salient consequence of decomposing liability insurance stories into constituent parts is that it forces recognition that "occurrence" and "claims–made" are not the only possible policy triggers, and that neither is free from troublesome questions of application. The fierce battles over the last two decades about how to apply "occurrence" triggers have resulted in

22. *See generally* ROBERT J. PRAHL ET AL., LIABILITY CLAIM CONCEPTS AND PRACTICES 458–75 (1985) (emphasizing difference between "settlement value" of claim at time of initial report and "ultimate probable cost"); RUTH E. SALZMANN, ESTIMATED LIABILITIES FOR LOSSES & LOSS ADJUSTMENT EXPENSES (1984) (emphasizing role of judgment in making and revising reserving decisions). *See also* INSURANCE SERVICES OFFICE, CLOSED CLAIM SURVEY FOR COMMERCIAL GENERAL LIABILITY: SURVEY RESULTS 4–5 (1991) (for "large claims of $75,000 or more that drive the costs of the liability insurance system," average elapsed time between date of report and date of final judgment or settlement more than three times averaged elapsed time from date of accident to date of report); FRANK A. SLOAN ET AL., INSURING MEDICAL MALPRACTICE 125 (1991) (only 21.1% of medical malpractice claims made and reported during policy year had been paid by end of three additional years; only 77.5% by end of six years).

decisions that locate the occurrence trigger at several different, sometimes overlapping, points on the continuum: some courts have been willing to say that "exposure to harm" satisfies an occurrence trigger; some say there has been no occurrence until manifestation; still others recognize a continuous trigger.[23]

The concept of a "claims–made" trigger also proves slippery, even about such fundamental questions as whether we mean a "claim made by the victim against the insured," or a "claim made by the insured against the insurer."[24] And what does our exploded sequence tell us about the now–nearly–standard characterization of "claims–made" policies as "discovery" policies,[25] and about the judicial refrain that "claims–made or discovery policies are essentially reporting policies?"[26] Claims made by whom against whom?

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23. *See generally* 1 EUGENE R. ANDERSON ET AL., INSURANCE COVERAGE LITIGATION §§ 4.1 – 4.24 (1997); 2 WINDT, *supra* note 21, §§ 11.04 – 11.05; Fischer, *supra* note 11, at 629 n.10 (collecting citations).

24. *See infra* notes 28–36 and accompanying text.

25. *See, e.g.*, Jones v. Continental Cas. Co., 303 A.2d 91, 93 (N.J. 1973) (quoting Zarpas v. Morrow, 215 F. Supp. 887, 888 (D.N.J. 1963)):

> The type of policy in question has been termed a discovery policy. . . . "In a 'discovery' policy the coverage is effective if the negligent or omitted act is discovered and brought to the attention of the insurance company during the period of the policy, no matter when the act occurred. In an occurrence policy, the coverage is effective if the negligent or omitted act occurred during the period of the policy, whatever the date of discovery."

The second sentence made it into *Appleman,* from whence it metastasized. *See, e.g.*, Merrill & Seeley, Inc. v. Admiral Ins. Co., 275 Cal. Rptr. 280, 282 (1990) ("By way of background, we note that the two common types of insurance policies offered in the professional liability field are the 'claims made' (or discovery) policy and the 'occurrence' policy"); James J. Brogger & Assocs., Inc. v. American Motorists Ins. Co., 595 P.2d 1063, 1064 (Colo. App. 1979) ("The policy is generally described as a 'discovery' or 'claims made' insurance agreement. *See 7 J. Appleman, Insurance Law & Practice* § 4262 (Cum. Supp. 1972)").

26. *See, e.g.,* Thoracic Cardiovascular Assocs., Ltd. v. St. Paul Fire & Marine Ins. Co., 891 P.2d 916, 920 (Ariz. 1994):

> The "claims made" policy differs from an "occurrence" policy in several important aspects. Because it triggers coverage, transmittal of the notice of the claim to the insurer is the most important aspect

Discovery of what by whom? Reports of what by whom to whom? We can imagine pure reporting policies in which the policy trigger would be a report, to the insurer, of *something*, by *someone*: it could be a report of a claim by the injured person against the insured, or a report of an injury, or a report of an act or omission that creates a risk of injury. And, of course, given the insurer's concerns about lags between the time the policy is priced and the time the insurer's liability is finally determined, we could imagine moving the trigger still deeper into the sequence: much of what we think of as "health" insurance is really "medical expense" insurance in which coverage is not triggered, no matter how long–standing the exposure or injury or disease and no matter how much the insurer knows about those things, until actual medical expense is incurred.

So, the possible triggers are many. What do insurers actually use as triggers in "claims–made" forms? A lawyer looking only in reported opinions will encounter at least those identified in Exhibit 2.[27]

> of the claims made policy. A claims made policy extends coverage if "the negligent or omitted act is discovered and brought to the attention of the insurer within the policy term." *Id.* (quoting 7A John Alan Appleman, Insurance Law and Practice § 4504.01, at 312 (Berdal ed. 1979)). "The timing of the making of the claim in such policies stands in equal importance with the error or omission as the insured event." [citation omitted] Notice to the insurer of a claim made against the insured is generally required to be given during the policy period or within a specified amount of time after the policy period. "The essence, then, of a claims–made policy is notice to the carrier within the policy period."

27. The events designated with a "?" — exposure and manifestation—are not, so far as I know, explicitly identified as triggers in any claims–made formats; however, following the practice for "occurrence" triggers, both exposure and manifestation might be adopted as the standard for when the injury in fact occurs.

The event designated with a "!" —payment to the victim—is not, so far as I know, a trigger in any reported decision, but the appearance of "claims–paid" medical malpractice policies has been chronicled in Ilene Davidson Johnson, *Occurrence vs Claims–Made Medical Professional Liability Insurance Policies: Fundamental Differences in the Concept of Coverage*, 266 JAMA 1570, 1571 (1991). For a discussion of some of the implications of such a trigger, see *infra* notes 313–15 and accompanying text.

Exhibit 2: Triggers Employed in Claims–Made Liability Formats

allegedly tortious act or omission by insured	**T**
exposure of potential victims	**?**
injury in fact	**T**
manifestation of victim's injury	**?**
insured should have discovered circumstances that may give rise to a claim	**T**
insured discovers circumstances that may give rise to a claim	**T**
insured discovers specific acts or omissions that may give rise to a claim	**T**
insured reports to insurer circumstances that may give rise to a claim insured	**T**
reports to insurer specific acts or omissions that may give rise to a claim	**T**
claim for compensation by victim against insured	**T**
insured reports claim to insurer	**T**
victim files suit against insured	
investigation by insurer	
defense and reserving decisions by insurer	
negotiations between insurer and victim	
judgment and settlement	
payment to victim	**!**

Why do we find such triggers lurking beneath face–page warnings that the policy is a "claims–made" policy and that "the coverage of this policy is limited generally to liability for only those claims that are first made against the insured while the policy is in force?"[28] Sometimes policy definitions attempt at least a rhetorical reconciliation: thus, for example, one prominent medical malpractice insurer begins by requiring that "[t]he claim must . . . first be made while this agreement is in effect," but then creates a reporting trigger by declaring: "A claim is made on the date you first report an incident

28. The quoted warning is drawn from the notice required by CAL. INS. CODE § 11580.01(c) (West 1988) (applicable to a professional liability policy "which generally limits the coverage thereof to liability for only those claims that are first made while the policy is in force"):

> Each such policy . . . shall contain on the face page thereof a prominent and conspicuous legend or statement substantially to the following effect:
>
> NOTICE
>
> "Except to such extent as may otherwise be provided herein, the coverage of this policy is limited generally to liability for only those claims that are first made against the insured while the policy is in force. Please review the policy carefully and discuss the coverage thereunder with your agent or broker."

or injury to us or our agent."[29] However, most of the variety of policy triggers in nominally claims–made policies are not the product of such semantic legerdemain; we will find no occurrence policies sailing under

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29. For example, a medical malpractice policy employed by St. Paul Fire & Marine Insurance Company uses the following language:

> When you are covered.
>
> To be covered the professional service must have been performed (or should have been performed) after your retroactive date that applies. The claim must also first be made while this agreement is in effect.
>
> When is a claim made?
>
> A claim is made on the date you first report an incident or injury to us or our agent. You must include the following information:
>
> *Date, time and place of the incident.
> *What happened and what professional services you performed.
> *Type of claim you anticipate.
> *Name and address of injured party.
> *Name and address of any witness.

For a telling criticism of the two different ways in which "claim" is employed in this policy, see *Thoracic Cardiovascular Assoc., Ltd. v. St. Paul Fire & Marine Ins. Co.*, 891 P.2d 916, 924–25 (Ariz. 1994) (dissenting opinion). *Compare* Skandia America Reinsurance Corp. v. St. Paul Fire & Marine Ins. Co., 951 F.2d 362 (9th Cir. 1991) (policy not ambiguous; "claim" means claim against insurer) *with* St. Paul Fire & Marine Ins. Co. v. House, 554 A.2d 404 (Md. 1989) (policy ambiguous as to whether trigger is claim made against insured or claim made to insurer). *See also* Driskill v. El Jamie Marine, Inc., 1988 WL 93606, at *1 (E.D. La. 1988) (policy specifying trigger as a claim made against an insured but defining a claim as having been made "when notice of such claim is received and recorded by any insured or by [the insurer], whichever comes first"). For what is arguably another way to create a pure reporting trigger, see Helfand v. National Union Fire Ins. Co., 10 Cal. App. 4th 869, 886 (Cal. App. 1992) (insurer promises to pay for loss arising from claims first made against the insured during the policy period, but then says that "[t]he time when a loss shall be incurred within the meaning of this policy shall be the date on which . . . Insureds shall give written notice to the Insurer as hereafter provided").

"claims–made" flags.[30] Rather, the reason nominally claims–made policies employ such a variety of policy triggers is that many of what we call "claims–made" policies in fact employ "multiple–event triggers" —triggers requiring that two or more events must happen within a particular policy period—or "alternative–event triggers" —triggers identifying two or more events some of which must happen within a particular policy period.

Thus, as we shall see, many "claims–made" forms in fact are multiple–event–trigger "claims–made–and–reported" or "potential–claim–discovered–and–reported" policies that require that at least two things must happen during a particular policy period in order to trigger the policy: with a "claims–made–and–reported" format, the injured party must assert a claim against the insured during the policy period, and the insured must report that claim to the insurer during the policy period;[31] with a "potential–claims–discovered–and–reported" format, the insured must both discover circumstances that might ripen into a claim during the policy period and report that discovery to the insurer during the policy period.[32] Moreover, many nominally "claims–

30. Sometimes hybrids may appear. Thus, CGL policies written on an occurrence basis may nonetheless have claims–made riders for certain exposures. Nominally claims–made formats that include a "circumstances–discovered–and–reported" trigger, or that include some form of extended reporting period, sometimes will operate by virtue of such provisions much as would an "occurrence" policy. And, of course, insurers and insureds continue to experiment with other triggering mechanisms. *See, e.g.,* Kate Tilley, *Australian Liability Form Has Different Trigger,* BUS. INS., Oct. 24, 1994, p. 37 (reporting growing use of "claims–occurring" coverage in Australia and some European markets).

31. For example, a lawyers' professional liability policy issued by Home Insurance Company contains the following insuring clause:

> To pay on behalf of the Insured all sums in excess of the deductible amount . . . which the insured shall become legally obligated to pay as damages as a result of CLAIMS FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD AND REPORTED TO THE COMPANY DURING THE POLICY PERIOD caused by any act, error or omission for which the insured is legally responsible, and arising out of the rendering or failure to render professional services for others in the insured's capacity as a lawyer or notary public.

32. "Potential–claim–discovered–and–reported" provisions, often misleadingly called "discovery" or "awareness" provisions, or more–usefully "notice of potential claim," "claim substitute," "claims–after–termination" or "occurrence first reported"

made" policies also include a "retroactive date" after which the injury to the victim or the negligent act or omission must have happened;[33] some more liberal "retro date" provisions provide "prior acts" coverage for negligence or injuries prior to the retro date if the insured neither knew nor should have

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provisions, permit an insured to lock in coverage before a claim has been made by reporting to the insurer circumstances that may ripen into a claim. Often the reporting requirements are quite detailed, demanding identification of specific acts or omissions or specific injuries that have been or may be suffered by potential claimants; in some policy formats, however, a more general notice is all that is required. The differences and their implications have been explored in a series of decisions arising out of efforts by the FDIC and FSLIC as receivers of failed financial institutions to recover on director's and officer's liability policies issued to the failed institutions. *Compare, e.g.*, FDIC v. Caplan, 838 F. Supp. 1125 (W.D. La. 1993) (report insufficient because if failed to identify specific wrongful acts and specific directors and officers); FDIC v. St. Paul Fire & Marine Ins. Co., 783 F. Supp. 1176 (D. Minn. 1991) (detailed information about potential claims in renewal application did not satisfy potential claim reporting provision); RTC v. Artley, 24 F.3d 1363 (11th Cir. 1994) (forwarding to insurer detailed information of improper lending practices did not satisfy potential claim reporting provision) *with* RTC v. American Cas. Co., 874 F. Supp. 961 (E.D. Mo. 1995) (general identification of potential claimant and circumstances enough to satisfy potential claim reported provision that did not require specificity); FSLIC v. Heidrick, 774 F. Supp. 352 (D. Md. 1991) (same). For treatment of the considerations that should go into deciding whether to take advantage of such a provision, see IRMI, PROFESSSIONAL LIABILITY INSURANCE, *supra* note 2, at VIII.C.9 – VII.C.12 (detailing "Advantageous Uses" and "Catch–22 Aspects" of use of such provisions); Laird Campbell, *The Claims Made Policy — A Trap for the Unwary Lawyer,* 18 COLO. LAW. 1121 (1989); Robert Knowles, *The Reporting of "Potential Claims" under a Claims–Made Policy,* FOR THE DEFENSE, July, 1993, p. 23.

33. The standard explanation for retro dates is that they are a necessary protection against adverse selection; without them, a prospective insured could wait until a claim is imminent before first buying claims–made coverage. *See, e.g.,* LUCEY, *supra* note 21, at 34. The literature of adverse selection is vast. Three classics are George A. Akerlof, *The Market for "Lemons": Quality Uncertainty and the Market Mechanism*, 84 Q. J. ECON. 488 (1970); Georges Dionne & Neil Doherty, *Adverse Selection in Insurance Markets: A Selective Survey*, in CONTRIBUTIONS TO INSURANCE ECONOMICS (G. Dionne, ed., 1992); Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: The Economics of Markets with Imperfect Information*, 90 Q. J. ECON. 629 (1976). More nuanced explanations recognize that retro dates can be used as a blunt alternative to laser exclusions for avoiding known risks, and to avoid problems associated with adjusting "stale" claims. *See* IRMI, PROFESSSIONAL LIABILITY INSURANCE, *supra* note 2, at VIII.C.3; IRMI, COMMERCIAL LIABILITY INSURANCE *supra* note 2, at II.C.5.

known of those circumstances at the time of the retro date.[34] And, as we shall see, some "claims–made" and "claims–made–and–reported" policies include an alternative "discovery" trigger that allows the insured to trigger coverage by reporting circumstances that might give rise to a claim to the insurer during the policy period during which the circumstances were first discovered, even though the victim's claim against the insured may not come until well after the end of the policy period.[35] Finally, claims–made formats

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34. For example:

> PROVIDED ALWAYS THAT such act, error or omission happens:
>
> a) during the policy period; or,
>
> b) prior to the policy period, provided that prior to the [start of continuous coverage from this insurer]:
>
> 1) The insured did not give notice to any prior insurer of any such act or error, and
>
> 2) The [insureds] had no reasonable basis to believe that the insured had breached a professional duty or to foresee that a claim would be made against the insured; and
>
> 3) There is no prior policy or policies which provide insurance for such liability or claim, unless the applicable limits of such prior policy or policies are insufficient to pay any liability or claim, in which event this policy will be excess over any such prior coverage . . . .

The retro date provision quoted above is relatively liberal, for it at least holds out the possibility of "nose" coverage for acts prior to the period covered by the current insurer; some claims made policies establish an absolute retroactive date at the beginning of the insuring relation, or even at the beginning of the particular coverage period.

35. For example:

> If, during the policy [or any tail coverage] . . . the insured first becomes aware that an insured has committed a specific act, error or omission in professional services for which coverage is otherwise provided hereunder, and if the insured shall during the [policy period or tail period] . . . give notice to the Company of:
>
> a) the specific act, error or omission; and
>
> b) the injury or damage which has or may result from such act, error or omission; and

often provide or permit the purchase of "extended reporting" coverage that applies the last policy period's coverage limits to the tail of claims made, or reported, or both, after the end of the policy period.[36]

C. The Trouble(s) with Claims–Made Formats

We may now feel ready for our first explorations into deepest claims–made land. There we encounter an insured who has purchased identical calendar–year claims–made professional liability policies continuously from the same insurer during the years 1985 to 1995. In 1994 a client for the first time makes a malpractice claim against him. Which, if any, of his ten policies has been triggered?

> c) the circumstances by which the insured first becomes aware of such act, error or omission then any claim that may subsequently be made against the insured arising out of such act or omission shall be deemed for the purpose of this insurance to have been made within [the coverage period].

36. Some "claims–made" policies contain "extended reporting" or "tail" coverage provisions that guarantee a right to purchase (for an additional premium) a limited extension of the coverage for future claims arising out of acts or omissions committed prior to the termination of the coverage. In effect, "tail" coverage is "occurrence" coverage for occurrences within the policy period producing claims within the specified extended reporting period. Such tail coverage may be "one way" —i.e, available for a price if the insurer cancels or nonrenews, but not if the insured terminates the relationship with the insurer—or, more infrequently, "two–way" —i.e., available for a price even if the insured terminates the relationship; the practice apparently varies with the kind of professional liability being insured. *See* IRMI, PROFESSSIONAL LIABILITY INSURANCE, *supra* note 2, at VIII.D.6. The same professional liability policy may carry two tail options, one for terminations of coverage while professional activities continue, another to provide coverage for a "non–practicing tail." Some forms provide an automatic extension of the reporting date; thus, a nominally "claims–made–and–reported" policy for calendar 1996 might in fact require that for the policy to be triggered the claim be made during calendar 1996 but permit the report to the insurer of the claim to be made during calendar 1996 or in the first sixty days of 1997. *See generally id.* at VIII.C.8.

Two factors may limit the value of tail coverage: 1) the premiums for the optional tail coverage may be left to negotiation at the time the tail coverage is purchased, or fixed for only the first few years of the tail coverage; 2) usually tail coverage only extends the last policy period's policy limits over the last policy period and the tail period, so that claims made in the last policy year may deplete the limits available during the tail period.

Presented in this fashion, the process for determining the answer may appear easy. We simply determine what each policy identifies as the trigger or triggers for coverage, and then determine whether the trigger or triggers were satisfied. If the policy employs a "pure" claims–made trigger like that summarized in Exhibit 3, the only thing that matters is the timing of the first claim. If that happened in 1994, the 1994 policy has been triggered.

Exhibit 3: Pure Claims–Made Trigger

A policy is triggered if, during the policy period, the victim first makes a claim against the insured

If the policy employs a pure "reporting" claims–made trigger like that summarized in Exhibit 4, the only thing that matters is when the insured reported a claim to the insurer. Equally simple. If the policy employs a "pure" claims–made trigger with a retro date like that summarized in Exhibit 5, we must determine not only whether the claim was first made during the policy period, but also whether the allegedly negligent act or omission that prompted the claim (or, in some policies, the injury to the victim) occurred after the retro date. In our case, if the retro date established in the 1994 policy (the policy covering the year in which the claim was first made) is a date prior to the insured's alleged negligence (or, where relevant, the injury), then the 1994 policy has been triggered; if the insured's negligence occurred prior to that retro date, then the 1994 policy has not been triggered.

Exhibit 4: Pure Reporting Trigger

A policy is triggered if, during the policy period, the insured first reports to the insurer that a victim has made a claim agaisnt the insured.

Exhibit 5: Claims–Made Trigger with Retro Date

A policy is triggered if: **1) the [allegedly tortious act, error or omission] [injury to the victim] took place after the applicable retro date; and** **2) during the policy period, the victim first made a claim against the insured.**

If the policy employs a "reported potential claim" trigger with a retro date like that summarized in Exhibit 6, then the timing of the claim by the victim against the insured is irrelevant; the policy will only be triggered if the insured reports to the insurer during the policy year that the insured has discovered circumstances that may ripen into a claim, and if the retro date is satisfied.

Exhibit 6: Potential–Claim–Reported Trigger with Retro Date

A policy is triggered if:
1) the [allegedly tortious act, error or omission] [injury to the victim] took place after the applicable retro date; and
2) during the policy year, the insured reported to the insurer [a specific wrongful act] [circumstances] that might give rise to a claim.

If the insured's policy employs a multiple–event "claims–made–and–reported" trigger with a retro date, like that summarized in Exhibit 7, then our inquiry becomes three-pronged. To trigger such a policy, the alleged negligence must have occurred after the applicable retro date, and both the first claim by the victim against the insured and the report of the claim by the insured to the insurer must have occurred during the policy period.

Exhibit 7: Claims–Made–and–Reported

A policy is triggered if:
1) the [allegedly tortious act, error or omission] [injury to the victim] took place after the applicable retro date; and
2) during the policy period,
a) the victim made a claim against the insured; and
b) the insured reported the claim to the insurer.

If the insured's policy employs the combination of dual and alternative triggers summarized in Exhibit 8, we in effect go through the process twice. Did the alleged negligence occur after the retro date and did the insured give notice to the insurer of circumstances that might give rise to a claim in the policy period in which the insured first became aware of those circumstances? If so, then the policy in effect at the time of the notice has been triggered. If no policy was triggered by that method, then we investigate the second possibility. Did the alleged negligence occur after the retro date and during a single policy period did the victim make a claim against the insured and the insured report the claim to the insurer? If so, then the policy in effect at the time the claim was made and reported has been triggered. Detailed perhaps, but still simple enough.

But what is it about this exercise that makes it so (tediously) simple? The answer is that we have assumed away all the juicy questions. We assumed that we knew the policy triggers, and we assumed that we knew the facts necessary to apply those policy triggers. In the claims–made thicket, things are not so simple. Might not an insured professional who each year tucks her prominently–labeled "claims – made" renewal policy into her safety deposit box feel aggrieved to learn that her insurer denies any obligation to defend or indemnify her because she really has a "claims–made–and–reported" policy, and the claim made against her on Friday fell in one policy year and her report the following Monday fell in a second policy year? And might not an insured who knows exactly what his claims–made–and–reported policy says and who conscientiously reports a suit against him on the same day he is served feel aggrieved to learn that the multiple–event "claims–made–and–reported" trigger was not satisfied because a billing dispute or a regulatory inquiry in an earlier year is deemed a "claim" that was first made then but went unreported until the victim's suit against the insured prompted action? They might indeed, and yearn for a world of simple hypotheticals where triggers are unequivocal and well understood, and events necessary to satisfy those triggers come with labels neatly attached. And then they might consult their lawyers.

Exhibit 8: Claims–Made–and–Reported/ Potential–Claim–Discovered–and–Reported Triggers with Retro Date

A policy is triggered if:

1) the [allegedly tortious act, error or omission] [injury to the victim] occurred after the applicable retro date; and

2) during the policy period, EITHER

A) the victim made a claim against the insured; and the insured reported the claim to the insurer; OR

B) the insured first discovered [a specific wrongful act] [circumstances] that might give rise to a claim; and the insured notified the insurer of [a specific wrongful act] [circumstances] that might give rise to a claim.

The exercise is artificially simple for another reason as well. It evinces no interest in when the insured first became aware that she might have committed an act or omission that could give rise to a claim. But insurers are interested, and claims–made policies and marketing practices are designed to assure that, when the insured knows or should know of circumstances that may give rise to a claim, the insurer soon will have that information too.

Sometimes, of course, pre–trigger knowledge by the insured is not an issue. Sometimes the first inkling an insured has that something has gone wrong comes when a claim is filed against her. But often the insured will receive warning signals that she may have committed an act or omission that could give rise to a claim in the future, and if she does, "notice"[37] provisions in the policy and renewal application questions are supposed to assure that the insurer soon will have access to that information as well. Where does that leave the insured? Identified to the insurer as especially likely to have a claim in the future, thus inviting the insurer to advance the retro date, or to use a laser exclusion to carve the identified source of potential liability out of policy coverage, or to raise the price of future coverage, or even to refuse to renew coverage for the future. For insurers, these devices are only common–place manifestations of their desire to avoid adverse selection when making underwriting decisions. For insureds, however, the conjunction of annual renewal underwriting with policy triggers that operate late in the tort insurance claim sequence means that the insured may be subjected to serious problems of "classification risk." Might not claims–made insureds feel aggrieved to learn that a change from an occurrence to a claims–made trigger means not only that insureds rather than insurers will bear the risk of increased costs due to correlated changes during the IBNR period, but also that insurers have been empowered to shift to individual insureds the burden of bearing the liability costs that become both inevitable and known during a coverage period but before any policy has been triggered? They might indeed. And then they might consult their lawyers.

D. Lawyering in a Claims–Made World

And what will their lawyers tell them? The news will not be good. Consider, for example, the lessons to be learned from the battle between Dolan, Fertig & Curtis, a Florida law firm, and its claims–made insurers. The Dolan firm purchased a claims–made errors and omissions policy from Gulf Insurance Company for the period from November 20, 1978 to November 20, 1979. In fact, the policy was a triple–event–trigger claims–made–and–

37. In some policies, the insured is only required to give prompt notice of a claim, a requirement that adds little to the "reporting" requirement of the insuring clause. But in some policies, the insurer's liability is conditioned on notice if the insured becomes aware of an act or omission that might reasonably be expected to ripen into a claim covered by the policy, even if there is as yet no claim to report, and even if there is no "discovery" clause to make the notice operate as a trigger of coverage.

reported policy with a retro date of November 20, 1978; thus, by its terms, the Gulf policy would be triggered only if 1) a claim was made against the law firm in the 1978–79 policy year, 2) the claim was reported to insurer during the 1978–79 policy year, and 3) the claim was based upon professional activities during the 1978–79 policy year. Toward the end of the policy year the Dolan firm contracted with a second insurer, Lawyers Professional Liability Insurance Company (LPLIC), to provide liability coverage for the period from November 20, 1979 to November 20, 1980. The LPLIC policy was a claims–made–and–reported policy with a retro date of November 20, 1977, but it expressly excepted from coverage

> any claim arising out of acts or omissions occurring prior to the effective date of this policy if the insured at the effective date knew or could have reasonably foreseen that such acts or omissions might be expected to be the basis of a claim or suit.

Thus, by its terms the LPLIC policy would be triggered only if 1) a claim was made against the law firm in the 1979–80 policy year, 2) the claim was reported to the insurer during the 1979–80 policy year, and 3) the claim was based upon professional activities after November 20, 1977, and the insured on November 20, 1979, was not chargeable with knowledge of a potential claim based on such professional activities.

On November 19, 1979, the final day of the Gulf policy period, the law firm received a letter from a client claiming that the law firm had been negligent in the provision of legal services during the period after the policies' retro dates. The law firm reported the claim to LPLIC on December 6, 1979; after being informed by LPLIC that two of the three triggers for LPLIC coverage had not been satisfied, the law firm on February 12, 1980, reported the claim to Gulf. Gulf too denied coverage; although two of its three triggers had been satisfied, the third—report of claim within the policy period—had not. By early 1988 the Florida courts had confirmed the obvious. In the straight–forward world of the conventional insurance law syllogism, all of a policy's conditions must be fully satisfied if an insurer is to have a duty to perform, the reporting condition in the Gulf policy and the retro date and claim conditions in the LPLIC policy were not satisfied, and therefore neither insurer had a duty to perform.[38]

38. Gulf Ins. Co. v. Dolan, Fertig & Curtis, 433 So. 2d 512 (Fla. 1983); Lawyers Prof. Liab. Ins. Co. v. Dolan, Fertig & Curtis, 524 So. 2d 677 (Fla. App. 1988).

Exhibit 9: *Dolan* Case: Claims–Made–and–Reported Policies with Retro Dates; Different Insurers

1978–79 Gulf Ins. Co.	1979–80 LPLIC
CONDITIONS: **1) Neg after 11/20/78** **2) Claim in 78–79** **3) Report in 78–79**	**CONDITIONS:** **1) Neg after 11/20/78** **2) Claim in 79–80** **3) Report to LIPIC in 79–80**
FACTS: **Neg in 78–79; Claim in 78–79; Reports in 79–80**	

For a lawyer in search of a way to escape the simple force of these catechetical understandings, the choices may seem dauntingly few. Absent facts sufficient to support equitable doctrines of waiver, estoppel, or reformation,[39] rummaging through the standard–issue lawyers' kitbag of neo–classical insurance law is likely to produce little more than what is often a litany of last resorts: Is the policy ambiguous so that it can be construed against the insurer? Does it violate the objective reasonable expectations of the insured? Is there something about it that makes it contrary to public policy? Usually, of course, the answers are "no," "no," and "no."

Still, in the early days of claims–made formats, a few lawyers did manage to guide their insureds along these routes. Thus, for example, in *Gyler v. Mission Insurance Company*, careless drafting that obligated a professional liability insurer to respond to "claims for breach of professional duty as Lawyers which may be made" during the policy period provided an opening for a court to declare itself uncertain as to "whether coverage is limited to claims asserted during the policy period or extends to claims maturing during the policy period but not asserted until later," and so to invoke *contra proferentem* rules of construction to assure that what the insurer thought was a claims–made–and–reported form would operate in that instance as an occurrence form.[40] And, at a time when claims–made formats could seem

39. *See, e.g.*, Cornell, Howland, Hayes & Merryfield, Inc. v. Continental Cas. Co., 465 F.2d 22 (9th Cir. 1972) (second insurer precluded from invoking retro date provision against insured by express assurances that coverage would be provided for a known circumstance); Stein, Hinkle, Dawe & Assoc., Inc. v. Continental Cas. Co., 313 N.W.2d 299 (Mich. App. 1981) (agent's failure to recommend prior acts endorsement precludes insurer from denying coverage for prior acts).

40. Gyler v. Mission Ins. Co., 514 P.2d 1219 (Cal. 1973). *See also* Chamberlin v. Smith, 72 Cal. App. 3d 835 (1977) (construing same language as in *Gyler*); J.G. Link & Co. v. Continental Cas. Co., 470 F.2d 1133 (9th Cir. 1972), *cert. denied*, 414

as strange to some judges as to the insureds seeking to escape them, a few decisions concluded that particular claims–made formats were unconscionable or contrary to public policy or violations of reasonable expectations of insureds because they did not provide either the prospective coverage of a pure occurrence policy or the retrospective coverage of a pure claims–made policy.

Thus, in one briefly–famous decision, *Brown–Spalding & Assoc. v. International Surplus Lines Ins. Co.*,[41] a California Court of Appeals held a reporting requirement contrary to public policy and a violation of reasonable expectations of insureds:

> A claims made policy which requires the insurer to be notified during the policy period severely limits the scope of coverage so that the objectively reasonable expectations of the purchaser of professional liability coverage are not met. . . . [T]he reporting requirement effectively precludes coverage for claims made toward the end of the policy period which cannot reasonably be reported until after expiration.[42]

And in one much–criticized 1985 decision, *Sparks v. St. Paul Ins. Co.*,[43] the New Jersey Supreme Court rescued a claims–made–and–reported insured who had failed to report a claim within the policy period by giving canonical status to an idealized characterization of a "pure" claims–made trigger providing unlimited retrospective coverage, and then refusing to enforce the policy because the presence of a retro date meant that the policy failed to live up to that unlikely ideal.

U.S. 829 (1973) (ambiguous as to whether policy requiring both negligent act and report of negligence act within policy period provided claims–made or occurrence coverage). For a recent example along the margins, see St. Paul Fire & Marine Ins. Co v. MetPath Inc., No. 3–96–703, 1998 U.S. Dist. LEXIS 2264 (D. Minn. Jan. 26, 1998) (exclusion of known prior acts ambiguous as applied to acts prior to acquisition of company by insured).

41. 254 Cal. Rptr. 192 (Cal. Ct. App. 1988).

42. 254 Cal. Rptr. at 195. The opinion was later decertified by the California Supreme Court. *See infra* note 60.

43. 100 N.J. 325, 495 A.2d 406 (N.J. 1985).

> [T]he policy at issue here is substantially different from the standard "claims made" policy. Indeed, St. Paul's policy combines the worst features of "occurrence" and "claims made" policies and the best of neither. It provides neither the prospective coverage typical of an "occurrence" policy, nor the "retroactive" coverage typical of a "claims made" policy.
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> . . . .
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> [A] policy that defines the scope of coverage so narrowly is incompatible with the objectively reasonable expectations of purchasers of professional liability coverage. We assume that there are vast numbers of professionals covered by "claims made" policies who are unaware of the basic distinction between their policies and the traditional "occurrence" policy. However, those professionals covered by "claims made" policies who do understand how their policies differ from "occurrence" policies would expect that in return for the loss of prospective coverage provided by "occurrence" policies, they would be afforded reasonable retroactive coverage by their "claims made" policies. A leading proponent of "claims made" coverage has characterized this quid pro quo—the relinquishment of prospective coverage in return for retroactive coverage—as "the essential trade–off inherent in the concept of 'claims–made' insurance."[44]

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44. *Id.* at 339–40, 495 A.2d at 414–15 (citation omitted). The "leading proponent," of course, was Sol Kroll. *See supra* note 20. In a companion case, *Zuckerman v. National Union Fire Ins. Co.*, 495 A.2d 395 (N.J. 1985), a similar failure to satisfy a reporting condition was fatal to the insured's claim because the policy contained no retro date and thus provided the "retroactive coverage" the court demanded. However, the force of the distinction was less than might appear. The *Sparks* decision indicated that multiple–event triggers would be permitted to truncate both "prospective" and "retroactive" coverage if the limitations were "specifically understood and bargained for" by the insured, 495 A.2d at 416 n.6, and the insured did not need coverage for pre–issuance activities because a newly–minted professional or covered by earlier occurrence coverage. *Id.* at 416 n.4. On remand, the insurer was able to convince the trial court that these conditions had been satisfied, and the Appellate Division affirmed. Sparks v. St. Paul Ins. Co., A–3213–85T8 (App. Div. Feb. 3, 1987). *See generally* Kenneth F. Oettle & Davis J. Howard, *Zuckerman and Sparks: The Validity of "Claims Made" Insurance Policies as a*

In similar fashion, a lower court in New Jersey declared contrary to public policy a retro date provision that provided coverage for earlier errors and omissions only if the same insurer had provided coverage in the earlier years,[45] and a lower court in New York refused to enforce as unconscionable a condition requiring the claim to be made in a policy year when the insurer refused to renew for subsequent years because it knew the insured had suffered an explosion almost certain to produce claims after the end of the policy period.[46] But such apostasies could easily be distinguished or ignored, and would pose little long–term threat to the prevailing orthodoxy. In the conventional understanding, modern claims–made formats are too well–established, and the buyers look too sophisticated, for the forms to fall prey to arguments that they offend public policy[47] or are unconscionable or violate the reasonable expectations of insureds.[48]

Function of Retroactive Coverage, 21 TORT & INS. L.J. 659 (1986); Richard D. Catenacci, *Sparks Revisited: Sparks v. St. Paul Insurance Co.*, 23 TORT & INS. L.J. 707 (1988). For a more supportive view of the *Sparks* decision and an argument that courts should use the doctrine of reasonable expectations to abrogate retro date provisions, see Carolyn M. Frame, Note, *"Claims–Made" Liability Insurance: Closing the Gaps with Retroactive Coverage,* 60 TEMPLE L.Q. 165 (1987).

45. Jones v. Continental Cas. Co., 303 A.2d 91 (N.J. Ch. 1973) (prior acts liberalization of retro provision contrary to public policy and reasonable expectations of insured because limited to prior acts while insured with the same insurer).

46. Heen & Flint Assoc. v. Travelers Indem. Co., 400 N.Y.S.2d 994, 998–99 (N.Y. Sup. Ct. 1977).

> It is my determination that a provision in a "claims made" policy that permits an insurer, where it has notice of a potential claim, to refuse to renew that policy, is unconscionable. Such a provision allows an insurer to avoid the risk of serious potential claims arising from accidents committed within the policy period, and leaves the insured without coverage after the expiration of the policy, since no other insurer will be willing to accept the known risk and thus buy its way into a potential lawsuit.
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> I, therefore, limit the provision of the Travelers' policy that requires a claim to be made against the insured during the policy period, to instances where continued coverage is available from the same or from some other insurer . . . .

47. *See, e.g.,* James & Hackworth v. Continental Cas. Co., 522 F. Supp. 785 (N.D. Ala. 1980) (reporting trigger not contrary to state statute prohibiting shortening

Still, there was one argument that might seem to commend itself to a lawyer in search of escape from the failure of her client to satisfy the conditions of a dual–trigger claims–made–and–reported policy. By the time that claims–made disputes began making their way into court in significant numbers many jurisdictions had "adopted" a "notice–prejudice rule" that, in the conventional understanding, alters the strict common law rule governing some failures of condition. If, for example, an insured involved in an auto accident fails to give the timely notice required by her personal automobile policy, the "notice–prejudice rule" permits the insurer a defense only if the failure of condition "prejudiced" the insurer.[49] Why not apply the "notice–prejudice rule" to liability coverage where the trigger is a claim in the same way it is applied when the trigger is an occurrence?

Why not indeed, some courts responded. In California,[50] Michigan,[51] Massachusetts,[52] Maine,[53] Minnesota,[54] and perhaps Maryland,[55] courts

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of statutes of limitations); James J. Brogger & Assoc., Inc. v. American Motorists Ins. Co., 595 P.2d 1063 (Colo. App. 1979) (claims–made format not anticompetitive tying arrangement because insured free to move to other insurers). *Cf.* Home Ins. Co. v. Adco Oil Co., 987 F. Supp. 1057 (N.D. Ill. 1997), *rev'd*, 154 F.3d 739 (7th Cir. 1998) (Illinois public policy means insured's intentional failure to report claim to insurer could not defeat victim's vested rights against insurer); Murray v. City of Bunkie, 686 So. 2d 45 (La. Ct. App. 1996) (direct action statute gives victim vested rights against insurer that cannot be lost by insured's failure to report claim within policy period).

48. *See, e.g.*, ROBERT H. JERRY, II UNDERSTANDING INSURANCE LAW 289 (1987) ("As long as consumers understand the limitations inherent in claims–made coverage and alternative occurrence coverage is available, no good reason exists for not having claims–made coverage available to consumers."). *See generally* Martin J. McMahon, *Event Triggering Liability Insurance Coverage as Occurring within Period of Time Covered by Liability Insurance Policy where Injury or Damage is Delayed—Modern Cases*, 14 A.L.R. 5th 695 (1997).

49. In Georgia, Maryland, Massachusetts, Texas and Wisconsin, the "notice–prejudice rule is a [statutory/administrative] creation; most other states have announced the rule judicially." Charles C. Marvel, Annot., *Modern Status of Rules Requiring Liability Insurer to Show Prejudice to Escape Liability Because of Insured's Failure or Delay in Giving Notice of Accident or Claim, or in Forwarding Suit Papers*, 32 A.L.R. 4th 141 (1984). For a recent survey of "late notice rules by state," see ANDERSON ET AL., *supra* note 23, at § 5.9 (1997). *See also* WINDT, *supra* note 21, at § 1.04.

50. Northwestern Title Ins. Co. v. Flack, 6 Cal. App. 3d 134 (1970); Mt. Hawley Ins. Co. v. Federal Sav. & Loan Ins. Corp., 695 F. Supp. 469 (C.D. Cal. 1987).

allowed the effect of failure to report a claim to the insurer within the policy period to turn on whether the insurer was prejudiced by that failure.[56]

The industry counter–attack was swift, mounted on several concurrent fronts, and strikingly effective. Did a panel of the United States Court of Appeals for the 9th Circuit apply the California prejudice rule to a reporting condition in a claims–made policy?[57] Then take advantage of the happy circumstance that both parties to the litigation were insurers and settle the litigation with a stipulation that the parties would join in a request that the decisions be vacated and the opinions withdrawn from publication; surely the court would go along.[58] Did a division of the California Court of Appeals

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51. Wood v. Duckworth, 401 N.W.2d 258 (Mich. App. 1986) (prejudice shown); Sherlock v. Perry, 605 F. Supp. 1001 (E.D. Mich. 1985); Stine v. Continental Cas. Co., 349 N.W.2d 127 (Mich. 1984) (dictum concerning application of statute excusing late notice when compliance impracticable).

52. Johnson Controls, Inc. v. Bowes, 409 N.E.2d 185 (Mass. 1980).

53. American Home Assur. Co. v. Ingeneri, 479 A.2d 897 (Me. 1984).

54. Reliance Ins. Co. v. St. Paul Ins. Cos., 239 N.W.2d 922 (Minn. 1976).

55. St. Paul Fire & Marine Ins. Co. v. House, 554 A.2d 404 (Md. 1989) (dictum). The court backed away in T.H.E. Ins. Co. v. P.T.P. Inc., 628 A.2d 223 (Md. 1993). *See generally* Whertley, *supra* note 9.

56. New Zealand and Australia also applied statutory prejudice requirements to failures to satisfy some claims–made triggers. *See* Sinclair Horder O'Malley & Co. v. National Ins. Co. of N.Z. Ltd, 2 N.Z.L.R. 257 (1995) (applying prejudice requirement of § 9 of NEW ZEALAND INSURANCE LAW REFORM ACT 1977 to a potential–claim–discovered–and–reported condition); Bradley West Clarke List and Anor v. Keeman and Ors, 9 ANZ Ins. Cas. 76,742 (1997) (applying prejudice requirement to claims–made–and–reported policy); East End Real Estate Pty Ltd v. C.E. Heath Cas. & Gen. Ins. Ltd., 7 ANZ Ins. Cas. 61,092 (Ct. App. N.S.W. 1992)(effect of failure to report claim governed by § 54 of Insurance Contracts Act 1984 (Cth)); FAI Gen. Ins. Co. Ltd. v. Perry, 7 ANZ Ins. Cas. 61,164 (Ct. App. N.S.W. 1993) (failure to report potential claim governed by § 54).

57. New England Reins. Corp. v. National Union Fire Ins. Co., 822 F.2d 887 (9th Cir. 1987), *rev'g* 654 F. Supp. 742 (C.D. Cal. 1986).

58. New England Reins. Corp. v. National Union Fire Ins. Co., 829 F.2d 840 (9th Cir. 1987) (vacating earlier decision). Policyholder Attorney Eugene Anderson, quoted in Roger Parloff, *Rigging the Common Law,* The American Lawyer, March 1992, p.74, said of the original court of appeals decision in *New England Reinsurance*: "That was a great case for us. . . . A few days later, zingo. It was gone." Not completely, however; though unavailable in the reporter systems, and on Westlaw and Lexis, the opinion still can be found at 1987 CCH Fire & Cas. Cases.

hold that a dual trigger claims–made–and–reported policy violated the reasonable expectations of insureds?[59] Get that opinion decertified too.[60] Did another division of the California Court of Appeals apply the prejudice rule to a claims–made–and–reported policy?[61] Then settle after oral argument contingent upon no opinion being filed in the case.[62] When the court refuses "[t]o bow to this pressure" and files its opinion[63] applying the

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407 and on Anderson's "Vacatur" web site. *See* Anderson Kill & Olick, *infra* note 60.

59. Brown–Spaulding & Assoc., Inc. v. International Surplus Lines Ins. Co., et al, 254 Cal. Rptr. 192 (Cal. Ct. App. 1988).

60. The *Brown–Spaulding* opinion was decertified on March 16, 1989, pursuant to CAL. CT. RULE 979. *See* 206 Cal. App. 3d 1580 (1989) (acknowledging deletion of opinion). Application of the "notice–prejudice rule" to claims–made–and–reported policies prompted "a massive letter–writing campaign" by insurers, according to one attorney for insureds, Stacy Gordon, *Only California Allows Justices to "Depublish,"* BUS. INS., June 15, 1992, p.14, and provoked howls that the industry was turning the courts into a "system of private justice," Stacy Gordon, *Vanishing Precedents: Policyholders Can Get Better Deal—if Rulings Are Erased,*, BUS. INS., June 15, 1992, p. 1 ("A system of private justice is emerging nationwide. Insurers are agreeing not to press appeals of pro–policyholder decisions and are even paying policyholders more than courts have awarded if policyholders help persuade judges to vacate their opinions.).

Eugene Anderson has been especially critical of the practices involved in *New England Reinsurance* and *Brown–Spaulding*: "You see brief after brief where [the insurance lawyers] say, 'The weight of authority is . . . .' or 'most of the cases hold that. . . .' The fact that they can manipulate the goddamn numbers is beyond belief." *See* Parloff, *supra* note 58, at 76. Anderson's campaign against disappearing authority now includes a web site clearing house. *See* Anderson Kill & Olick, *Vacatur Center,* <http://www.andersonkill.com/vacatur.htm>. For a rebuttal, see Fred F. Gregory, *Letters*, THE AMERICAN LAWYER, June 1992, p. 18. *Cf.* Roberto Ceniceros, *Decision Will Keep Rulings on the Books*, BUS. INS., Nov. 14, 1994, p. 1 (reporting reactions to U.S. Bancorp Mortgage Co. v. Bonner Mall Partnership, 513 U.S. 18 , 115 S.Ct. 386 (1994) (party to federal litigation cannot request that defeat in lower court be erased by settlement)).

61. Village Escrow Co., Inc. v. National Union Fire Ins. Co., 248 Cal. Rptr. 687 (Cal. Ct. App. 1988).

62. Stacy Adler, *Ruling Transforms Claims–Made Cover into Occurrence,* BUS. INS., July 25, 1988, p. 1.

63. The court noted that the case was of first impression in the United States, recited the terms of the proposed settlement, and refused to go along:

prejudice rule, organize a letter–writing campaign to the California Supreme Court and get the offending decision decertified.[64] Eventually a court would hold that the California notice–prejudice rule should not be applied to reporting conditions in claims–made policies.[65] In the meantime, flood the

> To bow to this pressure and refrain from filing our opinion would do disservice not only to the public interest implicated in this case but to the proper functioning of the appellate courts in future cases. For it would send a message to other appellants and respondents that they can wait until oral argument and, if they sense the probability or possibility the appellate court will rule against them, buy their way out of an unfavorable precedent often at the relatively cheap price asked by the single opponent they face in that appeal. This would tend to inhibit appellate judges from asking the tough questions at oral argument which might suggest the direction of their thinking. It would result in the squandering of public resources on the research, analysis and writing of opinions which never get filed even though they resolve issues of great public import. And it could even distort the law by allowing parties who possess ample means to prevent the filing of adverse precedents while those without means are unable to do so.

Village Escrow Co., Inc. v. National Union Fire Ins. Co., 248 Cal. Rptr. 687, 694–96 (Cal. Ct. App. 1988).

64. The American Insurance Association and eight insurers asked the Supreme Court to decertify that decision, even before the court decided whether to grant review. Stacy Adler, *Court Asked to Decertify Claims–Made Ruling*, BUS. INS., Mar. 6, 1989, p. 43. Less than three months later, the decision was decertified, Stacy Adler, *Ruling on Claims–Made Decertified in California*, BUS. INS., Nov. 28, 1988, p. 2, making it not available for citation in California and in practice — elsewhere. For a demonstration of the effects of decertification even outside the jurisdiction, see Civic Assocs., Inc. v. Security Ins. Co. of Hartford, 749 F. Supp. 1076, 1080 (D. Kan. 1990).

65. In *Burns v. International Ins. Co.*, 929 F.2d 1422 (9th Cir. 1991), the Court of Appeals reviewed the split in the California courts of appeal, read the tea leaves strewn by the California Supreme Court in *Village Escrow* and *Brown–Spalding*, and concluded that to apply the prejudice rule to a claims–made–and–reported policy would be to "extend coverage." *Id.* at 1425. By the time a California court, in *Pacific Employers Ins. Co. v. The Superior Court of Los Angeles County*, 270 Cal. Rptr. 779 (Cal. Ct. App. 1990), for the first time held that the insurer position should prevail, the three decisions that had applied the notice–prejudice rule to disputes arising in California had all but disappeared from the official records. Almost, but not completely. In *Slater v. Lawyers' Mut. Ins. Co.*, 278 Cal. Rptr. 479 (Cal. Ct. App.

trade press with complaints that courts are "refusing to enforce" claims–made forms and are "converting claims–made policies into occurrence policies."[66] And throughout, insist as an article of the insurers' faith that reporting conditions in claims–made liability policies are fundamentally different than notice conditions in an occurrence policy. *Gulf Insurance Company v. Dolan, Fertig & Curtis*[67] would supply one of the canonical texts:

> A claims–made policy is a policy "wherein the coverage is effective if the negligent or omitted act is discovered and brought to the attention of the insurer within the policy term." 7A Appleman at 312 . . . . The essence, then, of a claims–made policy is notice to the carrier within the policy period."
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> . . . .
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> Notice within an occurrence policy is not the critical and distinguishing feature of that policy type. . . . Coverage depends on when the negligent act or omission occurred and not when the claim was asserted. . . . The giving of notice is only a condition of the policy, and in no manner is it an extension of coverage itself. It does not matter when the

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1991), a summary judgment in favor of the insurer was affirmed even though the insurer had canceled the policy at the end of the policy year and even though the insured had not learned of the claim against him until months later. His anger palpable, Judge Johnson wrote a stinging dissent, *id.* at 1428–29, 278 Cal. Rptr. at 487–88, that essentially repeated his decertified *Village Escrow* opinion. Finally, in *Helfand v. National Union Fire Ins. Co. of Pittsburgh*, 13 Cal. Rptr. 2d 295 (Cal. Ct. App. 1992), the First District refused to apply the "notice–prejudice rule" even to a claims–made policy that was not explicitly "claims–made–and–reported."

66. *See, e.g.*, Stacy Adler, *Ruling Transforms Claims–Made Cover into Occurrence*, *supra* note 62, at 28 (discussing *Village Escrow*); Stephen Tarnoff, *Claims Made: Court Grants Coverage Despite Late Reporting*, BUS. INS., Aug 31, 1987, p. 1, 76 (quoting American Insurance Association official: "I don't think it is unreasonable to say that the effect is to turn the claims–made policy into an occurrence–based policy."). This characterization, though patently inaccurate, has become so much a part of the conventional wisdom that it is blithely repeated even in technical manuals. *See, e.g.*, IRMI, PROFESSIONAL LIABILITY INSURANCE, *supra* note 2, § VIII.C.1 ("[L]ate reports of claims made it more difficult for underwriters to project ultimate claim liabilities (which defeated the purpose of the claims–made coverage trigger) and, in effect, transformed the policies into occurrence forms.").

67. 433 So. 2d 512 (Fla. 1983) (discussed *supra* note 38 and accompanying text).

> insurer is notified of the claim by the insured, so long as the notification is within a reasonable time and so long as the negligent act or omission occurred within the policy period itself.
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> . . . .
>
> With claims–made policies, . . . coverage depends on the claim being made and reported to the insurer during the policy period. Claims–made or discovery policies are essentially reporting policies. If the claim is reported to the insurer during the policy period, then the carrier is legally obligated to pay; if the claim is not reported during the policy period, no liability attaches. If a court were to allow an extension of reporting time after the end of the policy period, such is tantamount to an extension of coverage to the insured gratis, something for which the insurer has not bargained. This extension of coverage, by the court, so very different from a mere condition of the policy, in effect rewrites the contract between two parties. This we cannot and will not do.[68]

Thus, by the early 1990s, the notice–prejudice heresy in California had been extirpated and the offending texts mostly purged. One by one other pockets of apostasy recanted,[69] and the growing orthodoxy was swelled by new adherents who made it clear that they brooked no uncertainties about the correctness of their position: the notice–prejudice rule should not be applicable to reporting conditions in claims–made liability insurance policies.[70] And that, so far as most cases and commentators were concerned, was that.[71]

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68. *Id.* at 514–16.

69. *See, e.g.,* T.H.E. Ins. Co. v. P.T.P. Inc., et al, 628 A.2d 223 (Md. 1993) (repudiating dicta in St. Paul Fire & Marine Ins. Co. v. House, et al, 554 A.2d 404 (Md. 1989)); Chas. T. Main v. Fireman's Fund Ins. Co., 551 N.E.2d 28 (Mass. 1990) (backing away from Johnson Controls, Inc. v. Bowes, 409 N.E.2d 185 (Mass. 1980)).

70. Recently, the New Zealand Law Revision Commission has recommended legislative reversal of decisions in New Zealand that applied a legislative "prejudice" requirement to reporting conditions in claims–made policies. NEW ZEALAND LAW REVISION COMMISSION, SOME INSURANCE LAW PROBLEMS (NZLCR 46) 20–23 (1998). Given the insular character of the debate, perhaps it should not surprise that

But, of course, for those willing to venture beyond such potted legal history, there is more that bears on the way claims–made formats operate and on the way insurance law is practiced at the end of the twentieth century. Do we wonder why so many claims–made insureds fail to satisfy claims–made reporting triggers? Under the strict common law rule, it doesn't matter, and consequently the reported opinions offer only occasional information on that subject, but there is enough to suggest the range of snares that claims–made formats can set. Sometimes the insured is careless,[72] or mistakenly expects the claim to be within the policy deductible,[73] loses a calculated gamble that he can resolve a claim without involving the insurer,[74] or reports the claim to some but not all of the relevant insurers.[75] Sometimes the claim arrives at the end of one policy year and the report, though quickly made, is untimely because it falls in the next policy year.[76] Sometimes the claim is made but the insured does not learn about it until much later,[77] or does not recognize it for what it is later held to be.[78] Sometimes the one seeking to invoke

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the Commission appeared to rely heavily on *Burns v. International Ins. Co.*, 929 F.2d 1422 (9th Cir. 1991) (discussed *supra* note 65) and Chamberlain, *supra* note 9.

71. *See, e.g.*, WINDT, *supra* note 21, at § 1.07 n.78 (collecting authorities). For passionate defense of the heresy, see Anderson, *supra* note 9; Pierce, *supra* note 9.

72. *See, e.g.*, Troy & Stalder Co. v. Continental Cas. Co., 290 N.W.2d 809 (Neb. 1980) (written report of claims mailed to wrong address).

73. *See, e.g.*, Zuckerman v. National Union Fire Ins. Co., 495 A.2d 395 (N.J. 1985).

74. *See, e.g.*, Home Ins. Co. of Illinois v. Adco Oil Co., 987 F. Supp. 1057 (N.D. Ill. 1997) (malpractice insured thought claim was frivolous and was concerned that notice to insurer would prompt a premium hike).

75. *See, e.g.*, Chas. T. Main, Inc. v. Fireman's Fund Ins. Co., 551 N.E.2d 28 (Mass. 1990) (timely report to primary insurer but not to excess insurer).

76. *See, e.g.*, United States v. Strip, 868 F.2d 181 (6th Cir. 1989) (applying Ohio law) (policy year ended August 2; complaint served on insured on July 26 while out of town); Gulf Ins. Co. v. Dolan, Fertig & Curtis, 433 So. 2d 512 (Fla. 1983) (claim made last day of policy period).

77. *See, e.g.*, Thoracic Cardiovascular Assocs., Ltd. v. St. Paul Fire & Marine Ins. Co., 891 P.2d 916 (Ariz. Ct. App. 1994) (suit filed October 15, 1987; coverage ended May 1, 1988; service on defendant not until July 12, 1988); Slater v. Lawyer's Mut. Ins. Co., 278 Cal. Rptr. 479 (Cal. Ct. App. 1991) (suit within policy period but service on defendant insured delayed more than four months); Village Escrow Co. v. National Union Fire Ins. Co., 248 Cal. Rptr. 687 (Cal. Ct. App. 1988) (suit filed within policy period but service on defendant insured delayed more than eleven months).

78. Is a claim made when the lawyer's client demands that the lawyer redo allegedly deficient work, or when the client gets mad enough to file suit? *Compare*

coverage is not the insured who failed to make a report;[79] sometimes the report was made, but later was determined to be inadequate.[80] Although our reactions to the stories insureds have to tell may depend on such differences, the strict common law of conditions remains stubbornly indifferent to such variations. If reporting a claim to an insurer within a particular policy year was an express condition of the policy, the decisions tell us, then the insured bears the risk of failing to satisfy that condition.

Do we wonder what effect failure to make a conforming and timely report to the insurer had on the insurer? Again, the strict common law of conditions professes indifference, but the cases and commentary nonetheless hasten to explain that any report that arrives late will deny the insurer pricing advantages that the shift from occurrence to claims–made formats was supposed to provide:

> The purpose of the notice requirement in "claims made" policies is to ensure "fairness in rate setting," whereas its purpose in an "occurrence" policy is "to permit an insurer to make an investigation of the facts . . . relating to liability." A late notice would clearly always inhibit the insurer's task of setting its future premiums and reserves with full knowledge of the outstanding claims it is obligated to meet, while it would not necessarily have the same effect with regard to the investigation of the facts pertaining to the insured event. Hence, a showing of prejudice is justly required in the latter while not in the former.[81]

Phoenix Ins. Co. v. Sukut Constr. Co., Inc., 186 Cal. Rptr. 513 (Cal. Ct. App. 1982) (client request that lawyer correct admitted error without charge later characterized as "claim") *with* Hoyt v. St. Paul Fire & Marine Ins. Co., 607 F.2d 864 (9th Cir. 1979) (client letter to lawyer questioning work on will held not a claim). When a regulator demands that a financial institution get its house in order, when it seizes the institution, or when it brings suit against the officers and directors for negligent supervision? *See, e.g.,* Mt. Hawley Ins. Co. v. F.S.L.I.C., 695 F. Supp. 469 (C.D. Cal.1987).

79. *See, e.g.,* Pacific Employers Ins. Co. v. Superior Court, 270 Cal. Rptr. 779 (Cal. Ct. App. 1990) (late report given by administrator of estate of deceased insured).

80. *See, e.g.,* St. Paul Fire & Marine Ins. Co. v. Tinney, 920 F.2d 861 (11th Cir. 1991) (timely report to insurer did not detail names and addresses of witnesses and date, time, and place of incident).

81. National Union Fire Ins. Co. v. Talcott, 931 F.2d 166 (1st Cir. 1991) (applying Massachusetts law and quoting from Chas. T. Main v. Fireman's Fund Ins.

Of course, it does not require great expertise with the niceties of loss reserving, loss development, trending, and other elements of the pricing process to recognize that even with perfect reporting of all claims by the end of the policy period, pricing and underwriting decisions will still be made with far less than the "full knowledge" of past experience the courts seem to imagine, that projection of that experience into the future still remains the most daunting part of the pricing process, and that most of the pricing and underwriting advantages of claims–made formats would remain even if the tardiness of an occasional report were excused.[82] Still, within the reigning orthodoxy, all this is quite fundamentally beside the point. The strict law of conditions makes clear that there is no need to ask whether an insurer was prejudiced by failure to provide a report necessary to trigger coverage. So why, we might wonder, do courts go to such lengths to adorn opinions with paeans celebrating the pricing advantages of claims–made triggers?

There is more about which we might wonder. Why, those who come to the question with some appreciation for the variety of claims–made formats

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Co., 551 N.E.2d 28 (Mass. 1990)). Kroll, *supra* note 19, at 928, provided one of the creedal formulations:

> An underwriter who is secure in the fact that claims will not arise under the subject policy . . . after its termination or expiration can underwrite a risk and compute premiums with greater certainty. The insurer can establish his reserves without having to consider the possibilities of inflation beyond the policy period, upward spiraling jury awards, or later changes in the definition and application of negligence.

Though Kroll's first sentence clearly is true—more information can only help—the second clearly is not; even if the insurer has received a report of all claims that may trigger a policy, the ultimate cost of those claims to the insurer still will be in doubt. *See generally* authorities cited *supra* note 22.

82. The rhetoric that equates the excuse of a reporting condition with a return to occurrence triggers is badly off the mark. Excusing a reporting condition in a claims–made–and–reported policy makes the provision operate much the same as do the large number of "claims–made" formats which do not insist that the report be made within the policy period, and those forms still provide the insurer with significant pricing advantages over occurrence formats. They free the insurer from the "incurred but not made" (IBNM) portion of the IBNR; a reporting trigger tries to free the insurer from the remainder of the IBNR, the "made but not reported" (MBNR) claims. *See* discussion of multi–event triggers *infra* Part III(a).

actually being employed in the market might ask, do those differences seem to matter so little in the claims–made litigation immunizing reporting conditions from the notice–prejudice rule? True, in a few pivotal early battles the fact that the insuring clause was explicitly "claims–made–and–reported" helped with the argument that the reporting condition should be regarded as coverage–defining.[83] But courts and commentators were far more likely to rely on Appleman, the Krolls, and other glossators of the claims–made canon for broad assertions that "[t]he essence . . . of a claims–made policy is notice to the carrier within the policy period"[84] and "claims–made or discovery policies are essentially reporting policies,"[85] and to treat those characterizations as determinative without regard for the niceties of the kind of claims–made format actually at issue. Would the same stubborn indifference to detail hold if the report were timely but failed to include the name or address of a witness required by the reporting condition?[86] If instead of invoking the "notice–prejudice rule," the insured predicated his excuse argument on a claim of impracticability, or waiver, or prior breach by the

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83. Most claims–made–and–reported policies carefully locate both triggers in the insuring clause; occurrence policies often leave notice provisions to languish pages later with other loss adjustment conditions. For an argument that location of a reporting condition in the insuring clause should insulate it from excuse arguments, see Barry G. Kaiman & Laura C. Nachison, *Courts in the Business of Insurance: Claims Made and Reported Policies,* DEFENSE COUNSEL. J. 43 (1990); for the contrary argument that function, not form, should govern, see *Slater v. Lawyers' Mut. Ins. Co.*, 278 Cal. Rptr. 479, 487–88 (Cal. Ct. App. 1991) (Johnson, dissenting).

84. Gulf Ins. Co. v. Dolan, Fertig & Curtis, 433 So. 2d 512, 514. *See, e.g.,* Thoracic Cardiovascular Associates, Ltd. v. St. Paul Fire & Marine Ins. Co., 891 P.2d 916, 920 (Ariz. Ct. App. 1994); Serrmi Prods. v. Ins. Co., 411 S.E.2d 305, 306 (Ga. App. 1991); Continental Cas. Co. v. Maxwell, 799 S.W.2d 882, 887 (Mo. 1990).

85. Gulf Ins. Co., 433 So. 2d at 515. *See, e.g.,* United Nat'l Ins. Co. v. Jacobs, 754 F. Supp. 865, 868 (M.D. Fla. 1990); First Alabama Bank v. First State Ins. Co., 1990 U.S. App. LEXIS 6744 (N.D. Ala. 1988); City of Harrisburg v. International Surplus Lines Ins. Co., 596 F. Supp. 954, 961 (D. Pa. 1984); Sletton v. St. Paul Fire & Marine Ins. Co., 780 P.2d 428, 430 (Ariz. 1989); KPFF, Inc. v. California Union Ins. Co., 66 Cal. Rptr. 2d 36, 42 (Cal. Ct. App. 1997).

86. *See, e.g.,* St. Paul Fire & Marine Ins. Co. v. Tinney, 920 F.2d 861 (11th Cir. 1991) (error to grant summary judgment to insurer simply because timely report to insurer did not detail names and addresses of witnesses and date, time, and place of incident).

insurer?[87] Are we to understand that every condition in a claims–made policy is immune from excuse arguments? If not, why not?[88]

And why, those who come to this same history with some knowledge of the development of the notice–prejudice rule might ask, has an argument that a particular nonoccurrence of a condition should be excused been so easily and so regularly conflated with arguments that the policy provision establishing that condition is contrary to public policy or unconscionable or did not make it into the contract because contrary to objective reasonable expectations of insureds? Whether a reflection of the conceptual and rhetorical poverty of insurance law, or a tactical choice by defense lawyers who know better, the result is an odd mix in which legal formalism, dominated by the assumption that policy provisions speak plainly to dictate precise results, combines with a bargain–basement legal realism that sees in every coverage dispute another skirmish in a titanic struggle between freedom of contract and social control. The insurance law on display in claims–made litigation is an insurance law that trades in results and disdains such doctrinal distinctions: application of the notice–prejudice rule to reporting conditions is characterized as a refusal to enforce claims–made formats; decisions declaring reporting conditions immune from the notice–prejudice rule are characterized as vindication of claims–made formats.

And why, those who venture into the thickets of claims–made litigation from outside the insular traditions of insurance may wonder, has the dispute over whether reporting conditions in claims–made policies should be immune from the notice–prejudice rule drawn so little on the sources of guidance available elsewhere in insurance law and the more generalized law of contracts? Whether the notice–prejudice rule should apply, both sides agree, turns on whether the reporting condition is a essentially a "coverage" clause

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87. *See, e.g.*, Thoracic Cardiovascular Associates, Ltd. v. St. Paul Fire & Marine Ins. Co., 891 P.2d 916, 923 (Ariz. Ct. App. 1994) (excuse of failure to report claim during policy period on grounds of impracticability unavailable even though insured did not receive service until many months after suit filed and policy period ended; according to the court, a claims–made–and–reported "insured assumes the risk that claims will not be covered unless they are both discovered and reported during the policy period"); St. Paul Fire & Marine Ins. Co. v. Estate of Hunt, 811 P.2d 432, 434–35 (Colo. Ct. App. 1991) (excuse for impracticability due to mental impairment not available because "the condition requiring the insured to provide notice of a claim during the policy period was a material part of the agreed exchange").

88. For one exception to the general obliviousness to these issues, see Richard L. Suter, *Insurer Prejudice: Analyis of an Expanding Doctrine in Insurance Coverage Law*, 46 ME. L. REV. 221 (1994).

and thus immune, or essentially something else—a "procedural," "loss adjustment," "administrative," "merely technical" condition—and thus not immune. The distinction between "core" and "noncore" contractual provisions is an important one both inside and outside insurance law,[89] and insurer resistance to the development of the "notice–prejudice rule" for occurrence policies included assertions that notice provisions there too were at the "essence of the contract."[90] But there is no hint of those connections in the claims–made literature. An insurance law that characterizes every insurer defeat as a refusal to enforce the policy is not likely to be looking for doctrinal guidance in the long history of insurance litigation concerning which policy provisions should be classed as "coverage" provisions immune from warranty statutes, incontestable clauses, and excuse on the basis of impracticability and waiver, and even less likely to break out of its insularity to consult the *Restatement (Second) of Contracts* about what should be involved in determining when a contract condition is so central to the bargain that noncompliance should not be excused.

And, so, we must finally wonder, what if insurance lawyers were not so easily convinced by their job description that they are adrift in conceptual backwaters in which traditional contracts rules cannot be expected to function in the normal ways? What if those involved in claims–made trigger litigation were to have recourse to the *Restatement* and to other windows into the general law of contracts in search of bases upon which to distinguish noncompliance with insurance policy conditions that sometimes may be excused from noncompliance with insurance policy conditions for which excuse will not be available? What would they learn about the various ways in which insurance policy conditions operate to lessen the insurer's obligation? And what might that mean for future claims–made litigation?

II. A LONGER PRIMER ON INSURANCE POLICY CONDITIONS AND WHEN THEIR NONOCCURRENCE MAY BE EXCUSED

We can now return to the questions with which we began: In what sense is the coverage provided by claims–made formats "less" than the coverage provided by "occurrence" formats? Is the coverage provided by various forms of claims–made policies less in the same sense that an insured under

89. *See infra* notes 240–45.

90. *See, e.g.*, Edward A. Shure, *Contract Provisions for Notice and Proof After Discovery of Loss Are Conditions Precedent to the Insured's Right of Recovery*, 1967 ABA INS. NEG. & COMP. LAW PROC. 95.

a family auto policy has less coverage than if she had purchased collision coverage to go with the other coverages she did buy? In the sense that her homeowner's policy provides less coverage than it otherwise would because it excludes liabilities arising out of business pursuits and excepts property damage caused by rodents? Should we regard these risk–allocation provisions differently than we regard provisions that purport to immunize the insurer from liability for property damage occurring while the insured property is vacant or unoccupied, for theft losses not evidenced by visible external marks of forced entry, and when notice of an otherwise–covered event is not given within a reasonable time? And what should we make of the recurrent reassurance that the coverage provided by a claims–made policy "may be less, but so, therefore, is the cost?"

Of course, within the reinforcing orthodoxies of neo–classical contract and neo–classical economics,[91] such questions are quite meaningless. In a world where value is equated with willingness to pay, where every preference can be satisfied at a price, and where both insurer and insured can be imagined to have foreseen, priced, and allocated all relevant risks for every possible future state of the world,[92] there simply is no reason to try to distinguish among the variety of provisions that populate insurance policies.

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91. "The classical contract ... is so to speak the legal corollary of the zero–transactions–cost conception of the world." Erik Furubotn & Rudolf Richter, *The New Institutional Economics: An Assessment*, 1992 J. INST'L & THEORETICAL ECON. 1, 20.

92. Rational choice models typically assume that the players "know, or can know, all the feasible alternative actions open to them, that they know, or can easily discover, all relevant prices, and that they know their wants or desires." Thomas S. Ulen, *Cognitive Imperfections and the Economic Analysis of Law,* 12 HAMLINE L. REV. 385, 385–86 (1989). When the decisions involve the future, as contracting decisions must, models of rational choice under uncertainty assume:

> that individual decisionmakers can compute (subjective) probability estimates of uncertain future events; that they perceive accurately the dollar cost or outcome of the uncertain outcomes; that they know their own attitudes toward risk; that they combine this information about probabilities, monetary values of outcomes, and attitudes toward risk to calculate the expected utilities of alternative courses of action and choose that action that maximizes their expected utility.

Id. at 386.

If each has been validated by the actual assent of expected–utility–maximizing parties, then each should be strictly enforced.

But in a world in which the soothing assumptions of expected utility models do not hold,[93] where bounded rationality[94] guarantees that not all

93. For an accessible introduction to the limits of rational choice models as guides to human decision making, and to contracts and contract law, see Melvin Aron Eisenberg, *The Limits of Cognition and the Limits of Contract*, 47 STAN. L. REV. 211 (1995). The literature of "behavioral economics" is expanding rapidly as both economics and law confront the "now incontestable point" that " economic rationality is systematically violated, and that decision–making errors are both widespread and predictable." David Laibson & Richard Zeckhauser, *Amos Tversky and the Ascent of Behavioral Economics*, 16 J. RISK & UNCERTAINTY 7, 9 (1998). *See generally* RICHARD H. THALER, QUASI RATIONAL ECONOMICS (1991); Christine Jolls, Cass R. Sunstein, & Richard Thaler, *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471 (1998); Mark Kelman, *Behavioral Economics as Part of a Rhetorical Duet: A Response to Jolls, Sunstein, and Thaler*, 50 STAN. L. REV. 1577 (1998); Matthew Rabin, *Psychology and Economics*, 36 J. EC. LIT. 11 (1998).

The lessons are applicable to decision making by both parties to the insurance transaction. *See, e.g.*, Robin M. Hogarth & Howard Kunreuther, *Risk, Ambiguity, and Insurance*, 2 J. RISK & UNCERTAINTY 5 (1989) (traditional expected utility models of insurance markets inadequate because imprecision of estimates of probability of loss affects decisions of both buyers and sellers of insurance); Eric J. Johnson et al., *Framing, Probability Distortions, and Insurance Decisions*, 7 J. RISK & UNCERTAINTY 35 (1993) (loss aversion framing and status quo framing found in actual insurance markets as well as experimental settings); Richard Kihlstrom & Alvin Roth, *Risk Aversion and the Negotiation of Insurance Contracts*, in FOUNDATIONS OF INSURANCE ECONOMICS 264, 268 (George Dionne & Scott Harrington, eds. 1991) (when insurer uncertain of ability to diversify, assumption that insurer will be risk neutral no longer holds; "behavior of negotiated insurance contracts for more general insurance problems thus remains an open question"); Gary H. McClelland et al., *Insurance for Low–Probability Hazards: A Bimodal Response to Unlikely Events*, 7 J. RISK & UNCERTAINTY 95 (1993) (bimodality found in laboratory reactions to low probability, high consequence risks); Paul J.J. Schoemaker & Howard C. Kunreuther, *An Experimental Study of Insurance Decisions*, 46 J. RISK & INS. 603, 616 (1979) (cost much more acceptable if framed as insurance premium rather than simple loss). *See also* HOWARD KUNREUTHER *ET AL.*, DISASTER INSURANCE PROTECTION: PUBLIC POLICY LESSONS (1978) (decisions by consumers of insurance inconsistent with expected utility models); Robert Eisner & Robert Strotz, *Flight Insurance and the Theory of Choice*, 69 J. POL. ECON. 355 (1961) (same).

94. By "bounded rationality," I mean not only that obtaining and using information can be costly, and not only that there may be absolute limits on abilities to acquire and process information, but also that there may be systematic cognitive

uncertainties will be converted effortlessly into probabilities, and where the potential for opportunism[95] must be included among the hazards the future may hold, we may be less inclined to concede that the presence of a visible external marks provision in the theft–from–automobile coverage provided by a homeowners policy means that the insured has manifested a preference for that condition—or that, along the margin, some more–sophisticated insured has manifested it for her[96]—in the same way she has manifested a preference for limiting price and coverage by choosing not to buy collision coverage. If bounded rationality prevents the parties from lingering over a complete menu

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and motivational barriers to rational choice. The first receives recognition in economic models that incorporate search costs and informational asymmetries, the second in economic models of decision making under uncertainty, but the third is potentially more deeply subversive. *See* Kenneth E. Scott, *Bounded Rationality and Social Norms*, 150(1) J. INST'L & THEORETICAL ECON. 315 (1994). The term is generally credited to Herbert Simon. *See, e.g.*, HERBERT A. SIMON, MODELS OF BOUNDED RATIONALITY (1982); Herbert A. Simon, *Rationality in Psychology and Economics, in* RATIONAL CHOICE: THE CONTRAST BETWEEN ECONOMICS AND PSYCHOLOGY 25 (Robin M. Hogarth & Melvin W. Reder eds. 1987); Herbert A. Simon, *A Behavioral Model of Rational Choice,* 69 Q.J. ECON. 99 (1955). For a useful modern summation, see John Conlisk, *Why Bounded Rationality?*, 34 J. ECON. LIT. 669 (1996).

95. By "the potential for opportunism," I mean the risk that "human agents will not reliably self–enforce promises but will defect from the letter and spirit of an agreement when it suits their purposes." OLIVER E. WILLIAMSON, THE ECONOMIC INSTITUTIONS OF CAPITALISM 388 (1985). For other efforts to define opportunism, *see, e.g., id.* at 65 ("self–interest–seeking with guile"); George M. Cohen, *The Negligence–Opportunism Tradeoff in Contract Law*, 20 HOFSTRA L. REV. 941, 957 (1992) ("any contractual conduct by one party contrary to the other party's reasonable expectations based on the parties' agreement, contractual norms, or conventional morality."); Charles J. Goetz & Robert E. Scott, *Principles of Relational Contracts*, 67 VA. L. REV. 1089, 1139 n. 118 (1981) ("strategic behavior designed to exploit a contractually created monopoly position"); Timothy J. Muris, *Opportunistic Behavior and the Law of Contracts*, 65 MINN. L. REV. 521 (1981) (conduct that is "contrary to the other party's understanding of the contract, but not necessarily contrary to the agreement's terms").

96. For a crisp statement of the argument, see Alan Schwartz & Louis Wilde, *Intervening in Markets on the Basis of Imperfect Information: A Legal and Economic Analysis*, 127 U. PA. L. REV. 630 (1979); for a recent examination of the limitations of that argument, see R. Ted Cruz & Jeffrey J. Hinck, *Not My Brother's Keeper: The Inability of an Informed Minority to Correct for Imperfect Information*, 47 HASTINGS L.J. 635 (1996).

of possible policy provisions—each with its associated price tag—as they make fully–informed, fully–rational choices about how to construct their fully–specified, fully–presentiated insurance contract, and if the threat of opportunistic behavior makes deferring decisions about how to allocate responsibility for the unknown an unattractive option, what then?[97]

A. Enforcing Reasonable Expectations or Policing Against Opportunism?

How we respond to that question may depend on which of the "twin behavioral assumptions"[98] of bounded rationality and opportunism we choose

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97. That question has fueled a vigorous debate. For a recent version of the claim that rational choice models should incorporate new insights about cognitive and motivational behaviors, see Cass R. Sunstein, *Behavioral Analysis of Law*, 64 U. CHI. L. REV. 1175 (1997). For the view from the other side of the methodological divide, see Robert E. Scott, *Error and Rationality in Individual Decisionmaking: An Essay on the Relationship between Cognitive Illusions and the Management of Choices*, 59 S. CAL. L. REV. 329 (1986); Alan Schwartz, *Proposals for Product Liability Reform: A Theoretical Synthesis*, 97 YALE L.J. 353, 380–82 (1988). For a sense of the passions that these issues can stir, see Richard Posner, *The New Institutional Economics Meets Law and Economics*, 149(1) J. INST'L & THEORETICAL ECON. 73 (1993); O.E. Williamson, *Transaction Cost Economics Meets Posnerian Law and Economics*, 149(1) J. INST'L & THEORETICAL ECON. 99 (1993); Richard Posner, *Reply*, 149(1) J. INST'L & THEORETICAL ECON. 119 (1993).

98. The phrase is taken from OLIVER E. WILLIAMSON, REVISITING LEGAL REALISM: THE LAW, ECONOMICS, AND ORGANIZATION PERSPECTIVE 16 (Working Paper No. 95–12, Center for the Study of Law and Society, Berkeley 1996). As Williamson delights in pointing out, the traditional assumptions of classical economics and classical contracts—that contracts are fully specified and leave no room for opportunistic behavior—render both economics and law uninteresting. In this "contractual utopia," relaxing but one assumption at a time does not change things: with unbounded rationality and opportunism, comprehensive ex ante contracting might be expected to take the sting out of opportunism; with bounded rationality and no opportunism, "general clauses" could be used to defer potential problems for peaceful resolution if and when they arise. Thus, says Williamson, the only interesting contracts questions are prompted by the coincidence of bounded rationality and opportunism, "which I maintain accords with reality and is where all of the difficult contracting issues reside." WILLIAMSON, *supra* note 95, at 67. Dieter Schmidtchen, *Time, Uncertainty, and Subjectivism: Giving More Body to Law and Economics*, 13 INT'L REV. L. & EC. 61, 75 (1993), summarizes the neo–institutional criticism of an exclusively ex ante perspective:

to emphasize. On the one hand, we might try to assess the effects of bounded rationality on the quality of the insured's assent to the inclusion of various provisions in standard insurance policy forms, and respond by trying to determine an appropriate insurance contract ex ante. On the other hand, we might focus on the vulnerability that results from sequential performance of aleatory insurance contracts chock–full of express conditions and try to derive ways to police contractual performance ex post. The first approach springs naturally from deeply–imbedded intuitions that contract law "is designed primarily to facilitate market exchange by providing ex ante safeguards against contract or market failure";[99] the second is animated by alternative visions of contract law offered by neo–institutionalists who seek to identify conditions under which opportunism is likely to flower and who emphasize the role of contract institutions and contract law as ex post governance mechanisms for controlling opportunism.[100] For lawyers contemplating an insurance coverage question, the first hand points toward the "Doctrine of

> The result of unbounded rationality and given probability distributions for all states of the world will be the perfect contingent contract. If we further assume that court ordering is efficacious, nothing unexpected will happen. All relevant issues of a contract are settled at the *ex ante* bargaining stage. . . . The *ex post* (execution) stage of a contract does not bring up any interesting issues for further analysis. This is the world of the traditional neo–classical theory . . . . Orthodox law and economics, in the Chicago style, for example, drops the assumption of perfect contingent contracts and efficacious cost adjudication. But the maximizing man stays on stage, while the analysis of the *ex post* (execution) aspects of contracts is withdrawn within the background.

99. JULES L. COLEMAN, RISKS & WRONGS 73 (1992).

100. As Professor Cohen notes, the second approach "has traveled under several different names—relational contracting, transaction cost theory, new institutional economics . . . . [T]he distinguishing feature common to all variants of this approach . . . is the focus on the need to deter opportunistic, as opposed to negligent, contracting behavior." Cohen, *supra* note 95, at 953. For an excellent survey of some of this work, see Howard A. Shelanski & Peter G. Klein, *Empirical Research in Transaction Cost Economics: A Review and Assessment,* 11 J. L. EC. & ORG. 335 (1995). For recent efforts to set out the agenda of the new institutional economics, see DOUGLASS C. NORTH, INSTITUTIONS, INSTITUTIONAL CHANGE AND ECONOMIC PERFORMANCE 17–18 (1990); OLIVER E. WILLIAMSON, THE MECHANISMS OF GOVERNANCE (1996); Furubotn & Richter, *supra* note 91.

Reasonable Expectations,"[101] construction contra proferentem,[102] and similar doctrinal tools concerned with determining the content and meaning of the contract;[103] the second hand beckons the lawyer in a different direction, toward "bad faith"[104] and "excuse of failure of condition"[105] and a host of similar devices for policing opportunistic performance and enforcement of

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101. The "Doctrine of Reasonable Expectations" properly is attributed to Professor (now Judge) Robert E. Keeton, who announced discovery of the "principle" underlying some judicial decisions "at variance with policy provisions" in 1969 and then guided its evolution into a "doctrine." *See* Robert Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 967, 1281 (1970); Robert E. Keeton, *Reasonable Expectations in the Second Decade,* 12 FORUM 275 (1976). *See also* JERRY, *supra* note 48, § 25D; ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINE AND COMMERCIAL PRACTICES § 6.3(a)(3), at 632 (Practitioners ed. 1988); Kenneth S. Abraham, *Judge–Made Law and Judge–Made Insurance: Honoring the Reasonable Expectations of the Insured*, 67 VA. L. REV. 1151 (1981); Stephen J. Ware, *A Critique of the Reasonable Expectations Doctrine*, 56 U. CHI. L. REV. 1461 (1989); William Mark Lashner, Note, *A Common Law Alternative to the Doctrine of Reasonable Expectations in the Construction of Insurance Contracts*, 57 N.Y.U. L. REV. 1175 (1982). For efforts to capture the modern state of the "doctrine," see BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES § 1.03[b][2] (3d ed. 1995); Roger C. Henderson, *The Doctrine of Reasonable Expectations in Insurance Law After Two Decades*, 51 OHIO ST. L.J. 823 (1990).

102. For useful recent indications of the sorts of things that go on under this rubric, and efforts to wrestle with their normative implications, see Kenneth S. Abraham, *A Theory of Insurance Policy Interpretation,* 95 MICH. L. REV. 531 (1996); Michael B. Rappaport, *The Ambiguity Rule and Insurance Law: Why Insurance Contracts Should Not Be Construed Against the Drafter*, 30 GA. L. REV. 171 (1995).

103. *See, e.g.*, JEFFREY W. STEMPEL, INTERPRETATION OF INSURANCE CONTRACTS: LAW AND STRATEGY FOR INSURERS AND POLICYHOLDERS § 5.2 (1995); James M. Fischer, *Why Are Insurance Contracts Subject to Special Rules of Interpretation?: Text Versus Context*, 24 ARIZ. ST. L.J. 995 (1992); Peter Nash Swisher, *Judicial Interpretations of Insurance Contract Disputes: Toward a Realistic Middle Ground Approach,* 57 OHIO ST. L.J. 543 (1996).

104. *See generally* STEPHEN S. ASHLEY, BAD FAITH ACTIONS: LIABILITY AND DAMAGES (2d ed. 1997); WILLIAM M. SHERNOFF, INSURANCE BAD FAITH LITIGATION (1984); KEETON & WIDISS, *supra* note 101, at §§ 6.2, 7.8, 7.9; Symposium, *The Law of Bad Faith in Contract and Insurance*, 72 TEX. L. REV. 1203 (1994).

105. *See generally* RESTATEMENT (SECOND) OF CONTRACTS § 225 cmt. b (1981) (identifying seven categories of excuse of failure of condition).

contract obligations.[106] Although contract law and contract institutions involve efforts of both sorts,[107] in insurance—as throughout contracts—the first hand is much better developed than the second.[108]

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106. *See infra* notes 196–207 and accompanying text.

107. *See generally* Cohen, *supra* note 95 (distinguishing "least cost avoider" and "opportunism" traditions in law and economics literature); Charles J. Goetz & Robert E. Scott, *The Mitigation Principle: Toward a General Theory of Contractual Obligation*, 69 VA. L. REV. 967, 968 n.5 (1983) (contrasting "two distinct and largely unrelated analytic traditions," which they label the "bargain model" and "transaction cost" traditions); Jason Scott Johnston, *Law, Economics, and Post–Realist Explanation*, 24 LAW & SOC'Y REV. 1217 (1990) (contrasting "model of precautions" and "transaction cost economics"). For Stanley Fish, those tensions give contract law its strength: "It is *because* it is a world made up of materials that pull in diverse directions that contract law can succeed in its endless project of making itself into a formal whole." Stanley Fish, *The Law Wishes to Have a Formal Existence*, *in* THE FATE OF LAW 159, 184 (Austin Sarat & Thomas R. Kearns eds., 1991).

Long before high–stakes coverage litigation sparked renewed interest in insurance law, Professor Slawson combined both perspectives in a single influential article. W. David Slawson, *Mass Contracts: Lawful Fraud in California*, 48 S. CAL. L. REV. 1 (1974). For a recent return visit to these themes, see W. DAVID SLAWSON, BINDING PROMISES 151–74 (1996) (posing choice directly for insurance). For a view from the outside, see Per–Olof Bjuggren et al., *Should A Regulatory Body Control Insurance Policies Ex Ante or Is Ex Post Control More Effective?*, 19 GENEVA PAPERS ON RISK & INS. 37 (1994).

108. The dominance of the first hand is easily explained. Neo–classical economics naturally is drawn by a powerful methodological tropism toward the ex ante. Academics who move away from classical contingent claims modeling to acknowledge the role of asymmetries of information gravitate toward agency theory, mechanism design, and similar efforts to construct efficient ex ante solutions to the problems posed by information costs; in such modeling, the threat of opportunistic behavior is collapsed into moral hazard, and moral hazard becomes just another aspect of asymmetric information. Neo–classical contracts displays the same methodological preoccupation with "anticipating problems, specifying contingencies, aligning incentives, and, in general, prespecifying obligations fully." Thomas Palay, *Relational Contracting, Transaction Cost Economics and the Governance of HMOs*, 59 TEMPLE L.Q. 927, 930 (1986). *See also* Wallace K. Lightsey, *A Critique of the Promise Model of Contract*, 26 WM. & MARY L. REV. 45, 49 (1984) (criticizing "three primary inadequacies of the promise model: discreteness, discontinuity, and presentiation"); Peter Linzer, *Uncontracts: Context, Contorts and the Relational Approach*, 1988 ANN. SURVEY AM. LAW 139 (exploring extent to which consent and presentiation remain the primary building blocks of contracts).

1. Vindicating Reasonable Expectations?

Law students, flushed with first recognition of how far the realities of standard insurance policy form marketing sometimes depart from idealized "strong assumptions about the capacities of rational commercial actors to calculate the probability of even remote events and, when desirable, to strike ex ante bargains that reflect their expected value,"[109] often are quick to conclude that not all provisions in standard insurance policy forms were created equal and that we should make distinctions on the basis of perceived differences in the quality of the insured's assent. Thus, for example, whether or not to buy collision coverage was a choice that almost certainly was brought home to the insured at the time she applied for auto insurance and again at each renewal. By contrast, the business exclusion from liability coverages is a standardized part of homeowners policies, but whether the insured realizes it or not, its effects often can be avoided by purchasing an inexpensive rider. And, of course, a prospective insured is not likely to know much about rodent damage exclusions, vacancy–or–unoccupancy warranties, visible–external–marks evidentiary conditions, or notice provisions, or to worry about them if she does know about them, and in any event, if she wants insurance there's probably nothing she can do to prevent them from becoming a part of her contract with the insurer. Shouldn't those differences count for something, law students habitually ask.

Not really, they quickly learn. True, standard form insurance contracting is in tension with conventional pieties of orthodox autonomy– and consent–based contracts models.[110] True, most of the provisions that repeat–player insurers, through the Insurance Services Office and other industry support organizations, think to include in standard insurance policy forms cannot fairly be said to have been validated by actual assent of the insureds. And, true, efforts within the academy to wrestle with the implications of relaxing assumptions about informational and cognitive resources of contracting parties have produced a rich theoretical literature concerning the inevitability of incomplete contracts, how to identify the resulting gaps, and how best to go about filling those gaps with default rules.[111] In insurance, those efforts have been mirrored by a parallel academic and practice literature working

109. Clayton P. Gillette, *Commercial Relationships and the Selection of Default Rules for Remote Risks,* 19 J. LEG. STUD. 535, 539 (1990).

110. For an especially useful description of this tension, see MICHAEL J. TREBILCOCK, THE LIMITS OF FREEDOM OF CONTRACT 78–146 (1993).

111. *See generally Symposium on Default Rules and Contractual Consent,* 3 S. CAL. INTERDISCIPLINARY L.J. 1 (1993); authorities cited *infra* note 116.

riffs on the theme that sometimes "objectively reasonable expectations" of insureds will be vindicated "even though a painstaking study of the policy provisions would have negated those expectations."[112]

But these developments do not mean that insurance law is now in the business of ignoring standard insurance policy forms in favor of building a contract by combining the dickered terms with judicially–supplied gap fillers designed to mimic the expectations of actual or hypothetical insureds. The reality, of course, is that real insureds simply do not have expectations of any kind about most of the subjects treated by the provisions that lurk unread in their policies, and no one who thinks about it for more than a moment is likely to imagine that it should be any other way.[113] But then what? It is difficult to muster much enthusiasm for telling insureds that coverage–enhancing provisions of their policies may not be available because they and other reasonable insureds did not know they were there, and even the most sanguine concerning judicial competence to construct appropriate gap–filling

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112. Robert Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961, 967 (1970). *See also* authorities cited *supra* note 101.

113. As Michael Trebilcock notes: "Almost implicit in the transaction cost justification for standard form contracts is the assumption that parties will often not read them or, if they do, will not wish to spend significant amounts of time attempting to renegotiate the terms." TREBILCOCK, *supra* note 110, at 119. *See also* Melvin Aron Eisenberg, *Text Anxiety*, 59 S. CAL. L. REV. 305 (1986) (reasonable for consumers to refuse to read form contracts); Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction,* 96 HARV. L. REV. 1173, 1226 (1983) ("The ideal adherent who would read, understand, and compare several forms is unheard of in the legal literature and, I warrant, in life as well."). Empirical work seems to validate these impressions:

> When asked about their insurance decisions, subjects in both laboratory studies and survey studies indicated a disinclination to worry about low probability hazards. Such a strategy is understandable in view of the fact that limitations of people's time, energy, and attentional capacities create a "finite reservoir of concern." Unless we ignored many low–probability threats we would become so burdened than any sort of productive life would become impossible.

Howard Kunreuther & Paul Slovic, *Economics, Psychology, and Protective Behavior*, 68 AM. ECON. REV. 64, 67 (May 1978).

default rules[114] are unlikely to find much in the thousands of law review pages to help with a project of judicial construction of off–the–rack gap fillers to supplement the parties' agreement in fact. "Whatever is, is efficient"[115] is one way out of the dilemma, but those who refuse to subscribe to such simple verities are unlikely to find in any of the contending theories of default rules[116] anything useful to say about whether damage to the front of an insured auto caused by striking a deer should be covered under the "collision" or "other than collision" coverage of a personal auto policy.

In practice, then, even the most aggressive of the insurance law analogs to the "hypothetical contract" literature do not try to build the undickered

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114. For less–than–sanguine evaluations of that competence, see TREBILCOCK, *supra* note 110, at 101; Richard Craswell, *Remedies When Contracts Lack Consent: Autonomy and Institutional Competence,* 33 OSGOODE H. L.J. 209 (1995); Gillian K. Hadfield, *Judicial Competence and the Interpretation of Incomplete Contracts*, 23 J. LEG. STUD. 159 (1994).

115. The phrase is attributed to Armen Alchian by John Lott, *In Celebration of Armen Alchian's 80th Birthday: Living and Breathing Economics*, 34 ECON. INQ. 412, 413 (1996).

116. Prescriptions include gap–filling default rules designed variously to "mimic the market," *e.g.*, Robert E. Scott, *A Relational Theory of Default Rules for Commercial Contracts*, 19 J. LEGAL STUD. 597 (1990); David Charny, *Hypothetical Bargains: The Normative Structure of Contract Interpretation*, 89 MICH. L. REV. 1815 (1991); to reflect "communitarian values," *e.g.*, Steven J. Burton, *Default Principles, Legitimacy, and the Authority of a Contract*, 3 S. CAL. INTERDISC. L.J. 115, 116–17 (1993); Jay M. Feinman, *Critical Approaches to Contract Law*, 30 UCLA L. REV. 829, 858 (1983); to recognize "norms implicit in the parties' relationship" to "avoid contractual breakdown," *e.g.*, Ian R. Macneil, *Contracts: Adjustment of Long–Term Economic Relations Under Classical, Neo–classical, and Relational Contract Law*, 72 NW. U. L. REV. 854 (1978); and to create incentives to induce potential contracting parties to disclose asymmetrically–distributed information. *E.g.*, Ian Ayres & Robert Gertner, *Filling Gaps in Incomplete Contracts: An Economic Theory of Default Rules,* 99 YALE L.J. 87 (1989).

For skepticism about the possibility of any overarching approach, and insistence on the importance of contextual issues, see Dennis Patterson, *The Pseudo–Debate Over Default Rules in Contract Law,* 3 S. CAL. INTERDISC. L.J. 235 (1993) (characterizing literature of default rules as pseudo debate posing old questions in language of other disciplines); Todd D. Rakoff, *Social Structure, Legal Structure, and Default Rules: A Comment,* 3 S. CAL. INTERDISC. L.J. 19 (1993) (emphasizing need for contextualization); W. David Slawson, *The Futile Search for Principles for Default Rules*, 3 S. CAL. INTERDISC. L.J. 29 (1993) ("Default rule analysts have contributed nothing new to the subject except the new word they have coined for it.").

portions of insurance contracts from scratch. Instead, they assume, more or less explicitly, that the policy must be the starting point for determining the contours of the insurance contract,[117] and that the "reasonable expectations" to be vindicated must be Llewellynesque generalized expectations that policy provisions will be neither unfairly surprising nor surprisingly unfair.[118] Now

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117. *See, e.g.*, RESTATEMENT (SECOND) OF CONTRACTS § 211 (1) (1981):

> Except as stated in Subsection (3), where a party to an agreement signs or otherwise manifests assent to a writing and has reason to believe that like writings are regularly used to embody terms of agreements of the same type, he adopts the writing as an integrated agreement with respect to the terms included in the agreement.

118. In Karl Llewellyn's familiar formulation:

> What has in fact been assented to, specifically, are the few dickered terms, and the broad type of the transaction, and but one thing more. That one thing more is a blanket assent (not a specific assent) to any not unreasonable or indecent terms the seller may have on his form, which do not alter or eviscerate the reasonable meaning of the dickered terms.

KARL N. LLEWELLYN, THE COMMON LAW TRADITION: DECIDING APPEALS 370 (1960). *See also* Karl N. Llewellyn, *The Standardization of Commercial Contracts and Continental Law*, 52 HARV. L. REV. 700 (1939) (book review). The policing function prescribed by Llewellyn finds somewhat circumspect expression in RESTATEMENT (SECOND) OF CONTRACTS § 211(3) (1981): "Where the other party has reason to believe that the party manifesting such assent would not do so if he knew that the writing contained a particular term, the term is not a part of the agreement." The critical explanation is provided in *Comment f:*

> *f. Terms excluded.* Subsection (3) applies to standardized agreements the general principles [governing interpretation of contracts]. Although customers typically adhere to standardized agreements and are bound by them without even appearing to know the standard terms in detail, they are not bound to unknown terms which are beyond the range of reasonable expectation. . . . [A] party who adheres to the other party's standard terms does not assent to a term if the other party has reason to believe that the adhering party would not have accepted the agreement if he had known that the agreement contained the particular term. Such a belief or assumption may be shown by the prior negotiations or

that most jurisdictions have abandoned jejune flirtations with enforcing only provisions about which the insured had actual subjective knowledge,[119] the outside possibility that a court might excise a provision of a standard insurance policy form on the grounds that it was unexpected is unlikely to put most standard form provisions in much jeopardy.[120] In the absence of any real expectations on the part of insureds about most of the subjects treated by standard insurance policy forms, the search for the unexpected almost inevitably will be degraded into a search for the extraordinary, and standardized forms are hardly the place to go prospecting for anything other than the ordinary.

Thus, even in jurisdictions where some version of the Doctrine of Reasonable Expectations is in full flower, there are good reasons not to embrace law student enthusiasms for a project of distinguishing among most standard insurance policy form provisions on the basis of the quality of the insured's assent. The Doctrine of Reasonable Expectations can be put to many uses, but refusing to enforce a policy provision because the insured did not know it was there or did not understand its purport should not be among them.[121] We know that the rodent–damage exception in a homeowners policy

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> inferred from the circumstances. Reason to believe may be inferred from the fact that the term is bizarre or oppressive, from the fact that it eviscerates the non–standard terms explicitly agreed to, or from the fact that it eliminates the dominant purpose of the transaction.

For a skeptical review of the limited use (and misuse) of § 211(3) in insurance decisions, see James J. White, *Form Contracts under Revised Article 2*, 75 WASH. U. L.Q. 315 (1997).

119. The highwater mark for this approach may have been *Hionis v. Northern Mutual Insurance Co.*, 230 Pa. Super. 511, 327 A.2d 363 (1974). The Pennsylvania court backed away from the implications of this approach in *Standard Venetian Blind Co. v. American Empire Insurance Co.*, 503 Pa. 300, 469 A.2d 563 (1983).

120. *See generally* Abraham, *supra* note 101 (cataloging variety of functions to which "Doctrine of Reasonable Expectations" can be put); Henderson, *supra* note 101 (similar project).

121. No one has improved on Professor Leff's characteristically pointed comment about such projects: "[D]eal control is ordinarily a stupid option; it is silly to seek to shape and control the contours of a process that does not take place." Arthur Allen Leff, *Contract as Thing*, 19 AM. U. L. REV. 131, 148 (1970). The problem, Leff argued, is that "so long as one is bemused by the word 'contract,' even

will be treated as an effective part of the integrated agreement of the parties even though we also know that the insured may not have been aware of the exclusion, usually will have no effective understanding of how it is affected by concurrent causation analyses, and as a practical matter could not have contracted to allocate the risk of squirrel damage to the insurer. So too will virtually every other provision to be found in insurance policy forms. And yet, experienced insurance lawyers will acknowledge, some of the provisions we are considering are more likely to receive rough treatment from judges than are others. Distinctions do get made. How should we make them?

2. Policing Against Opportunism?

The answer will not become truly accessible until we move beyond reflexive bargain–model ways of thinking about insurance contracts and begin to confront the implications of the neo–institutional claim that—in Williamson's trenchant phrase—"*ex post* support *institutions* of contract *matter*."[122] Neo–institutional economics incorporates into its models not only "bounded rationality" but also recognition that "some individuals are opportunistic some of the time and that differential trustworthiness is rarely transparent *ex ante*,"[123] and thus takes as part of its task to identify and to explore contract institutions that find their explanations in efforts to control opportunism by contracting parties.[124] For the neo–institutional economist working in the intersection of law, economics, and organization theory, the principal concern is to identify the conditions under which opportunism is most likely to occur and to match transaction types with the most appropriate mode of governance. For those who come to such questions from the legal side of the disciplinary divide, the agenda is the same: to determine when a combination of bounded rationality and transaction specific investments will create the potential for opportunism and to determine which institutional

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when it is intelligently modified by the cognomen 'adhesion,' it is likely that one will sometimes seek to impress his controls on a process which does not exist." *Id.* at 149.

122. WILLIAMSON, *supra* note 95, at 29 (emphasis in original).

123. *Id.* at 64 (emphasis in original).

124. "Taken together, the overall import of bounded rationality and opportunism for transaction cost economics is this: organize transactions so as to economize on bounded rationality while simultaneously safeguarding the transactions in question against the hazards of opportunism." OLIVER E. WILLIAMSON, THE MECHANICS OF GOVERNANCE 48 (1996). For an examination of private enforcement activities outside "the shadow of the law," see Edward L. Rubin, *The Nonjudicial Life of Contract: Beyond the Shadow of the Law*, 90 NW. U. L. REV. 107 (1995).

devices[125] offer the best protections against opportunism in contract negotiation,[126] performance,[127] and enforcement.[128]

In insurance, of course, it is not hard to find both industry practices and legal techniques that are prompted by concerns about effects of opportunism. Because asymmetric information renders insurers vulnerable to fraud and misrepresentation, adverse selection, and moral hazard,[129] insurers employ a battery of pre–issuance underwriting procedures designed to allow them to be selective about those with whom they will contract, buttress those with

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125. The case against "single institutionalism" is put most effectively in NEIL A. KOMESAR: IMPERFECT ALTERNATIVES: CHOOSING INSTITUTIONS IN LAW, ECONOMICS & PUBLIC POLICY (1994). For a quick introduction to the basic argument, see Neil A. Komesar, *Exploring the Darkness: Law, Economics, and Institutional Choice,* 1997 WIS. L. REV. 465; David A. Luigs, *Imperfect Alternatives: Choosing Institutions in Law, Economics, and Public Policy,* 93 MICH. L. REV. 1559 (1995) (book review). Although comparative institutionalism in the legal academy often poses the choices as between markets or legislative or judicial control, private ordering though contracts and organizational form also should be counted among the contenders. *See, e.g.*, Palay, *supra* note 108, at 931–32:

> In contrast to the traditional economics approach which always finds the necessary binding mechanisms [to hold the agreement together] in markets or legal orderings, the relational contracting and transaction cost approach argues that the relational glue sometimes is supplied by private orderings, that is, through the efforts and expenditures of the parties themselves . . . .

126. *See generally* G. Richard Shell, *Opportunism and Trust in the Negotiation of Commercial Contracts: Toward a New Cause of Action*, 44 VAND. L. REV. 221 (1991); Juliet P. Kostritsky, *Bargaining with Uncertainty, Moral Hazard, and Sunk Costs: A Default Rule for Precontractual Negotiations*, 44 HASTINGS L.J. 621 (1993).

127. *See generally* Steven J. Burton, *Breach of Contract and the Common Law Duty to Perform in Good Faith,* 94 HARV. L. REV. 369 (1980); Robert S. Summers, *The General Duty of Good Faith—Its Recognition and Conceptualization*, 67 CORNELL L. REV. 810 (1982).

128. *See generally* STEVEN J. BURTON & ERIC G. ANDERSEN, CONTRACTUAL GOOD FAITH: FORMATION, PERFORMANCE, BREACH, ENFORCEMENT chs. 5–7 (1995).

129. *See generally* KENNETH J. ARROW, ESSAYS IN THE THEORY OF RISK BEARING 142–43 (1971); CAROL HEIMER, REACTIVE RISK AND RATIONAL ACTION: MANAGING MORAL HAZARD IN INSURANCE CONTRACTS (1985); Michael Rothschild & Joseph E. Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q. J. ECON. 629 (1976).

contractual provisions designed to control the insurer's exposure to other potential sources of claims on the insurance fund, and reinforce those efforts with post–loss claims adjustment techniques designed to ferret out fraud and limit loss adjustment costs. Insurance law provides the underpinnings for such insurer efforts with the principle of *uberrimae fideii* and other doctrinal devices for protecting insurers against the dangers of dealing with insureds with power to behave opportunistically.[130]

Both insurance economics and insurance law historically have tended to emphasize the potential that insurers may be victimized by opportunism on the part of insureds.[131] However, in recent decades discussions have broadened to include consideration of how best to deter opportunistic behaviors on the part of insurers. Can traditional contract damages measures and concern for reputational effects really be expected to deter opportunistic breaches by insurers?[132] Or is their force significantly undercut by "legal

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130. *See generally* Hugh Gravelle, *Insurance Law and Adverse Selection,* 11 INT'L REV. L. & ECON. 23 (1991); THE NEW PALGRAVE DICTIONARY OF ECONOMICS AND THE LAW 344 (Peter Newman, ed. 1998).

131. Richard Epstein captures the dominant perspective this way:

> The English developed a law of marine insurance, and its content was shaped by the 19th century judicial presumption of distrust. The party to an insurance contract about which the Courts were most sceptical [sic] was not the rich and powerful insurance company, but rather the insured party. It is not difficult to see why. The insured was in possession of the property, and had the lion's share of the information about the nature of the risks that were being run.

Richard Epstein, *Do Judges Need to Know Any Economics?*, 1996 NEW ZEALAND L.J. 235, 236. *Cf.* Harris Schlesinger, *Uncommon Knowledge: Bilateral Asymmetry of Information in Insurance Markets*, RISK MGM'T & INS. REV., Vol. 1, No. 2, p. 1 (noting that classic treatments of imperfect information in insurance markets all focus on insureds' private information about their own loss probabilities, and decrying lack of work on how insurers' private information affects markets for insurance).

132. "In many transactional settings, promises are kept for reasons wholly unrelated to the existence of a legally enforceable contract." Lisa Bernstein, *Social Norms and Default Rules Analysis*, 3 S. CAL. INTERDISC. L.J. 59, 67 (1993). *See also* David Charny, *Nonlegal Sanctions in Commercial Relationships*, 104 HARV. L. REV. 375 (1990); Oliver E. Williamson, *Credible Commitments: Using Hostages to Support Exchange*, 73 AM. ECON. REV. 519 (1993). Muris, *supra* note 95, at 526–528, summarizes the literature on "non–contract solutions to the opportunism problem" as

efficiencies of scale" enjoyed by mass–contracting insurers[133] and by the difficulties consumers experience when they try to determine the "claims

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1) reputation; 2) price adjustments to recognize effects of opportunism or to create incentives to not shirk; 3) vertical integration; 4) precision in contract language to make opportunistic behaviors more clearly breaches of contract. Of course, as he notes, *id.* at 527, "[e]ach of these methods . . . will fail to deter opportunism in some situations." Insurance often is one of those situations. Although insurers are repeat players who must be concerned about consumer perceptions, individuals only infrequently have claims, and when insurers do resist claims, it is often difficult to determine whether or not the resistance was justified.

133. When the other party is a "mass contractor," the usual damage rules often operate to provide even less deterrence to unwarranted breaches:

> Since a mass contractor *is* a mass contractor, he will have had sufficient legal business both in and out of court to have at least one lawyer, and frequently a battery of lawyers, already familiar with his business, with the fields of law to which it pertains, and with his standard forms. Familiarity with the standard forms is particularly important. An attorney for an insurance company, for example, will know the clauses of the policy virtually by heart and will have available detailed legal memoranda already composed, providing all the pertinent law on the interpretation and probable enforcement of each clause. These legal efficiencies of scale not only significantly reduce the mass contractor's average cost; they lower the marginal cost of each case to nearly zero. . . . Thus, the mass contractor's attitude toward each particular case is likely to be, "Of course, we'll fight it. We're already tooled up and ready to go, so fighting it will cost us only X dollars—perhaps zero dollars—more than if we don't.

Slawson, *supra* note 107, at 29-30. *See also* STEMPEL, *supra* note 103, at § 19.3; at 466–67 ("[I]nsurers always get to 'play the float' in any dispute."); Mark Pennington, *Punitive Damages for Breach of Contract: A Core Sample From the Last Ten Years*, 42 ARK. L. REV. 31, 54 (1989) ("Insurance is far from the market ideals of complete information and no transaction costs. Opportunistic breaches are especially likely, and traditional damage rules do not sufficiently deter them.").

> With regard to claims for small amounts of money, the insurance company has some incentive to refuse payment because little likelihood exists that the claimant will pursue the claim. As for large claims, the insurance company may find it profitable to delay payment as long as possible to keep for itself the time value of the

service quality" of competing insurers?[134] Unfair claims practices statutes, prejudgment interest, statutory provisions for attorney's fees for insureds who successfully pursue coverage litigation against insurers, mutualization, and—especially—the emergence of theories for imposing extra–contractual liability on insurers who in bad faith drag their heels in paying claims or performing their defense or other obligations all can be understood as reactions to the threat of insurer opportunism.[135]

What does all this have to do with how we should regard different sorts of policy provisions purporting to allocate risks between insurer and insured? Unfortunately, for most involved in insurance litigation, the answer remains less than obvious. Say "bad faith" to an insurance lawyer, and you suggest the possibility of extra–contractual liability,[136] usually sounding in tort, and provoke worries about how best to keep the concept from metastasizing

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> amount due. Finally, prolonged delays in payment may make the insured more willing to settle for less than the amount due, particularly if the insured is financially desperate.

Id. at 53–4. The problem is not limited to claims by the small or the unsophisticated; in the words of the chairman of Dow Corning Corporation, "it has become standard operating procedure for some insurance companies to procrastinate and dispute rather than honor policies with companies that become embroiled in litigation." Richard Hazleton, *The Tort Monster That Ate Dow Corning*, WALL ST. J., May 17, 1995, at A21.

134. In some economic modeling, a lower quality insurance product is equated with a higher risk of default—through insolvency, or bad claims service. *See, e.g.*, Marla Stafford & Brenda Wells, *Service Quality in the Insurance Industry: Consumer Perceptions Versus Regulatory Perceptions*, 13 J. INS. REG. 462 (1995); Marla Stafford & Brenda Wells, *The Effect of Demographic Variables on Perceived Claims Service Quality*, 19 J. INS. ISSUES 163 (1996). For an important theoretical and empirical challenge to the "assumption that the market treats all alike," see Tom Baker & Karen McElrath, *Whose Safety Net? Home Insurance and Inequality*, 21 L. & SOC. INQ. 229 (1996) (documenting importance of adjuster discretion in claim settlement processes and outcomes).

135. S*ee generally* Gary Schuman, *The Covenant of Good Faith and Fair Dealing: Responsibilities of First–Party Insurers*, 47 FED. INS. & CORP. COUNS. 107 (1997) (explaining that competition does not protect insureds in claims context because insured no longer can take business of covering that risk to another insurer); William T. Barker et al., *Is An Insurer a Fiduciary To Its Insureds?*, 25 TORT & INS. L.J. 1, 8 (1989) (same).

136. *See generally* Ashley, *supra* note 104; Shernoff, *supra* note 104; The Law of Bad Faith in Contract and Insurance, *supra* note 104.

beyond its proper role as an incentive for insurers to promptly perform contractual obligations that clearly are owing.[137] Suggest that the implied obligation of good faith also imposes limits on when an insurer may invoke a failure of condition as a basis for refusing to perform or that hard–nosed insistence on the letter of the policy should be branded "opportunism," and at best you provoke head–shaking and politely–suppressed condemnation of the unworldliness of fuzzy–headed academics.[138] But, as Professor Eric Andersen most forcefully has argued, both the *Uniform Commercial Code* and the *Restatement* make clear that the good faith obligation implicit in contracts of all kinds operates as a restraint not just on opportunistic efforts to avoid clear–cut performance obligations, but also as a restraint on bad faith in the exercise of discretion granted by enforcement terms. Professor Andersen's gloss on the statutory and *Restatement* language, featured in a law review article[139] and more recently in his treatise on bad faith,[140] may not be

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137. *See, e.g.,* Alan O. Sykes, *"Bad Faith" Breach of Contract by First–Party Insurers*, 25 J. LEGAL STUD. 405 (1996); Alan O. Sykes, *Judicial Limitations on the Discretion of Liability Insurers to Settle or Litigate: An Economic Critique,* 72 TEX. L. REV. 1345 (1994).

138. In the conventional understanding, there can be no bad faith tort liability in the absence of coverage. *See, e.g.,* Schuman, *supra* note 135, at 115–118 (reviewing authorities).

139. Eric G. Andersen, *Good Faith in the Enforcement of Contracts*, 73 IOWA L. REV. 299 (1988). In Andersen's view,

> an enforcement term may be invoked only if, under the circumstances existing at the time enforcement is sought, the term would advance the purposes for which it was included in the agreement without imposing needless costs on the nonenforcing party. If that test is not satisfied, the benefits of the term should not be available to the party seeking them, even though inclusion of the term was unobjectionable when the contract was formed.

Id. at 301. Andersen emphasizes the difference between this "good faith in enforcement" obligation and standards of conduct required in order to avoid liability for tortious bad faith:

> Making effect rather than motive the touchstone of good faith in enforcement does not make the good faith doctrine a miserly one. To the contrary, it makes the doctrine more generous. The costs imposed when enforcement is inconsistent with the agreement's purposes are no more necessary or less expensive because they are

part of the stock in trade of most lawyers, but in fact if not in name[141] both the general law of contracts and the law of insurance are full of examples of doctrinal devices for policing exercise of discretion to employ enforcement mechanisms apparently authorized by the contract.[142] In the general law of

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> sought innocently rather than with malice. Thus, good faith in enforcement not only embraces the notions of "decency, fairness or reasonableness" by responding to the harm caused by malicious invocation of an enforcement term, it also covers those situations in which such a term would accomplish something other that what it was intended to do, even though the enforcing party invoked it in the honest belief that it was appropriate to do so.

Id. at 324.

140. *See* BURTON & ANDERSEN, *supra* note 128.

141. *See id.* at 271 (good faith in enforcement is "an emerging doctrine. Evidence of its influence is widespread, yet it is overtly applied in relatively few cases."). Andersen, *supra* note 139, at 301, says:

> The doctrine accounts for many cases in which courts have, or should have, declined to enforce an express contractual condition and illustrates that a number of decisions in which courts have cited public policy reasons for refusing to enforce a contract can be justified more satisfactorily by a good faith doctrine that respects, rather than trumps, freedom of contract.

142. Other useful explorations of this theme include Thomas A. Diamond & Howard Foss, *Proposed Standards for Evaluating When the Covenant of Good Faith and Fair Dealing Has Been Violated: A Framework for Resolving the Mystery*, 47 HASTINGS L.J. 585, 609–12 (1996) ("failure to utilize a less harsh alternative"as bad faith); Eisenberg, *supra* note 93; Mark P. Gergen, *A Defense of Judicial Reconstruction of Contracts*, 71 IND. L.J. 45, 46 (1974) (when "terms malfunction because of the unexpected," interpretive techniques must include "judicial reconstruction" of the contract to prevent opportunism and to vindicate the "principle of loss alignment [which] relieves a party from a significant and unexpected loss under a contract when such relief would leave the other party in a position no worse than she would have been in had the contract not been made"); Muris, *supra* note 95; Dennis M. Patterson, *A Fable from the Seventh Circuit: Frank Easterbrook on Good Faith*, 76 IOWA L. REV. 503 (1991) (good faith polices manner in which contract rights are exercised); Alan Schwartz, *Relational Contracts in the Courts: An Analysis of Incomplete Agreements and Judicial Strategies*, 21 J. LEGAL STUD. 271, 313 (1992)) ("Process values are offended . . . [if] the other party relies on minor contract technicalities to breach in bad faith or extort a more favorable performance.").

contracts, these efforts range from the mundanely familiar (constructive conditions[143] and the mitigation principle[144]) through the familiar but controversial (the rules against enforcing penalties[145] and regulating the use of limited remedies[146]) to more exotic and controversial applications of the bad faith principle (lender liability[147] and employer liability for strategic

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143. *See generally* Edwin W. Patterson, *Constructive Conditions in Contracts*, 42 COLUM. L. REV. 903, 926–28 (1942) (role of constructive conditions in avoiding forfeitures and unjust enrichment); Rakoff, *supra* note 113 (sensitivity of gap–filling constructive conditions to differences in context at time of performance).

144. *See generally* RESTATEMENT (SECOND) OF CONTRACTS § 350 (1981); U.C.C. § 2–708(1) (1977); Goetz & Scott, *supra* note 107.

145. *See generally* RESTATEMENT (SECOND) OF CONTRACTS § 356 (1) (1981); U.C.C. § 2–718(1) (1977). Andersen summarizes this way:

> [W]hen a contract is enforced through the invocation of a liquidated damages clause, the law requires the same accommodation of the parties' interests that is made under the common–law damages remedy. The enforcing party's expectation interest will be protected, but only in a way and to an extent that eliminates unnecessary costs to the breaching party.

Andersen, *supra* note 139, at 310. Under the traditional formulation of the anti–penalty rule, the measure of any disproportion compares the agreed sum with the damages anticipated at the time of contracting. 5A ARTHUR LINTON CORBIN, CORBIN ON CONTRACTS § 1059 (1964). That understanding has been relaxed in the modern *UCC* and *Restatement* provisions allowing the injured party to save a liquidated damages provision by showing that it was proportional to actual damages. *See* Melvin A. Eisenberg, *Comment, Liquidated Damages: A Comparison of the Common Law and the Uniform Commercial Code*, 45 FORDHAM L. REV. 1349, 1353–58 (1978). For a sense of the controversy penalty rules inspire, *compare* Eisenberg, *supra* note 93, and Gergen, *supra* note 142, *with* Charles J. Goetz & Robert E. Scott, *Liquidated Damages, Penalties and the Just Compensation Principle: Some Notes on an Enforcement Model and a Theory of Efficient Breach*, 77 COLUM. L. REV. 554 (1977), and Alan Schwartz, *The Myth That Promisees Prefer Supracompensatory Remedies: An Analysis of Contracting for Damage Measures*, 100 YALE L.J. 369 (1990).

146. *See generally* U.C.C. § 2–719 (1977); Jon Eddy, *On the "Essential" Purposes of Limited Remedies: The Metaphysics of UCC Section 2–719(2)*, 65 CAL. L. REV. 28 (1977).

147. *See generally* Daniel R. Fischel, *The Economics of Lender Liability*, 99 YALE L.J. 131, 139 (1989); Gillette, *supra* note 109; William H. Lawrence & Robert

violation of the implicit norms of internal labor markets[148]). In insurance, "the competing goals of contract enforcement: securing to the injured party the benefits of its bargain and avoiding the imposition of unnecessary costs on the breaching party"[149] have been forced to play out differently, but many otherwise inexplicable features of the insurance terrain reflect a common preoccupation with policing against opportunism by insurers in the use of failure of condition defenses apparently authorized by contract.

Thus, I will argue, when viewed through this neo-institutional lens, insurance contracts pose special problems for insureds not only because they often are embodied in standard policy forms full of provisions dealing with low-salience, low-probability contingencies—that can be said of many, perhaps most, contracts encountered in a modern mass economy[150]—but because three features of insurance contracts tend to make the insured especially vulnerable to opportunistic behavior on the part of the insurer. Put simply, because the obligations of parties to an insurance contract will be performed sequentially, if at all, the insured is vulnerable to opportunistic decisions by insurers that sometimes may produce disproportionate forfeitures. Because insurance contracts are full of express conditions, there is little room for creative use of constructive conditions to ameliorate that vulnerability. And because insurance contracts are aleatory, restitution is not available as a device for ameliorating the insured's vulnerability. The point is central enough—and, in the context of modern insurance law, unfamiliar enough—to warrant making it in some detail.

D. Wilson, *Good Faith in Calling Demand Notes and in Refusing to Extend Additional Financing*, 63 IND. L.J. 825 (1988).

148. *See generally* PAUL C. WEILER, GOVERNING THE WORKPLACE: THE FUTURE OF LABOR AND EMPLOYMENT LAW 63–67 (1990); Stewart J. Schwab, *Life-Cycle Justice: Accommodating Just Cause and Employment at Will*, 92 MICH. L. REV. 8 (1993).

149. Andersen, *supra* note 139, at 301.

150. For an early influential introduction, see Matthew O. Tobriner & Joseph R. Grodin, *The Individual and the Public Service Enterprise in the New Industrial State*, 55 CAL. L. REV. 1247 (1967).

B. The Special Vulnerability of the Insured to Insurer Opportunism

1. Ameliorating Techniques Available for Most Non–Insurance Contracts

Consider the following conditional promises to pay money, each in its own way a familiar part of the contracts canon: various promisors undertake to pay, respectively, *IF* (1) a promisee delivers a specific horse; or (2) a promisee constructs a mansion according to specifications; or (3) a promisee works for 12 months; or (4) an insured suffers a covered loss to covered property.

Scenario 1. Sale of Goods: Vulnerability Avoided by Concurrent Performances. A dusty crossroads sale: seller promises to deliver a particular horse; buyer promises to pay the specified price. Seller then fails to perform. Must buyer nonetheless pay?

Of course not, at least not since *Kingston v. Preston.*[151] Such a result would "outrage common sense,"[152] for we understand that the "parties contemplate not merely an exchange of their mutual promises, but also an exchange of the two performances that are being promised."[153] Indeed, if we imagine our hypothetical to be peopled by the rugged individualists of the great American horse–trading tradition, we do not really anticipate that they will be asking a court for guidance about how to flesh out their incompletely–specified one–time spot market exchange. Instead, we expect the seller to hold tightly to the reins until satisfied that she is receiving the payment she was promised, and we expect the buyer to part with his money only when the reins are firmly in hand. But should the parties fail to make this relationship between their performances clear, the law will supply gap–filling constructive concurrent conditions of exchange to assure that neither party is rendered too vulnerable to nonperformance by the other. True, if the buyer breaches, the seller may lose the value of her expectancy, but she still has her horse and still can go back into the market in search of an alternative buyer; if the seller breaches, the buyer may lose his expectancy, but he still has his money to spend at the local sale barn. By structuring perfect tender of the performances as concurrent conditions of exchange — either expressly, or with the help of judicially–supplied gap fillers—forfeitures can be avoided

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151. 2 Dougl. 689, 99 Eng. Rep. 437 (K.B. 1773).

152. Goodison v. Nunn, 4 T.R. 761, 764, 100 Eng. Rep. 1288, 1289 (K.B. 1792) (Lord Kenyon).

153. 3A CORBIN, *supra* note 145, § 728, at 399–400.

even without judicial intervention and neither side will be vulnerable to loss of more than the benefit of the bargain.

Thus, the great American horse trading tradition can work well enough when we are trading horses in spot market transactions structured to guarantee concurrent performances. But, as noted by observers ranging from Thomas Hobbes[154] and Arthur Allen Leff[155] to Danny Manning[156] and John Grisham,[157] with sequential performances comes vulnerability to opportunistic behavior. If sequential performances cannot be avoided, what then?

Scenario 2. Construction Contract: Vulnerability Due to Sequential Performances Ameliorated by the Doctrine of Substantial Performance. A construction contract: Jacob & Youngs promises to build a mansion for Kent according to detailed specifications, including a requirement that the

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154. "He that performeth first, has no assurance the other will perform after; because the bonds of words are too weak to bridle men's ambition, avarice, anger, and other passions, without the fear of some coercive Power." THOMAS HOBBES, LEVIATHAN 89–90 (Oxford ed. 1955) (first published in 1651).

155. "Under the American law of contracts, after the other party has fully performed his obligation, it is absolutely irrational for you fully to perform yours." Arthur Allen Leff, *Injury, Ignorance, and Spite — The Dynamics of Coercive Collection*, 80 YALE L.J. 1 (1970). In insurance, the most trenchant statements of the point have come from W. David Slawson:

> In reality, an insurer, or any other mass contractor whose obligation is to pay money, normally is not liable for any *damages* for breach of contract. All that he is liable for is to *perform* the contract. If criminal law or tort law worked the same way, the only penalty imposed on a driver who hit a pedestrian on a crosswalk would be to require the driver to back up and drive over the crosswalk again, this time without hitting the pedestrian.

Slawson, *supra* note 107, at 7.

156. "An insurance policy is just a lawsuit. You think they just hand over the money?" *Quoted in* Harvey Araton, *On Pro Basketball: Choosing the Soft Life Over the Good Life*, N.Y. TIMES, Dec 9, 1994, at B11.

157. In *The Rainmaker*, John Grisham imagines an insurer that initially denies all claims on the assumption that most claimants will never find their way to a lawyer. JOHN GRISHAM, THE RAINMAKER 313–16, 361–62 (1995). For a critical review from a legal perspective, see Alan I. Widiss, *"Bad Faith" in Fact and Fiction: Ruminations on John Grisham's Tale About Insurance Coverages, Punitive Damages, and the Great Benefit Life Insurance Company*, 26 U. MEM. L. REV. 1377 (1996).

plumbing be built of Reading Pipe; Kent promises to pay. The contract limits the occasions for opportunism by providing for a series of progress payments conditioned upon successful completion of stages of construction, but this simple self-help device cannot solve the "last period problem."[158] Kent moves into the completed house without much incentive to make the last progress payment, and six months after taking possession, his architect emerges from the basement with the good news: some of the pipe installed by Jacob & Youngs was Cohos Pipe rather than Reading Pipe. "Aha," we imagine lawyer Kent thinking to himself, "under the rule of *Kingston v. Preston*, I need not make the final payment because use of Reading Pipe was a condition precedent to my duty to pay."

"Wrong," Judge Cardozo informed Kent and succeeding generations of lawyers.[159] Not every breach of a performance obligation will excuse the

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158. For a helpful introduction to "last period" problems, see Muris, *supra* note 95, at 528 ("non-contract law solutions to the opportunism problem" less likely to be effective when "parties appear unlikely to contract with each other in the future").

159. Jacob & Youngs v. Kent, 129 N.E. 889 (N.Y. 1921). Although contracts students often cut their substantial performance eye teeth on *Jacob & Youngs v. Kent,* in fact the roots of the doctrine were planted only four years after *Kingston v. Preston* in *Boone v. Eyre*, 126 Eng. Rep. 160(a) (K.B. 1777). "[W]here a breach may be paid for in damages," Lord Mansfield opined, "there the [buyer] has a remedy on his covenant, and shall not plead it as a condition precedent." *Id.* Cardozo covered the same ground:

> Some promises are so plainly independent that they can never by fair construction be conditions of one another. Others are so plainly dependent that they must always be conditions. Others, though dependent and thus conditions when there is departure in point of substance, will be viewed as independent and collateral when the departure is insignificant. Considerations partly of justice and partly of presumable intention are to tell us whether this or that promise shall be placed in one class or in another. . . .
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> . . . .
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> We must weigh the purpose to be served, the desire to be gratified, the excuse for deviation from the letter, the cruelty of enforced adherence. Then only can we tell whether literal fulfillment is to be implied by law as a condition. This is not to say that the parties are not free by apt and certain words to effectuate a purpose that performance of every term shall be a condition of recovery. That question is not here. This is merely to say that the law will be slow to impute the purpose, in the silence of the parties, where the

other party's obligation to perform. Because the parties had not unequivocally made compliance with the Reading pipe specification an express condition precedent to Kent's obligation to pay, there was room for Cardozo to fill the gap with a constructive condition requiring only "substantial performance." Of course, Cardozo was able to assure us:

> The courts never say that one who make a contract fills the measure of his duty by less than full performance. They do say, however, that an omission, both trivial and innocent, will sometimes be atoned for by allowance of the resulting damage, and will not always be the breach of a condition to be followed by a forfeiture.[160]

Though the parties remain "free by apt and certain words to effectuate a purpose that performance of every term shall be a condition of recovery . . . the law will be slow to impute the purpose, in the silence of the parties, where the significance of the default is grievously out of proportion to the oppression of the forfeiture."[161] Thus, Cardozo was able to conclude, the constructive condition precedent to Kent's duty to pay had been satisfied, and Kent's remedy for failure to use Reading Pipe was limited to a claim for damages.[162]

> significance of the default is grievously out of proportion to the oppression of the forfeiture.

Jacob & Youngs v. Kent, 129 N.E. 889, 890–91 (N.Y. 1921) (citations omitted). *See generally* RESTATEMENT (SECOND) OF CONTRACTS § 241 (1981) (factor analysis for determining when performance is substantial). *See also* RICHARD DANZIG, THE CAPABILITY PROBLEM IN CONTRACT LAW 108–28 (1978) (details of *Jacob & Youngs* litigation); Patterson, *supra* note 143, at 926–28 (role of constructive conditions in avoiding forfeitures and unjust enrichment).

160. Jacob & Youngs v. Kent, 129 N.E. at 890.

161. *Id.* at 891.

162. Goetz and Scott employ a more modern vocabulary to describe the doctrine of substantial performance:

> The rule of substantial performance—or material breach—assures the breacher of his accrued contractual gains whenever the tender is consistent with the overall scheme of the contract, although deficient in some particulars. The doctrine expands the duty to mitigate in specialized environments by requiring the mitigator to

Scenario 3. Employment Contract: Vulnerability Due to Sequential Performances Ameliorated by Restitution. A simple employment contract: Britton promises to work for Turner for one year; Turner promises to pay Britton $120 upon completion of the work. Britton works for nine and a half months, but then breaches his obligation to complete the contract. May Britton nonetheless recover from Turner?

Indeed, Judge Parker told us in 1834,[163] he may. True, "the law will not imply and make a contract different from that which the parties have entered into,"[164] completion of the labor was a condition precedent to Turner's contractual duty to pay, and "[i]t is clear, then, that he is not entitled to recover upon the contract itself."[165] But, concluded the *Britton* court, off the contract, in restitution, things could be different: "[I]f . . . a party actually receives labor . . . and thereby derives an advantage, over and above the damage which has resulted from the breach of the contract by the other party, . . . the law thereupon raises a promise to pay to the extent of such excess."[166] By beginning performance, the court emphasized, Britton had placed himself in "a much worse situation than he who wholly disregards his contract";[167] nine and one–half months into the transaction Turner had

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> accept a deficient performance, together with objectively measured damages.
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> . . . .
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> The substantial performance doctrine reduces opportunistic claims by softening the breacher–nonbreacher distinction, thereby removing opportunities to exploit inadvertent breaches. Such a rule is sensible in cases such as construction contracts where the circumstances suggest that renegotiation costs will be substantial. Once construction is underway, the alternatives for both parties become inferior to the existing relationship . . . .

Goetz & Scott, *supra* note 107, at 1009–10.

163. Britton v. Turner, 6 N.H. 481 (1834).

164. *Id.* at 491.

165. *Id.* at 486.

166. *Id.* at 492.

167. *Id.* at 487.

> A party who contracts to perform certain specified labor, and who breaks his contract in the first instance, without any attempt to perform it, can only be made liable to pay the damages which the other party has sustained by reason of such non performance,

already received "nearly five–sixths of the value of a whole year's labor."[168] Any prejudice to Turner caused by Britton's early departure could simply be accounted for in the calculation of the amount of Turner's unjust enrichment.[169]

> which in many instances may be trifling—whereas a party who in good faith has entered upon the performance of his contract, and nearly completed it, and then abandoned the further performance —although the other party has had the full benefit of all that has been done, and has purhaps [sic] sustained no actual damage—is in fact subjected to a loss of all which has been performed, in the nature of damages for the non fulfilment of the remainder . . . .

Id. at 486–87.

168. *Id.* at 487. As the Vermont court explained a few years later, to deny any recovery under such circumstances "operates as a forfeiture and in the nature of a penalty" and "[i]t is not the object of the law to punish the party for a violation of his contract, but to make the other party good for all damages he may sustain by such violation." Gilman v. Hall, 11 Vt. 510 (1839) (following *Britton v. Turner*).

169. Of course, not all courts agreed. The traditional contractarian view denying restitutionary recovery emphasized two themes. First, allowing restitution would be an attack on fundamental contractual values. Stark v. Parker, 19 Mass. (2 Pick.) 267 (1824), sounded the refrain: "It will not admit of the monstrous absurdity, that a man may voluntarily and without cause violate his agreement, and make the very breach of that agreement the foundation of an action which he could not maintain under it." Second, allowing restitutionary recoveries would impose on employers the burden of proving the amount of the damages caused by the breach. *See generally* Edwin Patterson, *Restitution for Benefits Conferred by Party in Default Under Contract,* 1952 REPORT OF N.Y. LAW REVISION COMM'N 93 (N.Y. Leg. Doc. No. 65 (1952)).

The debate has been usefully examined from a variety of perspectives. *See, e.g.*, Wythe Holt, *Recovery by the Worker Who Quits: A Comparison of the Mainstream, Legal Realist, and Critical Legal Studies Approaches to a Problem of Nineteenth Century Contract Law,* 1986 WIS. L. REV. 677 (emphasizing class–based distinctions between treatment of workers in default and other contracting parties in default); Herbert Laube, *The Defaulting Employee—Britton v. Turner Reviewed*, 83 U. PA. L. REV. 825 (1935) (concluding, *id.* at 852: "After a hundred years of controversy, *Britton v. Turner* stands approved by considerations of morality, equality and social solidarity. Only the classic doctrine of contracts condemns it."). Of course, even where restitution was not permitted, other techniques might produce much the same results. Thus, courts could take the sting from the absence of a restitutionary remedy by treating the contract as divisible, rather than entire, and legislatures could enact periodic payment statutes to assure that latter–day Brittons would not suffer forfeitures and latter–day Turners would not retain undeserved windfalls. As

> This rule, by binding the employer to pay the value of the service he actually receives, and the laborer to answer in damages where he does not complete the entire contract, will leave no temptation to the former to drive the laborer from his service, near the close of his term, by ill treatment, in order to escape from payment . . . .[170]

Scenario 4. Insurance Contract: Vulnerability Unameliorated? An early insurance contract: DeHahn promises to indemnify Hartley up to policy limits for diminutions in the value of his interest in the ship Juno and its contents on a voyage from Africa to the West Indies, subject to the condition, among others, that the ship "sailed from Liverpool . . . with 50 hands or upwards." During the insured voyage, the ship is taken "by certain enemies of our lord the now King" and the insured's property "is wholly lost to him." DeHahn pays the limits of his contract, then discovers that the Juno had left Liverpool for Africa with only 46 hands, and sues to recover the payments mistakenly made to Hartley. The insured points out that 6 hours out of Liverpool the ship stopped at Anglesea to pick up 6 more hands, and thus had a full complement of seamen long before it arrived in Africa and the risk for the first time attached; the jury expressly finds that during the six–hour voyage from Liverpool to Anglesea, the ship "was equally safe as if she had had 50 hands on board her for that part of the said voyage." On such facts, was the insured entitled to payment from the insurer?

He was not, Lord Mansfield tells us, for "a warranty in a policy of insurance is a condition or a contingency" that "must be strictly complied with" without regard for why it was included in the contract, why it was not satisfied, or the effects of that failure on the insurer.[171] Thus, Hartley was entitled to nothing, even though the failure of condition in no way prejudiced

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Professor Levmore notes in a recent synoptic article, denials of restitution to the breaching party, though still sometimes characterized as the traditional view, are rare today. Saul Levmore, *Explaining Restitution*, 71 VA. L. REV. 65, 105 n.91 (1985). *See also* 2 E. ALLAN FARNSWORTH, FARNSWORTH ON CONTRACTS § 8.14 (2d ed. 1998).

170. *Britton*, 6 N.H. at 494.

171. DeHahn v. Hartley, 99 Eng. Rep. 1130, 1131 (K.B. 1786), *aff'd*, 100 Eng. Rep. 101 (Ex. 1787).

the insurer.[172] In other settings, substantial performance or restitution would be available to ameliorate the potential for forfeiture created by a minor defect in the first of two sequential performances. Why not here?

2. Why Insurance Is Different

a. Aleatory Contracts and the Fundamental Transformation

The answer, as we have seen, does not depend on niceties of eighteenth–century British marine insurance law; the black letter rule requiring strict compliance with express conditions is by its terms equally applicable to the boilerplate conditions in a modern homeowners policy or a professional's claims–made liability policy.[173] Rather, the answer lies in the way insurance policies of all kinds combine an aleatory promise with express conditions. Because insurance contracts are full of express conditions, there is little room

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172. Each of the judges took a stab at articulating the seriousness of the perfect compliance principle. Thus, in Lord Mansfield's view, "It is perfectly immaterial for what purpose a warranty is introduced; but, being inserted, the contract does not exist unless it be literally complied with." *Id.* at 346, 99 Eng. Rep. at 1131. Ashhurst added this emphasis: "The very meaning of a warranty is to preclude all questions whether it has been substantially complied with; it must be literally so." *Id.* And Buller concluded his opinion this way: "[T]he whole forms one entire contract, and must be complied with throughout." *Id.*

173. In this country, the citation of choice often has been *Wood v. Hartford Fire Insurance Co.*, 13 Conn. 533 (1840).

> If a house be insured against fire, and the language of the policy is, "warranted, during the policy, to be covered with thatch," the insurer will be discharged, if, during the insurance, the house should be covered with wood or metal, although his risk is diminished; for a warranty excludes all argument in regard to its reasonableness, or the probable intent of the parties. . . . Parties may contract as they please. When a condition precedent is adopted, the court cannot enquire as to its wisdom or folly, but must exact its strict observance.

Id. at 544. The opinion is a double–edged sword, for having framed the strict common law rule in its most virulent form, the court then promptly demonstrated how to avoid its application through the simple expedient of finding that the condition at issue has been satisfied. *See also* EDWIN W. PATTERSON, ESSENTIALS OF INSURANCE LAW § 61, at 239 (1935) ("[T]he rule came down to this, practically: that the insurer's motives for inserting the warranty would not be inquired into.").

for creative use of constructive conditions to ameliorate the insured's vulnerability. Because the insurer's promise is aleatory, restitution is not available as a device for ameliorating that vulnerability. Of course, neither feature of insurance contracts alone would be enough to create this vulnerability. The stringent effects of strict conditions can, in appropriate circumstances, be ameliorated through the use of restitution; *Britton v. Turner* showed us how, and section 374 of the *Restatement (Second) of Contracts* confirms the continued vitality of that approach.[174] Where necessary, an aleatory contract can be fleshed out by constructive conditions crafted to avoid forfeitures; much of Professor Corbin's treatment of aleatory contracts is devoted to how to do precisely that.[175] But standard insurance policy forms combine aleatory promises with express conditions, and thus render unavailable doctrinal techniques for avoiding forfeiture that routinely would be available in other settings.[176]

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174. *See* RESTATEMENT (SECOND) OF CONTRACTS § 374 (1981).

175. "A promise in an aleatory contract is constructively conditional on absence of action by the promisee that substantially increases the risk that the promisor assumed." CORBIN, *supra* note 145, § 730, at 416. Corbin offers this example of application of the principle: "The insurer against fire is discharged from duty to pay the loss if the insured himself sets fire to the property." *Id.*

176. Thus, it is no accident that so many of the illustrations found in the treatment of express conditions by the *Restatement (Second) of Contracts* are drawn from insurance cases. In other settings, the apparent sting of the strict black–letter law of express conditions has effectively been drawn by the combination of self–help measures and doctrinal devices reviewed in the text. Indeed, outside of insurance, so pervasive are the escape mechanisms that Professor Childres has argued that the *Restatement* should acknowledge that the black letter rule had been rendered moribund and abandon the rule altogether. *See* Robert Childres & Bruce Dennis Sales, *Restatement (Second) and the Law of Conditions in Contracts*, 44 MISS. L. REV. 591 (1973). *See also* Robert Childres, *Conditions in the Law of Contracts*, 45 N.Y.U. L. REV. 33, 34 (1970) ("[T]he traditional rule is a myth, not entirely abandoned verbally, but supplanted sub silentio."). Professors Kessler and Gilmore put it this way:

> In most respectable academic literature the idea that express conditions [must be literally performed] is introduced only to be dismissed as false or misleading. To many, if not most, practicing lawyers, however, the idea seems to commend itself as an article of faith. Counsel for insurance companies . . . have been particularly ardent believers in the sanctity of express conditions.

Well, might be the response, why not? After all, "aleatory" is a term derived from the Latin for "dice"; an "aleator" is a gambler.[177] People do wander into casinos and pull the arm and lose their quarters, without prompting us to wring our hands about forfeitures. Why should failure of a condition in an insurance policy be regarded any differently?

Such reactions reflect a flawed understanding of what makes an "aleatory contract" different. Although the *Restatement (Second) of Contracts* says that "[a] party may make an aleatory promise, under which his duty to perform is conditional on the occurrence of a fortuitous event,"[178] the presence of conditions to hedge in the obligations undertaken by itself is not enough to distinguish aleatory promises from the rest of the world of contracts. Rather, what makes an aleatory contract different from the sales, construction, and labor contracts is that it is not primarily an exchange of performances.[179] As Professor Corbin's treatise summarizes:

> When two parties make a bilateral contract, they are making an exchange of promises. Each party accepts the promise of the other party as the agreed equivalent of his own. . . . In most such cases the parties contemplate not merely an exchange of mutual promises, but also an exchange of the two performances that are being exchanged. . . .
>
> It is upon the facts stated in the foregoing paragraph that the rules of law respecting implied and constructive conditions, the rules of mutual dependency of exchanged promises, are based. It is not regarded as a square deal for one of the promisors to be required to render the performance promised by him when he has not received and is not going to receive the performance that was promised to him in return. Having reasonably anticipated an agreed performance in exchange for his own, it is not in accordance with prevailing notions of justice to give something for nothing.[180]

FRIEDRICH KESSLER & GRANT GILMORE, CONTRACTS CASES AND MATERIALS 846 (2d ed. 1970) (citation omitted).

177. *See* PETER L. BERNSTEIN, AGAINST THE GODS: THE REMARKABLE STORY OF RISK 47 (1996).

178. RESTATEMENT (SECOND) OF CONTRACTS § 76, cmt. c (1981).

179. *See* RESTATEMENT (SECOND) OF CONTRACTS §§ 232, 239 (1981).

180. CORBIN, *supra* note 145, at 194. *See also id.* § 728, at 399–400:

By contrast, in an aleatory contract,

> The performance that is promised may never be rendered, and yet the failure to render it may not be a breach of the promise. Both parties to such a promise . . . are incurring a hazard or taking a chance; and the hazard is so far conspicuously incurred that neither party can justly complain if the chance goes against him. . . . When such aleatory promises are exchanged, it is not necessarily contrary to prevailing notion of justice that one of the two parties should get something for nothing. This is because he himself took a similar chance and might have been compelled to give something for nothing.[181]

Thus, in the sales, construction, and labor contracts, the parties sought not just an exchange of promises, but an exchange of performances. In the sales agreement, the seller preferred the money to the horse and the buyer preferred the horse to the money; we do not understand either party to be assuming the risk of ending up with neither horse nor money. In *Jacob & Youngs v. Kent*

> In the great majority of bilateral contracts, the legal duty of each promisor is either expressly or constructively conditional upon substantial performance by the other contractor . . . . The fact that these promises are conditional in their legal operation does not make them aleatory, however. The performance of the condition in these cases may be uncertain; and a promisor may, therefore, never come under a duty of rendering the promised performance. In these cases, however, the condition precedent to a promisor's duty is concerned with the very return performance for which he has promised to give his own performance in exchange. . . . A contract is aleatory only when the parties contemplate that one of them may have to perform even though the other does not have to, even though the other party does not perform at all. The legal result of this is that in case of an aleatory contract one of the parties may come under a legal duty of rendering immediate performance even though the other party does not and never will come under such a duty.

181. *Id.* § 728, at 401.

and *Britton v. Turner* a similar understanding of the relationship between the promised performances was crucial to the decisions to use substantial performance or restitution to prevent the threatened forfeitures. By contrast, in the insurance contract, we may assume that both Hartley and the DeHahn devoutly hoped that no performance by the insurer would be necessary; there the parties may have regarded the premium as the agreed equivalent for the expected value of the insurer's conditional promise to perform, but that is not the same as saying they regarded the premium as the agreed equivalent for the insurer's payment of a covered claim. In 1998, in Lincoln, Nebraska, $210 buys an umbrella insurer's promise to pay up to $700,000 to settle liability claims exceeding my primary coverages, and I am content to believe that—properly discounted to reflect probabilities and expense loadings—the value of the insurer's promise is at least a rough actuarial equivalent for my premium. But that does not make the performances equivalent.

Much of the law of implied and constructive conditions is designed for non–aleatory contracts and has as its object vindication of the intuition that parties to most contracts will seek to avoid situations which put one party at risk of having given something for nothing. If the seller still has his horse, he can go back into the market; if the buyer still has his money, he can seek out other horse traders. But it is not always possible to structure a relationship to completely avoid rendering one party vulnerable to the opportunism by the other. The traditional understanding of the conditions under which opportunism is likely to thrive emphasizes both bounded rationality that prevents perfect ex ante contractual control of opportunism and "asset specificity"—"sunk investments that are undertaken in support of particular transactions, the opportunity cost of which investments is much lower in best alternative uses or by alternative users should the original transaction be prematurely terminated."[182] The pipe buried in Kent's

182. WILLIAMSON, *supra* note 95, at 55. *See also* Furubotn & Richter, *supra* note 91, at 21 (characterizing "*transaction–specific expenditures*" as those that "are irreversible in the sense that the principal cannot be regained through the market (i.e., by sale) if the original business relations are discontinued"). For an excellent survey of the economic literature, see Shelanski & Klein, *supra* note 100, at 340 (emphasizing the spectrum of governance structures that can be used to deal with the bilateral monopoly potential). For application to contract modification and mitigation problems, see, *e.g.*, Goetz & Scott, *supra* note 107, at 969 (chief variable for application of mitigation principle is whether there is a market for substitute performance); Jason Scott Johnson, *Default Rules/Mandatory Principles: A Game Theoretic Analysis of Good Faith and the Contract Modification Problem*, 3 S. CAL.

basement is one concrete example of a "sunk investment"; so too is Britton's nine months of labor. Neither could be readily recaptured and put to other uses. The result is, in Williamson's evocative formulation, a "fundamental transformation"[183] that moves the parties from a "thick or competitive market ex ante to a thin market or bilateral monopoly ex post."[184] Because insurance contracts are aleatory, the insured is rendered vulnerable by a form of "asset specificity" that makes other examples pale by comparison.[185] Hartley's

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INTERDISC. L.J. 335, 343 (1993) ("[M]arket for substitute performance and effectiveness of the legal remedy for breach combine to determine a party's vulnerability to modification holdup games.").

183. WILLIAMSON, *supra* note 95, at 61–63.

184. Cohen, *supra* note 95, at 955.

> . . . [W]hat was a large numbers bidding condition at the outset is effectively *transformed* into one of bilateral supply thereafter. The reason why significant reliance investments in durable, transaction specific assets introduces contractual asymmetry between the winning bidder on the one hand and nonwinners on the other is because economic values would be sacrificed if the ongoing supply relation were to be terminated.
>
> Faceless contracting is thereby supplanted by contracting in which the pairwise identity of the parties matters. Not only is the supplier unable to realize equivalent value were the specialized assets to be redeployed to other uses, but the buyer must induce potential suppliers to make the same specialized investments were he to turn to an outsider. The incentives of the parties to work things out rather than terminate are thus apparent. This has massive ramifications for the organization of economic activity.

Oliver E. Williamson, *The Economics of Governance: Framework and Implications*, 140 J. INST'L & THEORETICAL ECON. 195, 208 (1984) (emphasis in original).

185. The Supreme Court of Delaware recently made the point explicitly:

> Insurance is different. . . . Unlike other contracts, the insured has no ability to "cover" if the insurer refuses without justification to pay a claim. Insurance contracts are like many other contracts in that one party (the insured) renders performance first (by paying premiums) and then awaits the counter–performance in the event of a claim. Insurance is different, however, if the insurer breaches by refusing to render the counter–performance. In a typical

"investment" in his insurance contract includes not just the few pounds of premium, but the opportunity costs of forgoing other ways of dealing with his exposure, including at the extreme deciding to get out of the shipping game completely.[186]

> contract, the non–breaching party can replace the performance of the breaching party by paying the then–prevailing market price for the counter–performance. With insurance this is simply not possible. This feature of insurance contracts distinguishes them from other contracts.

E.I. DuPont de Nemours & Co. v. Pressman, 679 A.2d 436, 447 (Del. 1996). *See also* Rawlings v. Apodaca, 726 P.2d 565, 570 (Ariz. 1986) (in "both first– and third–party situations the contract and the nature of the relationship give the insurer an almost adjudicatory responsibility"). Unfortunately, old habits die hard. Most insurance lawyers, when confronted with an insurance opinion or commentary tying the obligation of good faith to the "unique relationship," or disparities in bargaining power, are more likely to understand those assertions as an invocation of ex ante disparities in bargaining power than as concern about the bilateral monopoly that can result from transaction–specific investments. *See, e.g.,* Epstein, *supra* note 131, at 239: "Courts imagine that standardization carries with it an element of coercive force that no contract should contain. So they take upon themselves the unwise task of neutralizing that power."

186. Thus, conventional variations on the theme that "an applicant for insurance stakes his premium payment on the chance that there will be a loss," *e.g.,* State Farm Mut. Ins. Co. v. Calhoun, 112 So. 2d 366, 372 (Miss. 1959), are fundamentally misleading, for costs of relying on a promise to provide insurance protection include more than a premium. The point is not just that, in an important sense, all costs are opportunity costs, *see generally* ARMEN A. ALCHIAN, ECONOMIC FORCES AT WORK 301 (1977), but that the opportunities forsaken by reliance on a promise to provide insurance can prove much different than the opportunities forsaken by reliance on a promise that is part of a nonaleatory exchange. If the paint doesn't arrive on time, there will be other days and other paint dealers. But once the boat has sunk or the *c'est tui que vie* has expired, it is too late to seek alternative sources of insurance coverage. The law reacts to the special character of reliance on aleatory contracts in many ways. For one example, promises to procure insurance provide one of the classic occasions for application of promissory estoppel. *See generally* RESTATEMENT (SECOND) OF CONTRACTS § 90, cmt. e (1981); 2 FARNSWORTH, *supra* note 169, § 2.119, at 169. The same concerns have prompted the development of special rules to police negligent handling of life insurance applications. *See, e.g.*, Duffie v. Bankers' Life Ass'n, 139 N.W. 1087 (Iowa 1913); Robinson v. United States Benevolent Soc'y, 94 N.W. 211 (Mich. 1903). *See generally* M.O. Regensteiner, Annotation, *Rights and Remedies Arising Out of Delay in Passing Upon Application*

Why does equity find a way to protect the breaching Britton against a forfeiture of his labors but leave Hartley to contemplate an empty pier with neither his premium nor the policy proceeds? The answer, of course, is that restitution at root is a way of forcing the defendant to disgorge what otherwise would be unjust enrichment.[187] Turner's restitutionary liability is limited to the value of the benefit he received from Britton's labors. Because insurance is aleatory, the rough equivalence between loss and benefit necessary for restitution to be an effective protection against forfeiture simply will not be present. Hartley will not be protected from forfeiture by getting his premium back.[188] The ship is gone and so is the opportunity to avoid or to transfer the risk of its loss.

If restitution cannot help Hartley, then what about substantial performance? After all, leaving Liverpool four men short no more prejudiced DeHahn than the substitution of Cohos for Reading pipe redounded to Kent's detriment. Why not conclude that too was only an immaterial breach, and allow the court to construct a condition of substantial performance that was satisfied because the changes in no way enlarged the insurer's obligation? The answer, of course, is that the substantial performance route charted by Cardozo does not run through insurance law.

In *Jacob & Youngs v. Kent*, Cardozo interpreted the Reading Pipe specification as a promise by the construction company to employ Reading Pipe, but did not interpret that provision as making provision of Reading Pipe

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for Insurance, 32 A.L.R.2d 487 (1953) (cataloging decisions based on both contractual and tort theories).

187. *See generally* 1 GEORGE E. PALMER, THE LAW OF RESTITUTION § 1 (1978); Levmore, *supra* note 169.

188. Of course, we could conclude that the measure of DeHahn's unjust enrichment is not the premium paid by Hartley, but rather the claim payment it would have had to make to Hartley but for the happy and immaterial coincidence that Hartley's crew was four men short; in this view, DeHahn hoped that he had gotten lucky in the same way that Turner and Kent hoped that they had gotten lucky. This gambit finds occasional support. *See, e.g.*, Jones v. Bituminous Cas. Co., 321 S.W.2d 798, 802 (Ky. 1991) (notice–prejudice rule based on recognition that "in the absence of prejudice a strict forfeiture clause simply provides the insurance company with a windfall"). But invocation of the restitutionary rationale seems a rhetorical flourish that is junior to the conclusion that the purpose of the notice provision is to protect the insurer against prejudice in claims adjustment activities. *See generally* Levmore, *supra* note 169, at 107 (courts that deny restitution for partial performers may be interpreting contract as designed to create super incentives to performance, so that pro rata restitution would not be appropriate).

an express condition precedent to Kent's obligation to pay. The dissent did not agree with that critical move,[189] and most of the admiration for Cardozo's opinion ultimately rests on the skill with which he was able to allow the consequences of treating the provision as a strict condition to inform his sense of what the parties must have intended.[190] But in insurance law, as usually understood, there is no such room to wiggle.[191] According to the *Restatement*, the "preference for an interpretation that merely imposes a duty on the obligee to do the act and does not make the doing of the act a condition of the obligor's duty" just "does not apply when the contract is of a type under which only the obligor generally undertakes duties":[192]

> It therefore does not apply to the typical insurance contract under which only the insurer generally undertakes duties, and a term requiring an act to be done by the insured is not subject to this standard of preference. In view of the general understanding that only the insurer undertakes duties, the term will be interpreted as making the event a condition of the insurer's duty rather than as imposing a duty on the insured.[193]

In insurance, then, if a provision makes it into the contract, no matter what its label, it almost always will be understood to have created an express

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189. *See* Jacob & Youngs v. Kent, 129 N.E. 889, 892 (N.Y. 1921) (McLaughlin, J., dissenting).

190. *See, e.g.*, Arthur L. Corbin, *Mr. Justice Cardozo and the Law of Contracts*, 48 YALE L.J. 426 (1938) ("Probably no other case can be found in which the question of dependency of promises and of implied conditions of an owner's duty to pay is discussed with as much enlightened intelligence and charm of expression as we find in Cardozo's opinion."); Lawrence A. Cunningham, *Cardozo and Posner: A Study in Contracts*, 36 WM. & MARY L. REV. 1379, 1381 (1995) (contributions of Cardozo in *Jacob & Youngs* "were achieved using a thickly textured doctrinalism involving conscious mediation amongst the competing values at stake in the law of contracts."); Patterson, *supra* note 23, at 282 (celebrating Cardozo's opinion as a "clash . . . between two classic argumentative forms . . . the textual and the prudential.").

191. "No satisfactory counterparts to the penalty and mitigation doctrines exist when contract enforcement is accomplished by express conditions that do not operate directly through a liquidated payment obligation." Andersen, *supra* note 139, at 311. Andersen's answer, of course, is rigorous use of "good faith in enforcement." *Id.*

192. RESTATEMENT (SECOND) OF CONTRACTS § 227 cmt. d (1981).

193. *Id.*

condition to the insurer's duties, and there simply will be no room for a gap–filling constructive condition of substantial performance. And if that express condition has not been completely satisfied, the black letter common law rule tells us, the insurer has no duty to perform.

For most failure of condition defenses, the results produced by the strict common law rule seem perfectly appropriate. Clearly we do not want to require a life insurer to start paying off for near death experiences or a hole–in–one insurer to start fending off claims based on truly remarkable double eagles. We know that the insured who opted for collision but not comprehensive coverage should not get any help from her auto insurer in repairing chips in her windshield even if they were caused by rocks thrown up in a near–collision. And we are confident that an insurer that promises to pay $1,000,000 if it snows four or more inches in Central Park on January 8 between 10 a.m. and 10 p.m. should not have to respond to the contention that three and three–tenths inches is close enough.[194]

Why do we know instinctively that to excuse less than full compliance with those conditions would be to do what Cardozo and Parker refused to do: to remake the contract of the parties? The answer may seem obvious: with an aleatory contract, Corbin tells us, the possibility that one party will give up something for nothing is a chance that "is so far conspicuously incurred that . . . [he cannot] justly complain if the chance goes against him."[195] That characterization fits conventional egoistic gambles—no one is likely to have much sympathy for the "Pick Six" lottery player who picks only five—and it fits some insurance policy provisions as well. Had Hartley's ship been lost after the term of the insurance had expired, we would be unlikely to waste time wondering if the insurer nonetheless should pay.

However, that explanation does not take us as far as we need to go for, as we have seen, most of the provisions that lurk in standard insurance policy forms hardly can claim that kind of validation. Must we nonetheless insist

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194. *See* Gavin Souter, *Snow Promotion a Near Miss; Less than an Inch More Snow Would Have Translated into a $1 Million Claim*, BUS. INS., Jan. 15, 1996, at 46 (insurer's obligation on $1 million policy covering insured's exposure on lease payments forgiveness promotion conditioned on 4 inches of snow in Central Park on January 8 between 10 a.m. and 10 p.m.). For a more commercially–significant version of snow insurance, see Michael Prince, *Interest in Snow Insurance Is Accumulating,* BUS. INS., Jan 6, 1997, at 31 (airport authority pays $35,000 premium for insurer's promise to pay $25,000 for each inch of snow above 40 inches that falls on Dulles, up to $1 million).

195. CORBIN, *supra* note 145, at 401.

that modern Hartleys are chargeable with having assumed the risk of failure to comply with each and every policy provision? Or should we be prepared to distinguish some risks of getting nothing that are part of the aleatory contract's gamble from some that are not? Why should it be impermissible opportunism for Kent to send his architect to the basement with a flashlight to look for immaterial departures from contract specifications but unremarkable business–as–usual for an insurer to instruct its claims department to deny a claim because of an immaterial, non–prejudicial failure of a boilerplate insurance policy condition?

b. Traditional Ameliorating Techniques for Insurance Contracts

The better response is that opportunism is opportunism, whether it appears authorized by the structure of a construction contract or by insurance policy boilerplate, and that insurance law, despite its formal fidelity to the strict common law rule, only sometimes has been blind to the potential for disproportionate forfeitures worked by the combination of aleatory promises with insurance policy forms full of express contractual conditions. True, insurance law continues to defend the proposition that — absent legislatively mandated benefits, of course—the insurer is free to decide what risks it is willing to assume, for courts will not make a contract for the parties. However, that underwriting discretion does not necessarily include discretion to use methods of avoiding unwanted risks that visit a disproportionate forfeiture on the insured. With "substantial performance" and "restitution" unavailable in insurance, the instinct to prevent inappropriate forfeitures has had to manifest itself in other ways. But quietly, sporadically, often atheoretically, insurance law manages to find ways to put limits on the ability of insurers to invoke failure of condition defenses when permitting the defense would create a disproportionate forfeiture.

Sometimes the limits are statutory. Many jurisdictions have turn–of–the–century statutes restricting insurer efforts to convert application representations into conditions in order to avoid the materiality constraints of misrepresentation law,[196] and standard policy statutes sometimes have converted broadly–framed conditions into more–narrowly–framed exceptions

196. *See, e.g.*, MASS. GEN. LAWS ANN. ch. 175, § 186 (West 1987). Such statutes apply only to representations and affirmative warranties applicable to circumstances at the inception of the contract; they thus do not apply to "continuing" warranties and conditions that seek to control post–inception changes in the risk.

that do not pose the same potential for disproportionate forfeitures.[197] Legislation in a few states denies the insurer a defense based on failure to satisfy a post–loss notice condition unless that failure prejudiced the insurer,[198] and an occasional statute denies the insurer a defense based on post–inception, pre–loss failures of some conditions unless the failure "increased the risk of loss"[199] or "contributed to the loss."[200] In Australia, a 1984 statute implementing the recommendations of a Crown Commission attempts to mirror *Jacob & Youngs v. Kent* by giving the insurer an offset in the amount of any injury to the insurer caused by certain failures of condition.[201] Such statutory alterations of the strict common law rule are few, and determining what policy provisions are governed by them is a continuing source of difficulty.[202] Consequently, when the sensibilities on

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197. *See generally* Thomas L. Wenck, *The Historical Development of Standard Policies*, 35 J. RISK & INS. 537, 544–45 (1968). This effect was especially pronounced in life insurance. *See generally* Robert Works, *Coverage Clauses and Incontestable Statutes: The Regulation of Post–Claim Underwriting*, 1979 U. ILL. L.F. 809, 856–57.

198. *See, e.g.*, WISC. STAT. ANN. § 631.81 (West 1995).

199. In New York, for example, a "warranty statute" drafted by Professor Patterson in the 1940's provides: "No breach of warranty shall avoid an insurance contract or defeat recovery thereunder unless such breach materially increased the risk of loss, damage or injury within the the coverage of the contract." N.Y. INS. LAW § 150(2) (McKinney 1985). For Patterson's explanation, see PATTERSON, *supra* note 173, § 74.

200. In Nebraska, a statute in effect since the Progressive Era makes certain post–inception, pre–loss failures of condition defenses available only if the failure of condition "was in existence at the time of loss and contributed to the loss." NEB. REV. STAT. § 44–358 (REISSUE 1993). *See generally* Robert Works, *Insurance Policy Conditions and the Nebraska Contribute to the Loss Statute: A Primer and a Partial Critique,* 61 NEB. L. REV. 209 (1982). New Zealand has a similar statute. Insurance Law Reform Act of 1977, § 11 (N.Z.), adopted on the recommendation of the Contracts and Law Reform Committee. *See* N.Z. LAW REFORM COMMITTEE, ASPECTS OF INSURANCE LAW ¶¶ 28–30 (1975). For Patterson's criticisms of "contribute–to–the–loss standards," see PATTERSON, *supra* note 173, § 73.

201. *See* Insurance CONTRACTS ACT, 1984, § 54 (Austl.). The approach is rationalized in AUSTRALIAN LAW REFORM COMM'N, REPORT ON INSURANCE CONTRACTS, NO. 20 (1982). Apparently both New Hampshire and Washington long ago flirted with similar statutory requirements that the insured's recovery sometimes be reduced in lieu of forfeiture. *See generally* PATTERSON, *supra* note 173, § 75.

202. In 1935, Patterson put it this way:

display in *Jacob & Youngs v. Kent* and *Britton v. Turner* manage to find expression in insurance law, it usually is because a court has found a way to skirt the strict common law rule without denying it.

Judicial techniques for avoiding the strict common law rule come in several familiar forms. An insurer may be estopped to rely on a failure of condition defense if the court is able to conclude that a representation chargeable to the insurer has produced reasonable detrimental reliance by the insured.[203] Noncompliance with a condition may be excused because compliance was "impracticable,"[204] because the insurer had already materially breached its obligations under the contract,[205] or because the insurer can be said to have "waived" compliance.[206] All these techniques are notoriously fact–dependent, all are said to be ineffective against a "coverage clause," and the decisions they generate do not travel well. The result is a "mushy body of case law"[207] in which courts sometimes appear to adhere to

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> If one merely lists the states in which a statutory modification of the common–law doctrine is now in force, the list would embrace a majority of the states of the Union, and one might rashly conclude that the common law rules had been entirely swept away. A closer scrutiny of the statutes reveals that this conclusion is far from being correct. Many of the statutes have avowedly only a limited application, and judicial interpretation has further limited their scope.

PATTERSON, *supra* note 173, at 309. Patterson's conclusion remains apt, as does his characterization of the difficulties posed by such statutes: "Many of the statutes just referred to were drawn by amateurs, and it is often well–nigh impossible to determine their meaning." *Id.* at 311.

203. *See* Clarence Morris, *Waiver & Estoppel in Insurance Litigation*, 105 U. PA. L. REV. 925 (1957).

204. *See* RESTATEMENT (SECOND) OF CONTRACTS § 271 (1981). *See also* Annotation, *Beneficiary's Ignorance of Existence of Life or Accident Policy as Excusing Failure to Give Notice, Make Proofs of Loss, or Bring Action within Time Limited by Policy or Statute,* 28 A.L.R.3d 292 (1969); C.T. Drechsler, *Property Insurance: Insured's Ignorance of Loss or Casualty, Cause of Damage, Coverage or Existence of Policy, or Identity of Insurer, as Affecting or Excusing Compliance with Requirements as to Time for Giving Notice, Making Proof of Loss, or Bringing Action Against Insurer,* 24 A.L.R.3d 1007 (1969).

205. *See* RESTATEMENT (SECOND) OF CONTRACTS § 255 (1981).

206. *See* RESTATEMENT (SECOND) OF CONTRACTS § 84 (1981).

207. The characterization is drawn from PATTERSON, *supra* note 173, § 94, at 278.

the black letter of the equitable doctrines they apply, and sometimes seem to allow the potential for forfeiture an unannounced place in the calculus of decision.

But the technique that most clearly mimics *Jacob & Youngs v. Kent* in evading the strict common law rule employs purposive interpretation to permit the conclusion that—first appearances sometimes to the contrary—no failure of condition occurred. We have seen how Cardozo allowed his appreciation of the consequences of a failure of condition to inform his interpretation of the purpose of the Reading Pipe provision. For Cardozo, "intention not otherwise revealed may be presumed to hold in contemplation the reasonable and the probable,"[208] and he thought it neither reasonable nor probable that the parties to that construction agreement would use a strict contractual condition in order to bet progress payments on whether Kent could discover an immaterial, not–readily–cured, departure from the specifications.

> [T]his is not to say that the parties are not free by apt and certain words to effectuate a purpose that performance of every term shall be a condition of recovery. . . . This is merely to say that the law will be slow to impute the purpose, in the silence of the parties, where the significance of the default is grievously out of proportion to the oppression of the forfeiture.[209]

Once Kent had conceded the insignificance of the substitution of Cohoes pipe for Reading Pipe, Cardozo had no difficulty discerning the disproportion between the harm done to Kent by the breach and the harm that would be done to the construction company if the provision were treated as an express condition. Interpreting the Reading Pipe provision as a promise, and constructing a condition of "substantial performance," permitted Cardozo to prevent "the oppression of the forfeiture."

Of course, a court confronting an immaterial failure to satisfy a provision in an insurance policy usually will not be free to follow Cardozo to the conclusion that the policy provision should be interpreted as a promise rather

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208. Jacob & Youngs v. Kent, 129 N.E. at 891. Professor Dennis Patterson calls this "perhaps the most important sentence in the entire opinion." Patterson, *supra* note 116, at 284, n.183.

209. Jacob & Youngs v. Kent, 129 N.E. at 891.

than a condition.[210] But it can follow Cardozo in rejecting the positivist conceit that the meaning of a provision can be determined without considering its effects, and it can allow its appreciation of the consequences of a failure of condition to inform its understanding of *whether* the provision was satisfied. Thus, no special creativity was required for courts to decide that the insurer's purpose for including an "increase in hazard" warranty in the standard fire policy could be satisfied without forfeiting coverage every time mom started the morning oatmeal or dad fired up his pipe,[211] and from such mine–run efforts to ascribe appropriate purposes to insurance policy conditions it is but a short move to the conclusion that less–than–literal compliance may still satisfy a wide variety of policy provisions.[212] In this

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210. Of course, in the heat of advocacy, the distinction sometimes is ignored. Occasionally an opinion will treat a policy provision as a promise rather than as an express condition. *See, e.g.*, Howard v. Federal Crop Ins. Corp., 540 F.2d 695, 697 (4th Cir. 1975) (loss adjustment condition construed as "promise" rather than "condition" because it involved "something to be done" rather than "something not to be done)"; Anderson et al., *infra* note 232, at 857 (urging use of "doctrine of 'substantial performance'" to assure that "[a] policyholder's breach of a policy condition should result, at most, in recoupment or damages to the insurance company."). Of course, that approach is impossible to square with the *Restatement*. *See* RESTATEMENT (SECOND) OF CONTRACTS § 261 Illus. 2 & 3 (1981).

211. *See generally* JERRY, *supra* note 48, at 295–96; PATTERSON, *supra* note 173, at 325–27; F.V. Lapine, Annotation, *Change in Purposes for Which Premises Are Occupied or Used as Increase of Hazard Voiding Coverage*, 19 A.L.R.3d 1336 (1968); M.T. Brunner, Annotation, *Casual or Temporary Repairs, and the Like, as Constituting Increase of Hazard So As to Avoid Fire or Other Property Insurance,* 28 A.L.R.2d 757 (1953).

212. Failure to satisfy the "iron safe clause" provided grist for both judicial and academic mills. *See, e.g.*, E. Le Fevre, Annot., *Insurance: Waiver of, or Estoppel to Assert, Iron Safe Clause,* 33 A.L.R.2d 615 (1954). As Williston somewhat grudgingly acknowledged, with iron safe conditions "the meaning of the words is perfectly plain. What influences the court is the fact that it is so unfair and harsh to make the condition applicable in view of the situation which has arisen." 5 SAMUEL WILLISTON & WALTER H.E. JAEGER, A TREATISE ON THE LAW OF CONTRACTS § 806, at 859 (3d ed. 1961).

> Nothing is commoner than for a promisor who wishes to protect himself by a condition to impose one which will certainly have that effect even though in some cases the condition may work undeserved hardship. On the natural construction of the policy in question it would seem that the insurer did not care to take the risk

fashion, "vacancy and unoccupancy" clauses can be read to speak only at the inception of the contract.[213] A provision excluding from coverage death "while . . . serving as a member of the crew of any aircraft" can be construed to apply only during portions of the flight when the individual actually is helping to fly the plane.[214] A warranty limiting the values a jeweler is to display in show windows can be said to be relevant only to smash–and–grab thefts from the window, and thus to be no bar to recovery for armed robbery losses.[215] With history like that to draw upon, we should not be surprised to find that modern courts, faced with a choice between interpreting a notice provision to say "I will pay, but not if your notice is late *regardless of whether its untimeliness in any way prejudices my claims adjustment efforts*" and "I will pay, but not if your notice is late *and its untimeliness prejudices my claims adjustment efforts*," often follow the counsel crystalized in the *Restatement (Second) of Contracts*[216] and choose the interpretation that avoids a forfeiture.[217] Over time some such interpretive moves can become so familiar that they acquire their own short–hand labels: "affirmative

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> of discussing reasons alleged for the nonproduction of the books, preferring instead to throw on the insured the duty of producing them at his peril. This construction works such hardship, however, that the court declines to give the words their natural meaning.

Id. at 861–62.

213. *See, e.g.*, Stout v. City Fire Ins. Co., 12 Iowa 371 (1861). *See generally* PATTERSON, *supra* note 173, at 310–14; Allan E. Korpela, Annotation, *What Constitutes "Vacant" or "Unoccupied" Dwelling within Exclusionary Provision of Fire Insurance Policy*, 47 A.L.R.3d 398 (1973); Joseph E. Edwards, Annot., *What Constitutes "Vacancy" or "Unoccupancy" within Fire Insurance Policy on Building Other Than Dwelling*, 36 A.L.R.3d 505 (1971).

214. *See, e.g.*, Alliance Life Ins. Co. v. Ulyssses Volunteeer Fireman's Relief Ass'n, 529 P.2d 171 (Kan. 1974); Vander Laan v. Educators Mutual Ins. Co., 97 N.W.2d 6 (Mich. 1959).

215. *See, e.g.*, Diesinger v. American & Foreign Ins. Co., 138 F.2d 91 (3d Cir. 1943). *See generally* Tracy A. Bateman, Annotation, *Construction and Effect of "Jeweler's Block" Policies or Provisions Contained Therein*, 22 A.L.R.5th 579 (1994).

216. RESTATEMENT (SECOND) OF CONTRACTS § 227 (1981).

217. *See, e.g.*, Iowa Ins. Co. v. Meckna, 144 N.W.2d 73 (Neb. 1966) (notice provision satisfied because insurer's purpose in requiring notice not impeded by insured's failure to give notice).

warranty,"[218] "temporary breach,"[219] "divisibility"[220] — and, most notably in recent years—the "notice–prejudice rule."[221]

But most do not. As Llewellyn wryly noted, and as generations of lawyers picking through appellate opinions from half–a–hundred jurisdictions can confirm, "the effect of such work on 'Words and Phrases' and the like can be pretty awful."[222] Reliance on equitable preclusions and purposive interpretation to ameliorate the harshness of the strict common law rule means lawyers for insureds, who come to the task only infrequently and often one policy provision at a time, are likely to find that each example of equitable and interpretive techniques being used to overcome a failure of condition defense seems to come with its own built–in counter example; efforts by commentators to generalize judicial techniques often get no further than a listing of the doctrinal tools or taxonomic efforts to classify provisions that seem especially vulnerable to judicial efforts to ameliorate the effects of the strict common law rule. We miss a lot when we view these cases individually. Without the perspective necessary to appreciate that sometimes they may be manifestations of the larger contractual program for controlling disproportionate forfeitures, we may celebrate judicial technique without understanding when and why it should be applied, and leave its manifestations vulnerable to the claim that they are ad hoc, perhaps

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218. *See, e.g.,* PATTERSON, *supra* note 173, at 310–14; JERRY, *supra* note 48, at 515–16.

219. *See generally* PATTERSON, *supra* note 173, at 317–23.

220. *See generally id.* at 342–46; Jerald H. Sklar, *The Divisibilty of Warranties in Insurance Policies*, 18 VAND. L. REV. 719 (1965).

221. *See generally* authorities cited *supra* note 49.

222. LLEWELLYN, *supra* note 118, at 365. The result, Llewellyn complained, is that "the sound impulse for fairness — better, against outrage — fails to cumulate into any effective or standard techniques, except in a very few areas such as life and fire insurance." *Id.* Llewellyn's rosy characterization of the situation in life and fire insurance may well have been apt at the time, for constructing taxonomies of insurance policy provisions and the judicial reactions they provoked once was at the core of academic work in insurance law. Thus, for example, Williston's contracts treatise devoted twenty–four sections to "Excuses for Non–Performance of Conditions in Insurance Policies." WILLISTON & JAEGER, *supra* note 212, at §§ 745–68. Today, however, Llewellyn's complaint seems especially applicable to insurance contracts. For an examination of the difference in the rhetorical and legal tools on display in insurance coverage litigation a century ago, see Robert Works, *Back to the Future of Post–Loss Insurance Conditions in Nebraska,* 70 NEB. L. REV. 229 (1991).

unprincipled, expressions of anti–insurer animus or the search for a deep pocket.

But these phenomena need not and should not be seen that way. Despite their diversity and the sporadic nature of their appearances, they are reactions to a common problem, and they should be seen as specific applications of the generic principle that nonoccurrence of some conditions should be excused under the "principle of special scrutiny"[223] articulated in Section 229 of the *Restatement (Second) of Contracts*: "To the extent that the non–occurrence of a condition would cause disproportionate forfeiture, a court may excuse the nonoccurrence of that condition unless its occurrence was a material part of the agreed exchange."[224]

Unfortunately, in recent years these connections only occasionally have been made explicit. When Connecticut first confronted whether to align itself with jurisdictions that had proclaimed a prejudice requirement for failure of notice condition defenses, the opinion was crafted by Justice Peters, fresh from the Yale Law School faculty and ready to locate both the "notice–prejudice rule" and section 229 within the same intellectual tradition as *Jacob & Youngs v. Kent*. In *Aetna Casualty & Surety Co v. Murphy*,[225] Justice Peters began with a quick survey of the legal landscape:

> We are confronted, in this case, by a conflict between two competing principles in the law of contracts. On the one hand, the law of contracts supports the principle that contracts should be enforced as written, and that contracting parties are bound by the contractual provisions to which they have given their assent. Among the provision for which the parties may bargain are clauses that impose conditions upon contractual liability. "If the occurrence of a condition is required by the agreement of the parties, rather than as a matter of law, a rule of strict compliance traditionally applies." . . . On the other hand, the rigor of this traditional principle of strict compliance has increasingly been tempered by the recognition that the occurrence of a condition may, in appropriate circumstances, be excused in

223. The phrase is drawn from Eisenberg, *supra* note 93, at 236.

224. RESTATEMENT (SECOND) OF CONTRACTS § 229 (1981). *See generally* Eisenberg, *supra* note 93, at 236–240; BURTON & ANDERSEN, *supra* note 128, at §5.5.4; II FARNSWORTH, *supra* note 169, at § 8.7.

225. 538 A.2d 219 (Conn. 1988).

> order to avoid a 'disproportionate forfeiture.' See, e.g., 2 Restatement (Second) Contracts (1981), § 229.[226]

Justice Peters acknowledged that section 229 and *Jacob & Youngs v. Kent* and the notice–prejudice rule in insurance shared a common intellectual lineage,[227] and then applied the standards of section 229 to determine whether nonoccurrence of the notice condition in the occurrence–triggered comprehensive general liability policy should be excused:

> In the setting of this case, three considerations are central. First, the contractual provisions presently at issue are contained in an insurance policy that is a "contract of adhesion," the parties to this form contract having had no occasion to bargain about the consequences of delayed notice. Second, enforcement of these notice provisions will operate as a forfeiture because the insured will lose his insurance coverage without regard to his dutiful payment of insurance premiums. Third, the insurer's legitimate purpose of guaranteeing itself a fair opportunity to investigate accidents and claims can be protected without the forfeiture that results from presuming, irrebuttably, that late notice invariably prejudices the insurer.[228]

Thus, failure to satisfy the notice condition should be excused. "Literal enforcement of notice provisions when there is no prejudice is no more appropriate than literal enforcement of liquidated damages clauses when there are no damages."[229]

Justice Peters' assimilation of strict conditions and penalty clauses was neither original or strained. The first *Restatement* confirmed the long–standing recognition that express conditions can present the same opportunities and concerns as do more familiar forms of penalty provision:

> A contract may be framed so that what is in form a condition will, if given effect, involve the consequences of a collateral agreement for a penalty in case of breach. Enforcement of

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226. *Id.* at 221.
227. *Id.* at 221–22.
228. *Id.* at 222.
229. *Id.* at 223.

> such a collateral agreement is confessedly opposed to public policy and provisions creating a condition that would produce the same result should be no more operative because put in the form of a condition.[230]

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230. RESTATEMENT OF CONTRACTS § 302, cmt. a (1932). *See also* WILLISTON & JAEGER, *supra* note 212, at § 739 ("A condition may be as penal in its effects as a promise to pay a penalty.... The substance of the two bargains is the same; it is only the form that differs, and relief against the effect of penalties should depend as little as possible upon form."); William Loyd, *Penalties and Forfeitures*, 29 HARV. L. REV. 117, 135 (1915):

> To habitually remake agreements on the strength of circumstances that have subsequently transpired would add an element of uncertainty to bargaining dangerous to freedom of contract and the extension of credit. To refuse to take account of the disproportion between the stipulated consequences of breach and the actual risk of loss would turn such transactions into a speculation. The function of jurisprudence, in the furtherance of progress, is to reduce to a minimum the purely fortuitous elements in the law of obligations . . . until through economic invention, perhaps insurance, perhaps the development of ideas still unknown to us, the problem itself becomes obsolete.

Id. at 135. *See also* BURTON & ANDERSEN, *supra* note 128, at § 5.2.3 (characterizing liquidated damages provisions and express conditions as alternative ways of protecting "performance interests," and, as such, subject to this "central" principle: "[C]osts to the party in breach unnecessary to the protection of the other's performance interests should be eliminated."). Eisenberg, *supra* note 93, at 238, puts it this way:

> The principle that governs the review of express conditions is very similar to the principle that governs the review of liquidated damages provisions. Both principles concern sanctions. Both principles allow the courts to override bargained–for provisions even in the absence of unconscionability. Both principles turn on a second look. And just as the special principle concerning liquidated damages is traditionally supported by a rhetoric that centers on the idea of penalty, the principle governing the excuse of express conditions is traditionally supported by a rhetoric that centers on the idea of forfeiture.

And the first *Restatement*'s precursor to section 229 provided: "A condition may be excused without other reason if its requirement (a) will involve extreme forfeiture or penalty, and (b) its existence or occurrence forms no essential part of the exchange for the promisor's performance"[231]

Unfortunately, though the rules governing when a liquidated damage provision should not be enforced because it will operate as a penalty are familiar to most modern lawyers, the cognate provisions for policing against forfeitures caused by the application of strict conditions seem to go mostly unnoticed outside the academy. The possibility that a failure to satisfy a notice condition might be excused under section 229, let alone that section 229 might have a wider range of application to some other failure of condition defenses, would appear to be news to most insurance practitioners, even though they labor in the most fruitful of forfeiture vineyards.[232] And

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> More importantly, the principle that governs the excuse of express conditions, like the principle that governs the review of liquidated damages provisions, is best explained not by the traditional rhetoric, but by the limits of cognition.

Id. at 238.

231. RESTATEMENT OF CONTRACTS § 302 (1932).

232. *See, e.g.*, Eugene R. Anderson et al., *Draconian Forfeitures of Insurance: Commonplace, Indefensible, and Unnecessary*, 65 FORDHAM L. REV. 825 (1996) (despite title and subject, fails to mention § 229) [hereinafter Anderson, *Draconian Forfeitures*]; Eugene R. Anderson & James J. Fournier, *The Reasonable Expectations Doctrine: Understanding the Law and the Lore Behind Upholding the Reasonable Expectations of Insurance Policyholders*, RISK MGMT. & INS. REV., Vol. 1, No. 2, p. 72, 84–88 (1997) (arguing that the "Doctrine of Reasonable Expectations" in part is an effort to police against opportunistic breach); Suter, *supra* note 88, at 235 (suggesting that "notice–prejudice rule" is application of § 229, but acknowledging that connections are "not generally recognized in the case law"). Of course, there are exceptions. In *Brakeman v. Potomac Ins. Co.*, 344 A.2d 555 (Pa. Super. Ct. 1975), perhaps the most influential early "notice–prejudice rule" decision, Judge Cercone's concurring opinion made the connections to § 229's predecessor. ("The two criteria, which must be weighed together, are the extremity of the forfeiture to the obligee (insured) and the materiality of the nonoccurrence of the condition to the obligor (insurer)."). *See id.* at 560. *See also* American Ins. Co. v. C.S. McCrossan, Inc., 829 F.2d 702, 705 (8th Cir. 1986) (dicta that § 229 would excuse noncompliance with authorization condition in retrospective rating terms of policy); Cessna Aircraft Co. v. Hartford Acc. & Indem. Co., 900 F. Supp. 1489 (D. Kan. 1995) (tying "notice–prejudice rule" to § 229); American Fire & Cas. Co. v. Collura, 163 So.2d 784 (Fla. Dist. Ct. App. 1964) (predecessor to § 229 applicable to failure to satisfy notice

that is unfortunate, for as Justice Peters was at pains to point out, the same concern to prevent disproportionate forfeitures that produced such contracts landmarks as *Jacobs & Youngs v. Kent* and *Britton v. Turner* is operative in insurance litigation, even though neither the doctrine of substantial performance nor restitutionary efforts to force disgorgement of unjust enrichment fit the insurance situation.

C. *Excusing Failures of Condition under* Restatement (Second) of Contracts *§ 229?*

What if we were to take section 229 seriously as a source of guidance about how to treat insurance policy conditions? Would section 229 help us to understand the instinct to treat a notice condition differently than a rodent exclusion? Would it provide us with better tools for isolating just how a claims–made format may be inferior to an occurrence format? And what would it have to say about the application of a "notice–prejudice rule" to failures to satisfy a reporting clause in a claims–made policy?

Section 229 forces us to ask and answer three questions: 1) Was satisfaction of the condition a "material part of the agreed exchange?" 2) What will be "the extent of the forfeiture" suffered by the insured if the condition is not excused? and 3) Will that forfeiture be disproportionate to the "protection that will be lost [by the insurer] if the non–occurrence of the condition is excused to the extent required to prevent forfeiture?"

1. Was Satisfaction of the Condition a "Material Part of the Agreed Exchange?"

In many contractual settings, whether occurrence of the condition was "a material part of the agreed exchange" may be among the most difficult parts of the section 229 inquiry. But in insurance, this first question need not detain us for long. Because insurance contracts are aleatory, the exchange

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condition in auto policy); Roberts Oil Co. v. Transamerica Ins. Co., 833 P.2d 222 (N.M. 1992) (same); Duerler v. Community Mut. Ins., No. 90AP–1337, 1991 WL 60660 at *4 (Ohio Ct. App. Apr. 18, 1991) (excuse of failure to satisfy cost management provision in medical expense coverage governed by § 229, but not available because provision was "material part of the agreed exchange"); Ashburn v. Safeco Ins. Co., 713 P.2d 742, 745 (Wash. Ct. App. 1986) (failure to satisfy one year suit clause not subject to excuse under § 229 because not a "condition precedent"); Mistler v. Horace Mann Ins. Co., 2 Mass. L. Rptr. 619 (Mass. Dist. Ct. 1994) (failure to satisfy cooperation clause said to pose question whether "loss of coverage is 'disproportionate' to 'loss' caused the insurer" by the failure of condition).

that takes place is an exchange of the insured's premiums for the insurer's contingent promise to pay.[233] Compliance with any condition other than payment of premiums usually will not be, in the sense in which the *Restatement* uses the term, a material part of the agreed exchange.[234] All the policy conditions may be material in the sense that they provide protection to the insurer against potential costs, and some failures of condition will certainly be material in the sense that the facts depart in significant ways from the assumptions under which the insurance was written. But that does not make every insurance condition—indeed any insurance condition *qua* condition—a material part of the agreed exchange.[235]

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233. *See* Cessna Aircraft Co. v. Hartford Acc. & Indem. Co., 900 F. Supp. 1489, 1517 (D. Kan. 1995); Roberts Oil Co. v. Transamerica Ins. Co., 833 P.2d 222, 230–31 (N.M. 1992). *But see* Duerler v. Community Mut. Ins., No. 90AP–1337, 1991 WL 60660, at *3 (Ohio Ct. App. Apr. 18, 1991) (policy condition that medical treatment be obtained from approved provider said to be "material part of the agreed exchange").

234. "Where the promises of either or both parties to a bilateral contract are wholly or substantially aleatory, the promises are not for an agreed exchange of performances unless the promise of each party is conditional on the same fortuitous event." RESTATEMENT OF CONTRACTS § 292 (1932).

235. The analysis in the text is quite different from that proposed by Professors Burton and Andersen. In their view, "§ 229's requirement that the condition not be a material part of the agreed exchange" becomes "the materiality requirement of § 229," and that requirement "turns on the importance of the term to the parties at the time the contract was made." BURTON & ANDERSEN, *supra* note 128, at 194–95. There are two objections to that reading. First, it ignores the *Restatement*'s distinction between conditions that cannot be excused because "a material part of the agreed exchange" and conditions that cannot be excused because "uncertainty of the occurrence of the condition was an element of the risk assumed . . . ." RESTATEMENT (SECOND) OF CONTRACTS § 84 (1981) (waiver); RESTATEMENT (SECOND) OF CONTRACTS § 271 (impracticability). In non–aleatory contracts, the two categories of immune conditions may involve substantial overlap, but with insurance contracts most immune conditions will be so because "uncertainty of the occurrence was an element of the risk assumed" by the insured. "Waiver . . . of the fire required by an insurance policy is not within this Section" not because having a fire was part of the agreed exchange, but because the risk of loss from a peril other than fire was "an element of the risk assumed" by the insured. *See* RESTATEMENT (SECOND) OF CONTRACTS § 84, cmt. c (1981)

The second objection is even more important. In the Burton and Andersen approach, whether a particular policy provision is immune from excuse arguments under § 229 turns on a traditional ex ante inquiry into the importance of the policy

Consequently, in insurance we are free to go directly to the weighing of the consequences of excusing or not excusing the condition prescribed by section 229:

> In determining whether the forfeiture is disproportionate, a court must weigh the extent of the forfeiture by the obligee against the importance to the obligor of the risk from which he sought to be protected and the degree to which that protection will be lost if the non–occurrence of the condition is excused to the extent required to prevent forfeiture.[236]

2. What Will Be "The Extent of Forfeiture" Suffered by the Insured if the Condition Is Not Excused?

According to the *Restatement*:

> "forfeiture" is used to refer to the denial of compensation that results when the obligee loses his right to the agreed

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condition to the insurer considering the entire array of different uses to which that condition might be put. But § 229 assumes that each policy condition is material in the sense that it will sometimes operate to protect the insurer from real costs the insurer wants to avoid. § 229 instead asks how the condition is being employed in the particular case. *See id.* at § 229 cmt. a. ("[T]his Section is concerned with forfeiture that would actually result if the condition was not excused."). Eisenberg refers to this as the "second look approach":

> If, in the scenario of imperfect fulfillment that actually occurred, a requirement of perfect fulfillment would result in a substantial loss to one party that is significantly out of proportion to the interest of the other in perfect fulfillment, and if the requirement of perfect fulfillment under that scenario appears to be one to which the parties would not have agreed if they has specifically adverted to the actual scenario, courts should not require perfect fulfillment unless it is established that the parties had a specific and well–thought–through intention that perfect fulfillment be required in a scenario like the one that actually occurred.

Eisenberg, *supra* note 93, at 240.

236. RESTATEMENT (SECOND) OF CONTRACTS § 229 cmt. b (1981).

> exchange after he has relied substantially, as by preparation or performance on the expectation of that exchange. The extent of the forfeiture in any particular case will depend on the extent of that denial of compensation.[237]

What does that mean for an insurance case? It means that the "extent of the forfeiture" to be placed in the section 229 balance is the amount of recovery from the insurer that will not be available because of the failure of condition. If insured property is damaged, and the insurer refuses to pay because of a failure of condition, the insured suffers a forfeiture regardless of whether the claim is denied because the insurance had lapsed, the cause of loss was an excepted cause, a warranty was breached, or the notice was late. The second prong of the section 229 inquiry is not concerned with the reasons for the denial. It keeps our attention focused squarely on the impact of the failure of condition on the insured. And from that perspective, a "no" is still a "no," no matter how it is justified. The "extent of the forfeiture" is the extent of the compensation denied.

At first blush, the conclusion that a forfeiture results whenever a failure of condition prevents recovery may seem less than obvious. After all, the *Restatement* does say that the insured suffers a forfeiture when he "loses his right *to the agreed exchange* after he has relied substantially,"[238] and that language might appear to invite insurers and insureds to offer their competing understandings of the essential core of the agreed exchange. Insurers can dust off the standard–issue argument that an insurer has no present active duty to pay on a loss unless all conditions have been satisfied, and that a failure of condition therefore can not cause an insured to lose a "right" she never had. Insureds, attempting to adapt the same language and logic to their own ends, might be tempted to concede that the insurer's refusal to perform because the loss occurred outside the policy period or because it was caused by an excluded peril involves no forfeiture, because those conditions are "coverage–defining," but to argue that a "technical only" nonprejudicial failure to satisfy a post–loss notice condition produces a forfeiture.

The question thus exposed is whether we should rationalize our intuition that section 229 does not authorize us to excuse failure to satisfy a rodent exception by saying that the insured did not suffer a forfeiture *of the agreed exchange*, or by saying that, though the failure of condition created a forfeiture, we are unprepared to excuse that failure because the forfeiture was

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237. *Id.* (cross reference to § 227 cmt. b omitted).

238. *Id.* (emphasis added).

not disproportionate to the protections thereby provided the insurer. The first formulation would say that the insured did not lose what he bargained for: *indemnification-for-loss-to-property-caused-by-fire-unless-fire-was-caused-by-rodents*. The second would say that the insured lost not only his house but also his claim to be indemnified by the insurer, and thus suffered a forfeiture, but that we are not prepared to excuse that failure because the forfeiture was not disproportionate because applying the condition strictly shields the insurer from the risk "from which he sought to be protected" by including the rodent exception.

The two-step approach is preferable, for several reasons. First, it is more consistent with the language of the *Restatement*, which elsewhere insists that most insurance policy conditions are not part of the agreed exchange[239] and which clearly contemplates an inquiry both into whether the insured suffered a forfeiture and, if so, into whether its effect on the insured was disproportionate to harms to the insurer that could have been avoided by compliance with the provision. Second, the alternative, to ask in each case whether the failure of condition caused the insured to lose "the agreed exchange," would condemn lawyers and judges to endless essentialist debates of the sort that in this country enervate efforts to apply the "Doctrine of Reasonable Expectations" and that in Britain and some former Commonwealth countries have condemned their counterparts to a gerbil-cage pursuit of the "core" or "essence" of a contractual undertaking hedged in by conditions.[240] Anyone who has reviewed the claims-made litigation of the past decade, contemplated whether a failure to satisfy an exception clause should be treated as a "fundamental breach,"[241] or has puzzled over the

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239. *See supra* note 235.

240. *See, e.g.*, Dafydd Jenkins, *The Essence of the Contract*, 27 CAMBRIDGE L.J. 251 (1969). Much of the debate has swirled around the work of Professor Coote. *See* BRIAN COOTE, EXCEPTION CLAUSES (1964); Nyuk Chin, *The Problem of Exception Clauses: A Theory of Performance Related Risks*, 15 U. WEST. AUST. L. REV. 347 (1983).

241. In *Karsales Ltd. v. Wallis*, 1 W.L.R. 936 (C.A. 1956), Lord Denning gave the doctrine of fundamental breach its modern incarnation: "exempting clauses . . . no matter how widely they are expressed, only avail the party when he is carrying out his contract in its essential respects." *Id.* at 940. The decision set off a world-wide hunt for a way to identify the "core" duties of contracts. As Professor Meyer explained:

> "fundamental obligation" would better express the doctrine's notion of an irreducible core duty, a duty which arises from the

implicit immunity of "coverage clauses" from warranty statutes,[242] incontestable clauses,[243] and equitable doctrines of waiver and estoppel[244] will recognize the difficulties of a search for the "essence" of a contractual obligation.[245] Consider, for example, the essentialist metaphysics required

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> relationship created by the contract rather than from the specific terms. As an irreducible duty, it limits party autonomy to provisions outside the core and invalidates attempts to exempt or exculpate within the core.

Alfred W. Meyer, *Contracts of Adhesion and the Doctrine of Fundamental Breach*, 50 VA. L. REV. 1178, 1188–89 (1964). As the difficulties of that project became clear, the doctrine fell on hard times. In *Suisse Atlantique Societe d'Arment Maritime S.A. v. N. V. Rotterdamsche Kolen Centrale*, [1967] 1 A.C. 361, the House of Lords rejected the principle and declared that courts had no general power to invalidate exemption clauses; it did, however, declare that the rule of construction that prima facie parties do not intend exemption clauses to protect against fundamental breaches retained its vitality. In *Photo Production Ltd. v. Securicor Transp. Ltd.* [1980] A.C. 827(H.L.), the House of Lords confirmed that fundamental breach as a rule of law was dead, and indicated that the adoption of the *Unfair Contract Terms Act of 1977* relieved much of the pressure for judicial tools to police exemption clauses. Similar histories were written in former Commonwealth nations. Nevertheless, the habits of thought that gave rise to the project survive. *See, e.g.*, P.S. ATIYAH, AN INTRODUCTION TO THE LAW OF CONTRACT 117 (2d ed. 1971) ("Every contract contains some fundamental obligation which is the primary object of the whole contract."). For a sustained criticism of the project, see COOTE, *supra* note 240.

242. *See, e.g.*, JERRY, *supra* note 48, § 101 at 523–26 (describing difficulties in distinguishing regulated "warranties" from "coverage provisions"); Works, *supra* note 200, at 232–50 (offering functional approach to classification of policy provisions subject to warranty statute).

243. *See, e.g.*, Works, *supra* note 197; William F. Young, *"Incontestable" — As to What?*, 1964 U. ILL. L.F. 323.

244. The difficulties of trying to distinguish between defensive and offensive use of waiver and estoppel in an insurance setting are summarized in Works, *supra* note 197, at 820–23. *See also* PATTERSON, *supra* note 173, § 94; W.C. Crais III, Annotation, *Comment Note: Doctrine of Estoppel or Waiver as Available to Bring Within Coverage of Insurance Policy Risks Not Covered by Its Terms or Expressly Excluded Therefrom*, 1 A.L.R.3d 1139 (1965).

245. Professors Burton and Andersen provide a good demonstration of the difficulties. In their view, "confusion about when and why express conditions should be enforced" can be "eased by recognizing that many conditions serve to enforce the agreement, not to define the required performance." BURTON & ANDERSEN, *supra* note 128, at 8. "If the condition is an enforcement term, good faith allows it to be

for any dispute about whether a notice condition in an ordinary homeowners' policy should be treated as part of the agreed exchange. If we define whether there is a forfeiture by whether the insured will get "the agreed exchange," that means that for notice provisions we must be willing to say that the agreed exchange should be interpreted to be "*indemnification-for-loss-to-property-caused-by-fire-unless-fire-was-caused-by-rodents-but-not-if-notice-is-not-given-within-10 days-and-the-insured-can-prove-that-the-insurer-was-prejudiced*" rather than "*indemnification-for-loss-to-property-caused-by-fire-unless-fire-was-caused-by-rodents-but-not-if-notice-is-not-given-within-10 days.*" Such a conceptualist effort to imagine answers to all questions ex ante is consistent with habits of contractual thought that imagine that all questions of application were presentiatated, explicitly or implicitly, at the time of contracting. But that is not the focus of *Jacob & Youngs v. Kent*, nor of the subterranean insurance traditions we have been exhuming, and it not the focus of section 229. Those traditions are self-consciously and aggressively ex post.[246]

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invoked only when doing so advances the purpose for which it was included in the agreement, without unnecessary cost to the party against whom enforcement is sought." *Id.* However, when "the purpose of the express condition is to qualify or describe performance, or to limit the circumstances under which it is due, rather than to provide incentives for its completion or compensation for its breach," *id.* at 305, the condition should be treated as a performance term which cannot be excused.

Whatever the merits of this approach for non-aleatory contracts, in the insurance context the distinction between performance and enforcement terms does not advance us beyond the more familiar distinction between "coverage" and "noncoverage" provisions. Just as every insurance policy condition plausibly can be said to help establish what "coverage" the policy provides, so every insurance policy condition plausibly can be said to "qualify or describe [the insurer's] performance, or to limit the circumstances under which it is due." To make the distinctions necessary in the insurance context, we need a more robust version of what an insurer is trying to accomplish, and that requires a fuller appreciation of what sorts of risks the insurance contract is seeking to allocate. *See generally infra* section II.C.3.

246. RESTATEMENT (SECOND) OF CONTRACTS § 229 cmt. a (1981) provides in pertinent part:

> Although both this section and § 208, on unconscionable contract or term, limit freedom of contract, they are designed to reach different types of situations. While § 208 speaks of unconscionability "at the time the contact is made," this Section is concerned with forfeiture that would actually result if the condition were not excused. It is intended to deal with a term that does not

But there is a third reason as well. By treating every failure of condition as creating a forfeiture, and then asking if the forfeiture was disproportionate, we force ourselves to look where we should—at the impact of the failure of condition on the insurer. Much of modern insurance law reacts to the realities of insurance policy boilerplate by treating the insurer's purpose in employing the provision as less important than the insured's real or hypothetical purposes in purchasing the coverage. Under the Doctrine of Reasonable Expectations, the objective reasonable expectations of insureds —but not insurers—are determinative of coverage; under construction contra proferentem, if any meaning contrary to that intended by the insurer can be wrung from policy language, it can be declared ambiguous and given the meaning the insurer does not want. But under section 229, the insurer's purpose in employing the condition returns to center stage. If every failure of condition defense creates a forfeiture, then the proper question is whether the extent of that forfeiture is disproportionate to the harms to the insurer that could have been avoided by compliance with the condition. Sometimes compliance with a condition buys freedom for the insurer from costs that are commensurate with the costs imposed on the insured by failure of a that condition, and sometimes it does not. Sometimes the forfeiture is proportionate, and sometimes it is not.

But when is a forfeiture "disproportionate?" Unless we can answer that question, we have accomplished nothing.[247]

> appear to be unconscionable at the time the contract is made but that would, because of ensuing events, cause forfeiture.

See also Eisenberg, *supra* note 93 (emphasizing "second look" function of § 229).

247. A preliminary draft of what became § 229 would have set a different standard. Rather than excusing failures of condition "to the extent that non–occurrence of a condition would cause disproportionate forfeiture," RESTATEMENT (SECOND) OF CONTRACTS § 255 (Tentative draft # 7, 1972), would have excused conditions "[t]o the extent that non–occurrence of a condition would cause extreme forfeiture." As Professor Murray noted at the time, "the difficulties in determining whether the non–occurrence of the condition is 'relatively unimportant' to the obligor and whether the forfeiture is 'extreme' should not be underestimated." JOHN E. MURRAY, MURRAY ON CONTRACTS § 168, at 331 (2d ed. 1974). *See also infra* notes 274–288 and accompanying text.

3. When Is a Forfeiture Disproportionate?

We begin our search for a way to distinguish disproportionate from other forfeitures by returning yet again to the deceptively simple question: What do we mean when we say that the coverage provided by an insurance policy is "less?" Ignoring for the moment whether we mean less than would be provided by another policy, or less than the insured wanted, less than is warranted by the price, or less than something else,[248] we usually mean that the insurer is assuming less risk, and the insured is retaining more risk, than would be the case under some other alternative.[249] That is consistent with the conventional understanding that an insurance contract is one choice among the classic alternatives for dealing with risk. In the usual telling, a person facing a risk of, for example, fire loss can choose to retain that risk, can take steps to eliminate or to reduce that risk, or can transfer that risk.[250] Insurance contracts involve a transfer of risks from insured to insurer: the insured takes on a certain present cost in order to avoid an uncertain future cost; the insurer takes on an uncertain future liability in order to obtain a present premium.

We often find it convenient to think and talk as though it really were that simple. Absent the fire insurance contract, we say, the risk of a fire loss would have been borne by the insured; with the insurance contract to transfer that risk, the burden of the loss will be borne by the insurer. Because the collision coverage was subject to a $250 deductible, we say, the collision insurer will pay $350 of the $600 repair bill; had there been no deductible, the risk of the entire $600 loss would have been transferred to the insurer. In

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248. For thoughtful treatments of the difficulties if we try to move beyond the assumption that value is measured by the price willingly paid by informed buyers and willingly taken by informed sellers, see ELIZABETH ANDERSON, VALUE IN ETHICS AND ECONOMICS (1993); HENRY WOO, COGNITION, VALUE & PRICE: A GENERAL THEORY OF VALUE (1992).

249. Of course, the characterization is not limited to insurance contracts; we are all accustomed to thinking of contracts of all kinds as ways of allocating risks between the contracting parties. *See, e.g.,* OLIVER W. HOLMES, THE COMMON LAW 239 (1881) (characterizing contracts as a "wager" on uncertain future events); RICHARD POSNER, ECONOMIC ANALYSIS OF LAW 92–93 (3d ed. 1986) (contracts as device for allocating future uncertainties). *But see* Morris R. Cohen, *The Basis of Contract,* 46 HARV. L. REV. 553 (1933) (emphasizing role of contract law in distributing unallocated risks).

250. One near–canonical statement of the choices, drawing on early theoreticians of risk in this country and Europe, is ALAN WILLETT, THE ECONOMIC THEORY OF RISK AND INSURANCE 71–89 (1951).

such casual modeling, we assume that the expected value of the risk will remain the same whether it is borne by the insured or by the insurer or is carved up between them.[251] If pressed, we may point to different risk preferences, or the insurer's superior ability to diversify, to explain why an insured sometimes will be willing to pay a premium in order to be relieved of a risk and an insurer sometimes will be willing to assume a risk that the insured is willing to pay to avoid.[252]

But, of course, it really is not that simple. Insurance involves the combination as well as the transfer of risks, and with increased numbers comes a reduction in uncertainty; as a result, "[t]he risk that an insurance company carries is far less than the sum of the risks of the insured[s]."[253] Moreover, when we separate control of an activity from responsibility for the costs of that activity,[254] we create moral hazard.[255] The fire insurance

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251. This way of thinking is bred in the bones. Thus, Professor Chirelstein:

> In general, the function of a contractual condition is to place the risk of the non–occurrence of the critical event on one party rather than the other. One speaks of "risk" in this connection because the failure of a condition would often entail a loss, or at least a disadvantage, to one of the parties, with some corresponding advantage or immunity to the other.

MARVIN A. CHIRELSTEIN, CONCEPTS AND CASE ANALYSIS IN THE LAW OF CONTRACTS 99 (3d ed. 1998).

252. *See, e.g.*, CHARLES J. GOETZ, CASES AND MATERIALS ON LAW & ECONOMICS (1984). "Risk *transferral* thus reduces risk costs when an otherwise unchanged risk is reallocated to a person who, merely for psychological reasons, attaches a lower certainty equivalent to the risk." *Id.* at 123. Of course, the willingness of a commercial insurer to assume a risk that the insurer will pay to avoid has less to do with differences in psychological attitudes toward risk than with the insurer's superior ability to diversify by pooling the risk with other independent risks. Pooling permits the insurer to reduce the variance around the mean, and that reduction in uncertainty makes the expected value of the aggregated risks less than the sum of the individual risks being pooled.

253. WILLETT, *supra* note 250, at 73.

254. *See* NEIL DOHERTY, INSURANCE PRICING AND LOSS PREVENTION 6 (1976).

255. The classic economic treatments of moral hazard include Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963); Bengt Holmstrom, *Moral Hazard and Observability,* 10 BELL J. ECON. 74 (1979); Mark V. Pauly, *The Economics of Moral Hazard: Comment,* 58 AM. ECON. REV. 531 (1968); Steven Shavell, *Risk Sharing and Incentives in the Principal and*

contract may cause the risk of loss by fire to "mutate":[256] the insured, by virtue of the fire insurance contract, may have less—or more[257] —incentive

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Agent Relationship, 10 BELL J. ECON. 55 (1979); Joseph E. Stiglitz, *Risk, Incentives, and Insurance: The Pure Theory of Moral Hazard*, 8 GENEVA PAPERS ON RISK & INS. 4 (1983). For important recent contributions, see HEIMER, *supra* note 129; Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237 (1996); Ralph A. Winter, *Moral Hazard and Insurance Contracts*, *in* CONTRIBUTIONS TO INSURANCE ECONOMICS 61 (Georges Dionne ed., 1992).

256. *See* DOHERTY, *supra* note 254, at 1. As Doherty notes, "moral hazard" is used in at least two senses:

> In one sense, moral hazard refers to abuses of insurance protection which relate to deficiency of character on the part of the insured, for example, faking a claim or exaggerating its amount or even deliberate destruction of property in order to claim the insurance money. . . . A broader interpretation, sometimes called morale hazard, refers to factors such as carelessness and indifference which may not suggest moral deficiency but still refer to personality traits which react with the security of insurance protection.

Id. at 2. But that "narrow and emotive" focus distracts from the more important sense in which insurance contracts create moral hazard:

> Whilst the contract of insurance transfers incentives for loss prevention to the insurer, it is rarely accompanied by a corresponding right to interfere with the insured's life, activity or property. There is a separation of incentive and control. Nevertheless, the insurer is not without bargaining power since he may vary the terms and conditions on which he goes on cover. There may be a system of premium reductions and /or extensions of cover if the insured does specific things to reduce the risk. Alternatively, there may be premium penalties, exclusions of cover or threatened withdrawal of cover altogether in the face of adverse features of the risk. A third possibility is that insurance premiums may be directly related to claims experience such that bad risks will, on average, pay more for their insurance than good risks. It is therefore clear that the pricing of insurance and the conditions of cover may create a system of secondary incentives for loss prevention. . . .

Id. at 3.

to install sprinklers, to avoid smoking in bed, or to preserve damaged property after a fire.[258] Insurance, thus, not only transfers risks and reduces risks; it also may change risks by affecting the likelihood that a loss will occur and by affecting the likely magnitude of any loss that does occur. Though we are correct in thinking that an insurance contract transfers a quantum of risk from insured to insurer, if we are careful we will acknowledge that the effects of diversification and of moral hazard may make the expected value of the risk borne by the insurer different than would be the expected value of the risk if it were retained by the insured.

And it gets more complicated in less familiar ways. Insurance contracts are not self–executing. Even a simple insured fire loss must be adjusted to determine the fact and amount of the insurer's obligation. Often there will be uncertainties about the contract, the law, the facts, and how the law and contract will be applied to the facts.[259] Answering such questions involves loss adjustment costs and uncertainty costs for both insurer and insured. Economists, when they do not assume such costs away, speak generically of "transaction costs," or more specifically of "decision costs," "probable error costs," "implementation costs," "enforcement costs," or the risk that the contract will prove "unverifiable"; in the language of insurance law associated with Edwin Patterson, these are costs attributable to "juridical

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257. *See* Isaac Ehrlich & Gary Becker, *Market Insurance, Self Insurance, and Self–Protection*, 80 J. POL. ECON. 623 (1972), who argue that if insurance is structured to provide price or other incentives for increased prevention activities, increases in insurance protection may actually lead to increases in prevention activities — a phenomenon that has been dubbed "moral imperative." *See* Chunchi Wu & Peter Colwell, *Moral Hazard and Moral Imperative* 55 J. RISK & INS. 101 (1988).

258. Insurance texts emphasize that moral hazard has both an ex ante and an ex post character. The first deals with the insured's altered incentives to avoid loss; the second deals with the insured's altered incentives to mitigate losses after they have occurred. Deductibles are widely regarded as the insurer's chief practical technique for controlling moral hazard; however, a deductible perversely may enhance moral hazard by creating incentives to inflate claims to get above the deductible. *See* Richard J. Butler & John D. Worrall, *Claims Reporting and Risk Bearing Moral Hazard in Workers' Compensation*, 57 J. RISK & INS. 191 (1991).

259. "Law must be applied, and it is applied by a system of courts and administrative agencies in which the human element is all too apparent." Spencer Kimball, *Nature of the Liability Hazard*, PROPERTY & LIABILITY INSURANCE HANDBOOK 447, 457 (J. Long & D. Gregg eds., 1965).

hazards."[260] Though introductory insurance texts—perhaps because they tend to focus on potential causes of "loss" rather than potential causes of "costs"—do not give "juridical hazard" the same prominence as "physical hazard" and "moral hazard" as potential sources of burdens insurers assume by underwriting an insurance contract, the real–world importance of "juridical hazard" clearly is reflected in a variety of insurance practices and institutions, not the least of which is the accounting practice that expresses the insurer's burden as the sum of "loss costs" and "loss adjustment expenses."

How does this venture into bargain–basement scholasticism help us to understand the role of conditions in insurance contracts and insurance law? At the least, it offers a vocabulary that will permit us to be more precise about just what costs will be borne by whom when an insurer and an insured include various kinds of provisions in an insurance contract, and it provides a warning that the casual conventions that treat policy provisions as allocating discrete and immutable risks to either the insured or the insurer must be approached with some caution. Risk, after all, is in this setting a probability statement about the likely incidence and magnitude of *costs*; potential and actual *costs*—whether they are occasioned by physical, moral, or juridical hazards—should be the focus of our attention.

Of course, we know that an insurer need not take on responsibility for all of these potential costs. It can use marketing strategies and underwriting rules and price to make sure that some risks are not added to its portfolio, and it can use insurance policy provisions to identify conditions that must be satisfied if the insurer is to become obligated to perform. And therein lies the

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260. PATTERSON, *supra* note 173, §§ 66–69 at 272–98. As Patterson explained:

> If the elements of coverage were unambiguously defined and if the insured fully understood and honestly abided by them, or even if all the facts were indisputably ascertained and the terms of the contract infallibly applied by court and jury, insurers could get along with fewer conditions. These "ifs" are violent assumptions.

Id. at 200. Friedrich Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629, 631 (1943), employed the term more as it is used among members of the lay insurance community: "The insurance business probably deserves credit also for having first realized the full importance of the so–called 'juridical risk,' the danger that a court or jury will be swayed by 'irrational factors' to decide against a powerful defendant."

second set of complications: as we have seen, express conditions can be very blunt instruments for limiting the risks to which the insurer is subject.

A few simple examples will help to explain why some express conditions carry the potential for disproportionate forfeitures and some do not. Consider first the way an auto insurance policy allocates the costs of an ordinary insured fender–bender: the policy provides that, if damage to the insured automobile is caused by collision, the insurer will pay repair costs in excess of a $250 deductible. If the cost to repair the automobile to its pre–collision value is $600, we expect $350 of those costs to be borne by the insurer and $250 of those costs to be borne by the insured, and we feel comfortable saying that the insured retained the risk of the first $250 in collision damage and transferred the risk of damage above that deductible to the insurer. Of course, when we think and talk that way we are ignoring other costs of the collision that go unmentioned in the policy language. The insured must miss a couple of hours of work to secure appraisals of the damage; he may have transportation costs while the car is being repaired; he certainly will regard the whole process as an unfortunate aggravation. And the insurer's costs attributable to the accident are not limited to $350; at the least there will be loss adjustment costs that can be allocated to this collision claim. But though a fully–specified, fully–nuanced risk–allocating contract would spell out who will bear the burden of each of these costs, the insurance policy's bare–bones conditional promise to pay repair costs in excess of $250 accomplishes the same results by maintaining an eloquent silence about these additional costs. If there is no mention of lost wages or rental car costs or loss adjustment costs, those costs will remain where they fall.

But what if we complicate things a little more by asking how we should understand the risk allocation worked by the deductible applicable to the collision coverage? We felt comfortable saying that the risk of collision damage of less than $250 was not among the risks transferred to the insurer; therefore that risk was retained by the insured. But is the quantum of risk avoided by the insurer by virtue of the deductible really equivalent to the quantum of risk retained by the insured as a result of the deductible? Not exactly, for risk is a compound of physical, moral, and juridical hazards, and the net expected value of a risk may differ depending upon which party is being asked to bear it. Making the collision coverage subject to a deductible, insurers hope, will give the insured additional incentives to forgo the extra trip to the store in freezing rain, and make it more likely that minor bumps will go unreported and unfixed and unadjusted and unpaid. Here the language of risk allocation fits less well, for adding the deductible to the auto policy

does not simply allocate a discrete, fixed, and finite risk to the insured; it actually makes the total quantum of risk to be divided up between the parties less than if would be if there were no deductible. And this sort of inevitable mismatch between the quantum of risk avoided by the insurer and the quantum of risk retained by the insured as a result of policy conditions is not limited to deductibles and other policy provisions explicitly aimed at controlling moral and juridical hazards. Even a provision apparently intended to eliminate a physical hazard from the insurer's calculus of concerns—for example, the homeowners policy provision excepting from coverage "loss. . . caused by rodents"—will affect moral and juridical hazard as well, so that the net expected value of the risks allocated by that provision also may differ depending upon which party is being asked to bear them.

Still, such academic quibbles should not prevent us from taking advantage of the simplifying verbal shorthand of "risk allocation." Insurance policy provisions like deductibles and rodent exceptions do function as devices for allocating risks between insurer and insured. Liability limits, deductibles, coinsurance provisions, and terms defining the duration of the contract, covered and excluded kinds of loss, and covered and excluded causes of loss all usefully can be regarded as techniques by which the insurer, in the language of the *Restatement*, "makes an event a condition of his duty in order to shift to the obligee the risk of its nonoccurrence."[261] Such "coverage provisions" share an intrinsic complementarity that allows us to equate what the coverage is with the insurer's burden and what the coverage is not with the insured's burden. If the condition has been satisfied, then the insurer must bear some costs that otherwise would have fallen on the insured; nonoccurrence of a condition means that the insured will bear some costs that otherwise would have been shifted to the insurer. In that sense, policy conditions allocate risks between insurer and insured, and usually we need not pause to point out that the risks avoided by virtue of the provision may not have exactly the same expected value as the risks thereby retained.

But for some kinds of insurance policy conditions, most visibly notice and other loss–adjustment conditions, continuing warranties, and evidentiary conditions, the potential mismatch is fundamentally different. For example, when a personal automobile insurer makes prompt notice of loss a condition of its duty to perform, we understand that the insurer is trying to avoid costs associated with late notice—costs that we would classify as the product of

261. RESTATEMENT (SECOND) OF CONTRACTS, § X (*Topic 5. Conditions and Similar Events. Introductory Note*) (1981).

juridical hazard.[262] But is it helpful to say that the insurer is using the notice condition to allocate to the insured the risk of having to bear those costs? We can imagine a policy provision that unambiguously would do exactly that, by providing that the insured rather than the insurer shall bear any costs caused by untimely notice; under such a nuanced risk–allocation provision, if the insurer were forced by the delay in the notice to conduct a more expensive investigation, the extra costs of that investigation would be paid by the insured. But insurers typically do not include such narrowly–tailored provisions to shift the costs of noncompliance with the notice provision from insurer to insured.[263] Instead, they employ an express condition that operates

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262. The classic ascription of purpose to notice conditions was provided in *Brakeman v. Potomac Ins. Co.*, 371 A.2d 193, 197 (Pa. 1977):

> [A] reasonable notice clause is designed to protect the insurance company from being placed in a substantially less favorable position than it would have been in had timely notice been provided, e.g., being forced to pay a claim against which it has not had an opportunity to defend effectively. In short, the function of a notice requirement is to protect the insurance company's interests from being prejudiced.

See generally WINDT, *supra* note 21, § 1.04.

263.

> In the absence of transaction costs, an ideal insurance arrangement would address these contingencies, specifying the exact proof required to "establish" essential facts, the circumstances under which the insurer must respond to doubt about the facts by incurring additional costs of investigation, and the disposition of the claim pending the outcome of additional investigation or litigation. It would be attentive to the relative burden of establishing the facts, placing the costs of establishing them on the party that can bear them most cheaply . . .
>
> Given the range of contractual provisions in play and the way in which the optimal bargain may depend on particular facts and circumstances, however, we might anticipate that the transaction costs of addressing these matters expressly will often exceed the benefits ex ante and that insurance contracts will then fail to provide much guidance as to the appropriate treatment of factual uncertainties. Indeed, express attention to the treatment of factual uncertainties in insurance agreements appears to be fairly rare.

quite differently: when notice is late, the condition shields the insurer from juridical hazards associated with late notice, but it does so by excusing the insurer from any obligation to perform and by denying all recovery to the insured. This potential mismatch between the costs that the insurer avoids when the condition is satisfied and the costs that the insured bears when the condition is not satisfied is different in kind from the rather incidental mismatches due to moral hazard and juridical hazard we encountered with the deductible and the rodent exception. The condition purports to authorize the insurer to deny all obligations to the insured whether or not the failure of condition prejudiced the insurer.[264]

The same phenomenon can be seen at work in "continuing warranties" employed by insurers to control their exposure to moral and physical hazards.[265] Consider, for example, the once–common provision in property

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Alan O. Sykes, *"Bad Faith" Breach of Contract by First–Party Insurers*, 25 J. LEGAL STUD. 405, 424–25 (1996) (noting one exception: travel insurance with elaborate provisions governing presumption of death). Compared to the complete contingent claims contract with which Professor Sykes is comparing standard insurance policy forms, that is doubtless true. But insurance policies do display efforts to deal with factual uncertainties, most notably by employing express conditions that turn on easily–established facts rather than real object of the insurer's concern.

264. Of course, an insurer need not assert a defense every time the policy language provides a colorable argument that a claim is not covered. What in Scandinavian insurance circles is called *kulanse, see, e.g.*, Knut S. Selmer, *Gratuitous Deviation from the Terms of Form Contracts: Scandinavian Insurance Companies' Administration of Deferred Acceptance–of–Risk Clauses*, 33 U. CHI. L. REV. 502, 503 (1966), and in this country sometimes is called a payment *ex gratia*, is simply recognition of the discretion that broadly–framed policy language can confer. Apparently that recognition is sometimes formalized in claims adjustment manuals: "If there is six months to a year delay, use your discretion relative to acceptance if there is no prejudice." AETNA TECHNICAL CLAIM MANUAL B–5–1 (Oct. 1977), *quoted in* Anderson, *Draconian Forfeitures*, *supra* note 232, at 862–69. In legal terms, the result often is characterized as a "waiver." *See generally* RESTATEMENT (SECOND) OF CONTRACTS § 84 (1981). *See also* Baker & McElrath, *supra* note 134 (exploring exercise of discretion in adjustment of claims).

265. *See generally* PATTERSON, *supra* note 173, §§ 53–55 at 199–204 (detailing a "conception of warranty that includes the *purposes* for which warranties are used, the *legal consequences* which flow from noncompliance, and the *evils* or *injustices* that ameliorative statutes are intended to remedy"); Edwin Patterson, *Warranties in Insurance Law*, 34 COLUM. L. REV. 595 (1934); Edwin Patterson, *The Apportionment of Business Risks Through Legal Devices*, 24 COLUM. L. REV. 335 (1924). William

insurance policies declaring the policy void "if the property . . . shall be encumbered by mortgage."[266] The primary purpose of such provisions was unremarkable: to alleviate insurer concerns that less–than–full ownership of insured property might entail greater moral hazard than if the insured's interest were full. But the method of the moral hazard warranties created the same potential for a fundamental mismatch between the costs the insurer avoids when the condition is satisfied and the costs the insured bears when the condition is not satisfied as do notice provisions and other loss adjustment conditions explicitly aimed at controlling the insurer's exposure to juridical hazards. In theory, an insurer who recognized that informational asymmetries and quantification difficulties will make it impossible to price the moral hazard posed by a mortgage on the property could choose to limit its exposure to the most egregious manifestations of moral hazard by crafting a narrowly tailored exception from coverage for losses "caused by reduced incentives to care resulting from a change in the insured's ownership interest." Such a provision would respond directly to the insurer's concerns about having its costs increased by moral hazard, but—as the recent history of "expected or intended" litigation demonstrates—that formulation obviously would present the insurer with a considerable juridical hazard. A provision declaring the policy void "if the property . . . shall be encumbered by mortgage" involves much less juridical hazard than would one that required the insurer to show that partial ownership contributed to the loss, for the simple reason that a trip to the register of deeds for proof of a failure of condition usually will be much easier than would be a courtroom safari through the insured's psyche or soul. But this effort to avoid the juridical hazards associated with more nuanced risk allocation provisions comes at a price: a potential mismatch between the costs avoided by the insurer when the provision is satisfied and the costs borne by the insured when it is not.

R. Vance, *The History of the Development of Warranty in Insurance Law*, 20 YALE L.J. 523 (1911), is much less helpful, for it focuses chiefly on the struggle over whether insurers would be allowed to convert pre–issuance underwriting representations into warranties in order to avoid the materiality and other limitations of the law governing rescission on the grounds of misrepresentation. *See* note 196 *supra* and accompanying text. The warranties we are considering are those which would be satisfied, or not, by what occurs during the term of the policy.

266. *See generally* PATTERSON, *supra* note 173, § 68 at 280–90; George W. Goble, *The Moral Hazard Clauses of the Standard Fire Insurance Policy*, 37 COLUM. L. REV. 410 (1937).

So too with physical hazard warranties. It is not difficult for us to imagine the concerns about physical hazards that prompted insurers to include "vacancy or unoccupancy" clauses in their property insurance policies. And it is not difficult to understand why they did not choose to frame those clauses to except from coverage losses "caused by" vacancy and unoccupancy. Such a provision would require that the insurer demonstrate a causal nexus between the fact that the owners were on sabbatical in New Zealand and destruction of their house by a covered peril. In some proportion of fires that occur while the owners are away, the insurer will not be able to convince the trier of fact of the causal nexus; even when it succeeds, the effort may prove costly. By crafting the policy as a warranty that will be violated if the loss occurs "while" the house is vacant or unoccupied, the insurer can avoid even having to try. Choosing a "while" formulation rather than a "caused by" formulation thus produces a reduction in the expected value of the insurer's loss costs and loss adjustment costs under the policy, but it also creates a potential that the insured will suffer a forfeiture that is disproportionate to the costs the insurer thereby avoids.

Evidentiary conditions like the familiar "visible external marks of forced entry" requirement of some theft coverages[267] pose the same potential for a

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267. "External marks" conditions are the most familiar example of evidentiary conditions, chiefly because they posed the problem for two judicial decisions that are much studied in American law schools. *See* Ferguson v. Phoeniz Assur. Co., 370 P.2d 379, 387 (Kan. 1962) ("[W]here a rule of evidence is imposed by provision of an insurance policy, as here, the assertion of such rule by the insurance carrier, beyond the reasonable requirements necessary to prevent fraudulent claims against it in proof of the substantive conditions imposed by the policy, contravenes the public policy of this state."); C & J Fertilizer, Inc. v. Allied Mut. Ins. Co., 227 N.W.2d 169 (Iowa 1975) (placing result on grounds of "reasonable expectations," "implied warranty," and "unconscionabilty"). Together the two opinions provide a mini catalog of the sort of ex ante regulatory perspectives that still dominate the thinking in insurance. BURTON & ANDERSEN, *supra* note 128, prefer their "good faith in enforcement" analysis.

Another fecund source of evidentiary condition litigation are conditions found in policies that promise benefits if the insured dies, or is disabled, or suffers a dismemberment, as a result of an accident. In order to avoid the juridical hazard associated with such causal inquiries, insurers sometimes condition liability on proof that the death, disability, or dismemberment occurred within a specified period of time. *See generally* Eric M. Holmes, *Interpreting an Insurance Policy in Georgia: The Problem of the Evidentiary Condition*, 12 GA. L. REV. 783 (1978); William Young, *Insurance Policy Defenses: In Search of Restatements*, 34 ARK. L. REV. 507,

mismatch between costs avoided by the insurer when the condition is satisfied and costs borne by the insured when it is not. We can acknowledge the legitimacy of the insurer's wish to limit its exposure to some juridical uncertainties about whether a theft, as opposed to an inside job, really occurred, but at the same time recognize that failure to narrowly tailor the evidentiary condition to serve that purpose could permit denial of a claim even when there is no doubt that a theft occurred. But with evidentiary conditions there is at least a taxonomic difference. Compliance with the notice condition and moral and physical hazard warranties usually will be within the control of the insured. Those provisions could be characterized as designed to create incentives for the insured to provide timely notice, leave the property unmortgaged, and keep furniture and people in the insured dwelling, and the insurer's failure to more narrowly tailor those conditions to fit those purposes could be explained in at least two ways: as an effort to avoid the juridical hazards that would result from the use of more nuanced provisions, or as an effort to create even more powerful incentives to comply. Just as contracts scholars speculate that basketball fanatics who worry that default rule damage measures may not give the bus driver with whom they have contracted sufficient incentives to get them to the tournament on time, and may thus bargain for a contract provision requiring super–compensatory damages in the event of breach in order to create additional incentives for timely performance,[268] so we might imagine that insurers employ broadly framed strict conditions in order to create a threat of a complete forfeiture as an added inducement to the insured to make sure that the conditions are satisfied. But with evidentiary conditions, that alternative explanation for the broadly–framed condition is not available. The point of the evidentiary condition requiring visible external marks is not to change the insured's conduct. The point is to avoid a juridical hazard.

Still, our concerns about the potential mismatch between risk avoided and risk retained occasioned by such provisions do not depend on whether we think a particular policy condition was drafted to play a "risk allocation" or "incentive creating" role. Whether we understand the overbreadth to be the product of sloppy drafting, a conscious program to minimize juridical hazard,

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521–23 (1981); Laurent B. Frantz, Annotation, *Validity and Construction of Provision in Accident Insurance Policy Limiting Coverage for Death or Loss of Member to Death or Loss Occurring Within Specified Period After Accident*, 39 A.L.R.3D 1311 (1971).

268. The hypothetical *Case of the Anxious Alumnus* was introduced in Goetz & Scott, *supra* note 145, at 578–79.

an effort to create supercompensatory incentives, or a cynical effort to create random defenses of the sort so often encountered in comic strips, in application it may operate as a kind of penalty provision, and—as Justice Peters recognized—in those circumstances noncompliance should be excused to the extent necessary to prevent disproportionate forfeiture.

We can now attempt a modest and provisional summation of the way section 229 should be applied to failures of insurance policy conditions. An insured who does not recover on a fire policy because a rodent exception was not satisfied suffers a forfeiture, but the forfeiture is not disproportionate because the provision operates to protect the insurer from the very costs that are thereby assigned to the insured. However, an insured who does not recover on a fire policy because a notice condition was not satisfied suffers a forfeiture that may or may not be disproportionate depending upon how the failure to satisfy the notice condition affected the insurer. In both cases, "the coverage is less" in the sense that the insured is bearing more risk than would have been the case if the condition were not present, "and so, therefore, is the cost." But less is a "syntactically mobile modifier"[269] and section 229 asks us to consider whether the coverage afforded the insured is less in quite a different sense: less than it need be in order to achieve the insurer's purpose in employing the condition. The rodent exception cannot make the coverage "less" in this second sense, for it subjects the insured to the risk of forfeiture of all claims for rodent damage in order to protect the insurer from the risk of having to pay for rodent damage. However, the notice condition may make the coverage less in this second sense, for it subjects the insured to the risk of forfeiture in order to protect the insurer from some of the costs associated with claims adjustments—costs that in particular cases may range from zero to well in excess of the value of the insured's claim.

Of course, this sort of imbalance does not make an auto policy with a notice provision substantively unfair, any more than the rodent exception made the homeowners policy substantively unfair. Viewed ex ante, which is the only proper perspective when the question is whether a provision is to be treated as an enforceable part of the contract, it makes sense to say of all these conditions: "the coverage is less, but so, therefore, is the cost." But section 229 tells us to take a "second look" ex post at provisions that undeniably are a part of the contract in order to determine whether on particular facts a failure to satisfy the condition should be excused, and sometimes from that vantage loss adjustment conditions, warranties, and evidentiary conditions

269. George P. Fletcher, *The Right and the Reasonable*, 98 HARV. L. REV. 949, 953 (1985).

will be seen to work a fundamental mismatch between the costs that would have been avoided by the insurer if the condition had been satisfied and the costs the insurer says should be borne by the insured because the condition was not satisfied.

Does that mean that an insurer is acting in "bad faith" if denies what is clearly an otherwise covered theft claim because a "visible external marks" condition has not been satisfied? Professors Burton and Andersen say "yes."[270] Does that mean that any insurer who invokes a failure of condition defense when to do so is not necessary to protect the insurer against the costs that prompted inclusion of the provision is behaving "opportunistically?" That is the label employed by Professor Muris and a number of other commentators.[271] Of course, so long as "bad faith" and "opportunism" are deployed within texts where their meanings and consequences can be carefully controlled, there is no reason to quarrel with these characterizations. But in application, where the critical differences between Professor Andersen's "contractual bad faith in enforcement" and the bad faith that gives rise to extra–contractual damages may prove illusive,[272] the rhetoric that asks whether a particular failure of condition should be excused in order to avoid a disproportionate forfeiture can claim important advantages. In conventional

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270. BURTON & ANDERSEN, *supra* note 128, at 194. They acknowledge that "[t]he effect of such holdings [under section 229] is often identical to that of an application of the good faith in enforcement analysis." Nevertheless, they conclude: "The good faith analysis provides a more focused approach to achieving the end sought by § 229." *Id.* Elsewhere, Burton and Andersen provide this capsule summary:

> . . . . [I]f the facts of the particular case make it plain that the safe burglary was not an inside job, then the court is justified in declining to give effect to the condition. Doing so would fail to advance the purpose for which the condition was included in the agreement in the first place. Claiming the benefit of it for other reasons would be bad faith.

Steven J. Burton & Eric G. Andersen, *The World of a Contract*, 75 IOWA L. REV. 861, 874 (1990) (citation omitted).

271. *See generally* authorities cited *supra* note 95.

272. For an exploration of the way in which "fear of imposing exemplary damages for breach of implied duties ... led the Texas Supreme Court to gut the doctrine of good faith in contract," see Mark Gergen, *A Cautionary Tale About Contractual Good Faith in Texas*, 72 TEX. L. REV. 1235, 1237 (1994).

usage, "bad faith" and "opportunism" carry connotations of blameworthiness and breach of duty that we may be reluctant to ascribe to an adjuster or lawyer who believes in the strict common law rule and uses it to justify denying a claim on the basis of a technical failure of condition. Section 229 trains attention where it should be: on the effect of the failure of condition on the insurer.

Even those who see in section 229 an analog to more familiar mechanisms for ex post policing of limited remedies and penalty provisions may resist this effort to lay a section 229 template over insurance cases. Thus, their argument might go, in neither the rodent damage case nor the late notice case is the forfeiture "disproportionate" because the financial consequences to the insurer when there is compliance with the condition are commensurate with the financial consequences to the insured when there is not compliance. If a house covered by fire insurance suffers $100,000 in damages, that $100,000 loss will be borne by the insurer if the damage was caused by fire and all other conditions were satisfied; however, the $100,000 loss will be borne by the insured if the damage was caused by rodents, or if the notice was not timely, or if any other policy condition was not satisfied. Thus, the argument might go, there is nothing disproportionate about a result that denies compensation to an insured because of a failure of condition—any failure of condition.

This argument misunderstands the question the *Restatement* poses for us. Under section 229 we are not to compare the financial consequences to the insurer of compliance with all conditions (insurer pays) with the financial consequences to the insured of noncompliance with even one condition (insurer does not pay). Rather, we are to compare the costs avoided by the insurer when there is compliance with the condition with the costs avoided by the insurer (and thus borne by the insured) when noncompliance with the condition gives the insurer a defense.[273] When we put a failure to satisfy a

273. Although a focus on the relative impact of compliance and noncompliance on the insurer might seem to shift attention away from the forfeiture suffered by the insured when there is a successful failure of condition defense, we must remember that there is no question about the extent of the insured's forfeiture: it equals the amount of the insurer's nonpayment. The question is whether that forfeiture is "disproportionate." To what? To the costs caused by noncompliance with the condition. Framing the question in this way keeps attention on the relevant issue: does enforcing the term "advance the purposes for which it is included in the agreement without imposing needless costs on the [insured]." BURTON & ANDERSEN, *supra* note 128, at 194. *See also* Gergen, *supra* note 142, at 70 ("Disproportionate

rodent condition on the section 229 scales, we find that the cost avoided by the insurer and thus borne by the insured by virtue of a successful failure of condition defense ($100,000 in damages caused by rodents) is at least roughly commensurate with the cost that would have been avoided by the insurer had the condition been satisfied ($100,000 in damages caused by rodents). The same will be true of most insurance policy conditions dealing with traditional "coverage" questions: what property, whose interests, what events, caused by what perils, with what limits, during which period? Such provisions do operate to allocate roughly proportionate risks to one party and away from the other, and thus failure to satisfy such provisions will never be excused under section 229. But when we put a failure to satisfy a notice condition on the section 229 scales, we find that the cost borne by the insured as a result of the failure of condition ($100,000 in damages) may or may not be commensurate with the costs to the insurer caused by failure to comply with the condition. In order to determine whether the failure of condition works a disproportionate forfeiture we will have to put a value on the costs to the insurer that would have been avoided by compliance with the condition but were not avoided because of noncompliance.

Sometimes that will be easy. At one end of the spectrum is the case most closely analogous to *Jacobs & Youngs v. Kent*: the notice condition was not satisfied, but both parties agree that the insurer was in no way prejudiced. At the other end of the spectrum is another easy case: the condition was not satisfied, and as a result the insurer lost its right to recover the full amount of its obligation from a third party. In the first, the failure of condition defense would produce a disproportionate forfeiture, and the failure of condition should be excused; in the second, the forfeiture suffered by the insured is matched by the harm to the insurer that could have been avoided by compliance, and thus the failure of condition should not be excused.

But what about cases that fall somewhere in between? What if the late notice caused an adjuster to spend an extra half–day in his car retracing a route already taken, or meant that one of six witnesses no longer is available? In *Jacob & Youngs v. Kent*, the decision that the construction company was entitled to the final progress payment depended in part on the conclusion that Kent did not need the protections of withholding payment because he could be protected by his ability to recover damages resulting from breach of the promise to provide Reading Pipe. Of course, in insurance, failure to satisfy

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forfeiture occurs when enforcement of a condition would leave the obligee with a reliance loss while significantly overcompensating the obligor for his loss from nonfulfillment of the condition.").

a condition almost never will be a breach of promise and thus damages are not an option. Can section 229 accomplish the same thing by authorizing excuse of the nonoccurrence of the condition only to the extent necessary to avoid disproportionate forfeiture?[274] Or do the costs of applying that more discriminating standard warrant recourse to relatively crude proxies like the "prejudice" and "materiality" standards?[275] And who bears the burden of proof on these questions?[276]

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274. RESTATEMENT (SECOND) OF CONTRACTS § 229 (1981).

275. Some insight may be provided by theoretical work on the optimal degree of tailoring of contractual rules and standards, which in turn draws on the burgeoning debate about rules versus standards and the optimal complexity of each. *See, e.g.*, Ian Ayres, *Preliminary Thoughts on Optimal Tailoring of Contractual Rules*, 3 S. CAL. INTERDISC. L. J. 1 (1993). *See also* Colin S. Diver, *The Optimal Precision of Administrative Rules,* 93 YALE L.J. 65 (1983); Isaac Ehrlich & Richard A. Posner, *An Economic Analysis of Legal Rulemaking,* 3 J. LEGAL STUD. 257 (1974); Louis Kaplow, *A Model for the Optimal Complexity of Legal Rules*, 11 J.L. ECON. & ORG. 150 (1995); Louis Kaplow, *Rules Versus Standards: An Economic Analysis,* 42 DUKE L.J. 557, 624–29 (1992); Eric A. Posner, *Standards, Rules, and Social Norms,* 21 HARV. J.L. & PUB. POL'Y 101 (1997). But our very real concerns that the benefits of more nuanced approaches to determining the effects of failures of insurance conditions will be overwhelmed by the costs of administration should be seen in light of the many other ways in which the law of contracts seeks to reconcile "the competing goals of contract enforcement: securing to the injured party the benefits of its bargain and avoiding the imposition of unnecessary costs on the breaching party." Andersen, *supra* note 139, at 301. For an accessible introduction to the subtle difficulties of determining the costs and benefits of judicial approaches to policing opportunism, see Cohen, *supra* note 95, at 987–90; Muris, *supra* note 95, at 529–31.

276. The "notice–prejudice rule" at an early stage divided into two lines of authority, one placing the burden of showing that the insurer was not prejudiced on the insured, and the other placing the burden of showing that the insurer was predjudiced on the insurer. *See generally* WINDT, *supra* note 21, § 1.04 (collecting authorities). For surveys of the allocation of burdens of proof in notice–prejudice rule jurisdictions, see BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES § 4.02[b][5] (8th ed. 1995); Anderson, *Draconian Forfeitures*, *supra* note 232, at 862–69. WINDT, *supra* note 21, § 1.04, at 15, reports that the rule placing the burden on the insurer "is followed in most states, and it is continuing to gain wider acceptance." Of course, in other settings, the mitigation doctrine normally assigns to the breaching party the burden of establishing that part of the loss actually incurred could have been avoided by the victim of the breach. *See, e.g.*, III FARNSWORTH, *supra* note 169, § 12.12, at 228. As often has been noted, shifting burdens may serve as transitional devices from one substantive rule to

The moment we begin to ask such questions, we invite several obvious potential objections to using section 229 to police against disproportionate forfeitures. If, as I have argued, policy provisions should be interpreted purposively, and if a plausible understanding of loss adjustment conditions and continuing warranties and evidentiary conditions includes recognition that their apparent overbreadth may reflect insurer efforts to avoid juridical hazard that would attend more nuanced provisions, won't holding out the possibility that a failure of condition might be excused subject the insurer to exactly the kind of juridical hazards the insurer sought to avoid? Or, put another way, isn't the insurer prejudiced whenever it is required to attempt to prove whether or how much it was prejudiced by a failure of condition, or even to defend against claims that it was not prejudiced? The answer, of course, is "yes." Once we move beyond classroom hypotheticals where the critical facts concerning the impact of the failure of condition on the insurer can be supplied by assumption, any approach that denies the insurer the benefits of the strict common law rule can be said to prejudice the insurer because a more nuanced treatment of the effects of noncompliance will, on average, be more costly to apply. When we make the factual and legal predicates for decision more complicated, we create additional juridical hazards for the parties.

Shouldn't the insurer be as free to choose which juridical hazards it is willing to assume as it is to choose which physical hazards or moral hazards it is willing to assume, and shouldn't it be as free to manifest those choices in insurance policy boilerplate? The answer, of course, is "yes." The underwriting discretion traditionally enjoyed by insurers should apply also to juridical hazards. Section 229 does not police the insurer's ends, only its means. Section 229 still permits the insurance contract to assign the costs of juridical hazards to insureds, so long as the means employed are narrowly tailored to accomplish that result.[277] Thus, section 229 in no way affects the

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another. *See generally* Tamar Frankel, *Presumptions and Burdens of Proof as Tools for Legal Stability and Change,* 17 HARV. J.L. & PUB. POL'Y 759 (1994).

277. In the same way that the law encourages contracting parties to create bonds and other hostage mechanisms as incentives for performance, but balks when the hostages are human and when the self-help collection techniques include the application of ball bats to kneecaps, so in insurance it balks when the policy provisions sweep so broadly that they produce disproportionate forfeitures. For a sophisticated and entertaining introduction to these themes, see Charles J. Goetz, *Contractual Remedies and the Normative Acceptability of State-Imposed Coercion,*

ability of an insurer to assign juridical costs to the pool of insureds by incorporating such costs in its premium calculations, and section 229 would not inhibit efforts by an insurer to provide that the payout to an individual insured will be offset by an amount equal to the juridical costs caused by the individual insured's delay in giving notice, including the costs of determining the application of section 229 to the individual insured's claim.[278] But when a condition operates to assign costs to an individual insured that are significantly greater than the costs that compliance with the condition would allow the insurer to avoid, that is a penalty, works a disproportionate forfeiture, and section 229 tells us the failure of condition should be excused to the extent necessary to avoid that disproportionate forfeiture.[279]

Won't excusing some failures of condition mean an increase in the loss and expense costs for the insurer's risk portfolio, and aren't those costs likely to be reflected in insurance prices? Of course. But the assertion that an unnuanced, broadly–framed, cheaply–applied provision may be in the interests of both insurer and insureds as a group ought not to carry the same

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4 CATO J. 975 (1985). *See also* F. Eric Fryar, Note, *Common–Law Due Process Rights in the Law of Contracts*, 66 TEX. L. REV. 1021 (1988).

278. For a familiar example of contract provisions explicitly allocating some of the costs of juridical hazard, see III FARNSWORTH, *supra* note 169, § 12.18, at 310 (attorney's fees provisions). Of course, efforts to allocate juridical costs to the individual insured creating them in practice likely will be limited to direct costs; uncertainty costs and reputational costs likely will be so difficult to value that they will be borne by the party bearing the burden of proof. But that is not unique to excuse of express conditions; it is a usual consequence of mitigation rules.

279. But wait, a skeptic who has followed the argument this far might object. Why measure the amount of the forfeiture in the individual failure of condition scenario against the effect on the insurer of the individual failure of condition? Is not the more relevant question whether the costs of forfeitures worked by all failures of conditions in this class of cases are disproportionate to the juridical costs imposed on insurers and the pool by all failures of condition in this class of cases? The response is simple. Both questions are relevant. A pool can be priced in an appropriate way, on average, but still create disproportionate forfeitures if strict conditions operate to penalize insureds who fail to satisfy conditions beyond what is necessary to compensate the pool for the costs of noncompliance. We do not say that penalties are permissible because they reduce the ex ante costs for everyone, and we police limited remedies in sales of goods to assure not only that there is real agreement, and that the agreement is conscionable, but also that the conscionable and bargained for remedy does not "fail of its essential purpose." U.C.C. § 2–719 (1981). So too with failures of express conditions under § 229.

rhetorical weight now that we have been reminded of *Jacob & Youngs* and *Britton* and section 229 and their analogs throughout contracts and insurance law. We are unlikely to think Kent should escape his obligation to make the last progress payment on his mansion because he is economically literate enough to speculate that the purchase price of the house must have included an implicit risk premium to compensate Jacob & Youngs for the expected value of the risk that accidental use of functionally equivalent but nonconforming pipe would cause a forfeiture of the last payment. And we will not think it an answer to Britton's restitution claim to be told that his wages must have been enhanced to compensate him for the expected value of the risk that he might enrich his employer by walking away from both work and wages. Why not? Because, though we must concede that the parties *are free to* strike bargains that included egoistic gambles on whether Cohoes pipe would show up in Kent's basement or Britton would leave after nine months, we simply do not think that they *did* choose to roll the dice in that way. As Cardozo put it, several different ways:

> This is not to say that the parties are not free by apt and certain words to effectuate a purpose that performance of every term shall be a condition of recovery. . . . This is merely to say that the law will be slow to impute the purpose, in the silence of the parties, where the significance of the default is grievously out of proportion to the oppression of the forfeiture.[280]

So too with boilerplate conditions in standard insurance policy forms. If fully–informed insureds blessed with unbounded rationality really were choosing from a menu of policy conditions that includes both the narrowly tailored and those with a potential for disproportionate forfeitures, each with its associated price tag, we would have no compunctions about telling the insured whose gamble on a cheaper policy with a strict notice condition turns out to be a loser to toss his claim form in the trash along with his losing lottery tickets. But in a world that poses few such clear–cut choices to insureds ex ante and where bounded rationality constrains the insured's

280. *Jacob & Youngs v. Kent*, 129 N.E. at 891. Earlier in the opinion, Cardozo sounded the same refrain: "Intention not otherwise revealed may be presumed to hold in contemplation the reasonable and probable. If something else is in view, it must not be left to implication. There will be no assumption of a purpose to visit venial faults with oppressive retribution." *Id.*

ability to evaluate the options that are available, the important choice often will be the ex post choice of what purpose(s) we should impute to the language that did make it into the standard insurance policy.

For most insurance policy conditions, the argument from costs informs this interpretive enterprise in familiar ways. When the issue is whether a loss was caused by a rodent or medical expense resulted from "experimental treatment," the interpretive heuristic that asks "what coverage and implied cost these consumers would want ex ante, when faced with the choice and the bill"[281] functions chiefly as a reminder that we should regard the insurer as trustee for the greater number of insureds who comprise the risk pool, and thus should insist that conditions that allocate roughly commensurate costs to the insured and away from the insurer (and the pool of insureds) should be rigorously enforced undiluted by ex post sympathies for individual claimants. As Patricia Danzon, focusing on medical expense coverage disputes, makes the familiar point:

> Courts must recognize that insurance creates an intrinsic conflict between the insured patient's preferences ex ante, when he or she selects a health plan and pays the premium, and those preferences ex post, when illness strikes and care appears to be virtually free, because of insurance coverage. An alternative view of this ex ante versus ex post tension is the conflict between the individual interest of the patient who wants care and the interest of insured consumers as a group, all of whom face some probability of falling ill and who collectively bear the cost of care through higher premium payments. . . . [E]fficient standards of care should reflect the ex ante preferences or, equivalently, the average preferences of insureds as a group.[282]

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281. Patricia Danzon, *Tort Liability: A Minefield for Managed Care?*, 26 J. LEGAL STUD. 491, 494 (1997).

282. *Id.* at 493. Of course, opposition to ex post second looks at the risk allocations worked by contract provisions is a natural concomitant of contract models that assume complete presentiation, for on that assumption the individual insured is trying to shift responsibility for costs not covered by the insurance to the larger group of insureds. *See generally* Louis E. Wolcher, *The Accommodation of Regret in Contract Remedies*, 73 IOWA L. REV. 797, 800–03 (1988). If the insured has not accurately discounted the possibility that his initial decision to purchase might be in error, this objection loses much of its force. *See id.* (identifying ways in which legal

And that seems exactly right. The purpose of such conditions, though not the precise boundaries of their application, rarely will be in dispute. Section 229 should offer no help to homeowners with squirrel damage or medical expense insureds seeking insurance funding for experimental treatments because we recognize that the purpose and effect of denying those claims is to shield the insurer and the pool from roughly the same costs unsuccessful claimants thereby will be forced to bear.

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rules governing contract remedies accommodate ex post regret); Eisenberg, *supra* note 93 (tying "second look" to cognitive limitations that prevent full presentiation); Gergen, *supra* note 142, at 46 (denying tension between concerns for freedom of contract and ex post doctrines of impracticability, mistake, penalties, forfeiture, and good faith, which operate in a "twilight zone of contract where terms malfunction because of the unexpected").

However, when assumptions of complete presentiation are relaxed so that there is genuine uncertainty about the contours of the agreement of the parties, the concern about the ex post perspective is not that it may produce decisions that trump earlier choices, but that the first serious look at the question will come after a low–probability contingency has occurred and a particular victim has been identified. For example, when the question is what frontier medical treatments are or should be covered by medical expense insurance—a question that may be posed by vague policy language about medical necessity—"disputes are most appropriately viewed as an insurance–purchasing decision by a pool of subscribers, not a medical treatment decision made by an individual patient." MARK HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS 70 (1997). *See generally id.* at 68–73; Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1464–65 (1994). PETER W. HUBER, LIABILITY: THE LEGAL REVOLUTION AND ITS CONSEQUENCES 192 (1988), makes the point this way:

> [S]table insurance requires unemotional assessment of risk and disbursement of payments, with the temperament of an actuary and a bookkeeper, treating people as statistics. The driving force in liability law today is sympathy and emotion in the individual case. Legal rules rooted in a spirit of compulsion, and applied emotionally case by case, are profoundly inimical to insurance.

Id. But see Don Welch, *Ruling with the Heart: Emotion–Based Public Policy*, 6 S. CAL. INTERDIS. L.J. 55 (1997) (decrying the general aversion to affective, emotion–based arguments): "Heeding one's emotions can, in general, be a good guide to remaining in harmony with the fundamental commitments that result from one's considered judgment." *Id.* at 85.

But when the argument from costs is applied to a loss adjustment condition, a warranty, or an evidentiary condition, it may appear to frame a choice between two quite different ways of understanding the purpose(s) of the provision. Thus, to contend that we should not excuse failure of a notice condition even when the failure did not prejudice the insurer's efforts to adjust the individual claim because to do so will increase the cost of insurance is to challenge the assumption that the purpose of a notice provision is to protect the insurer from increased juridical costs caused by late notice. The implicit assertion is that insurers also employ unnuanced notice conditions in order to be able to deny payments to insureds whose notice is late even if the insurer's claims–adjusting efforts and other juridical costs were not affected by the delay, and that insureds should be taken to have consented to this allocation of risks in order to secure less costly coverage. In this interpretation, insurers (and insureds) expect a number of successful defenses based upon failures of condition—some prejudicial and some not prejudicial —and to deny them the savings that result from those defenses will drive up claims costs and prices, to the detriment of all but the unfortunate few caught in the snare set by the conjunction of express policy conditions with the strict common law rule.

Faced with a choice between interpreting a notice condition as designed to protect the insurer from adverse effects on its claims adjustment efforts, or as designed also to create a reverse lottery in which savings on juridical costs and occasional disproportionate forfeitures fund small premium reductions for the many, both Cardozo and the *Restatement* counsel choosing the interpretation that reduces the risk of disproportionate forfeitures.[283] And that too seems exactly right. Acknowledging that a forfeiture may redound to the benefit of the other, more fortunate, members of the pool does not make that forfeiture any more or less disproportionate; if compliance with a notice condition saves the insurer (or the pool) $500, and noncompliance costs the insured $100,000, the disproportion of the forfeiture is the same whether the windfall is pocketed by the insurer's shareholders or its policyholders.

The reality is that the argument from costs, if framed in the usual way as a speculation about the choices prospective insureds might make if presented

283. *See* RESTATEMENT (SECOND) OF CONTRACTS § 227 (1972). *See also* ROBERT E. SCOTT & DOUGLAS L. LESLIE, CONTRACT LAW AND THEORY 606 (2d ed. 1993) ("Since viewed from the lens of a typical transaction, the express condition appears unusual, it is treated with suspicion. A metaphor such as how 'the law abhors a forfeiture' is simply a reflection of the presumption that ordinary people do not expressly condition their obligations.").

with a complete menu of appropriately priced policy conditions, cannot tell us which interpretation should prevail.[284] Perhaps a representative insured, if squarely presented with the choice, might opt to save a few dollars in premium costs by authorizing the insurer to deny payment if notice is late without regard to the effects of that tardiness on the insurer. But, then again, perhaps she would not. True, we all know individuals who leave their insured homes to drive to the convenience store in their insured automobiles in order to buy a lottery ticket, but the apparent incongruity of this juxtaposition of risk–avoiding and risk–seeking behaviors is less than it may appear.[285] When insureds arrive at the convenience store, they bet a few dollars, not the house or the car.

Not everything has a price, after all, and security perhaps least of all. My complaint that there are few good restaurants in Lincoln scarcely is met by the rejoinder that at least they're cheap, and my discovery that the dark things in my scone are not raisins is unlikely to be more pleasant because I am told that rat droppings are free and that lax sanitation keeps the price of bakery products low. So too with insurance policies. Do we really think that a

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284. For particularly accessible introductions to why, see Gillette, *supra* note 109, at 542 (explaining why "the area of remote risks . . . is not a fruitful area for application of majoritarian default rules"); Jeffrey L. Harrison, *Trends and Traces: A Preliminary Evaluation of Economic Analysis in Contract Law*, 1988 ANN. SURV. AM. L. 73, 100–04 (demonstrating "practical indeterminacy" of efforts to derive efficient default rules); Jeffrey L. Harrison, *The Chicago School and the Development of a Comprehensive Legal Theory: A Comment on Professor Crespi*, 22 LAW & SOC. INQUIRY 185, 187 (1997) (rehearsing reasons conventional economic thinking cannot illuminate preferences regarding "qualitative differences among contracts").

285. Edward J. McCaffery, *Why People Play Lotteries and Why it Matters*, 1994 WIS. L. REV. 71 (discussing efforts to square participation in lotteries with usual assumptions concerning consumer choice under uncertainty): "A general teaching of [the literature of cognitive biases] is that, due to the reflection effect, individuals are risk averse as to gains but risk preferring as to loss. This finding . . . would have individuals failing both to take fair gambles and to insure against likely losses." *Id.* at 78. In fact, of course, individuals routinely do both. McCaffery's resolution "has people rationally playing lotteries to get what lotteries rather efficiently, easily and uniquely offer: a shot at instant wealth." *Id.* at 93. In short, "people may have a 'compartmentalized' view of their life and finances, with different utility functions for different spheres of activity. In particular, individuals might consider their periodic lottery play as a certain type of savings, while pursuing more risk averse activities in other areas." *Id.* at 122. For an historical treatment of the tension between gambling and insurance, see Baker, *supra* note 255, at 257–59.

policy provision declaring that one in every one thousand meritorious fire insurance claims will be randomly denied, with savings in premium costs for everyone, would be embraced by the hypothetical fully–informed rationally–maximizing insureds of the simpler economic models? Or, for that matter, that the hypothetical fully–informed rationally–maximizing insurer would choose to reduce premiums enough to induce those insureds to retain a forfeiture risk more cheaply diversified by the insurer?[286] And if we are not confident that the answer is "yes," then why should we impute to real–world insureds an intent to use a strict notice condition unconcerned with how the tardiness affected the insurer?

Section 229 and its subterranean analogs throughout contracts and insurance law are confirmation that we need not, and should not, no matter what the strict common law rule may purport to say about it. By making the interpretive inquiry focus on the purpose(s) of the insurer in employing the condition, and counting those purposes as served to the extent the insurer escapes costs that would have been avoided had the condition been satisfied,[287] they free us from fruitless speculations about what faceless

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286. Eisenberg, *supra* note 93, at 240, makes the obvious point:

> It might be argued that even if one party, A, would be reluctant to agree to a condition if he fully understood that he would face draconian sanctions for insignificant variations from perfect fulfillment, the other party, B, would insist on those sanctions. That is possible, but unlikely. If both parties fully understand the operation of the condition, then the price B pays for A's performance will be higher than it otherwise would be, to reflect A's additional risks. Given perfect knowledge by both parties, B would probably prefer to pay less, without the power to impose draconian sanctions for imperfect fulfillment of the condition, than to pay more with that power.

287. In the words of the *Restatement*, the task is to identify the "risk from which [the insurer] sought to be protected and the degree to which that protection will be lost if the non–occurrence of the condition is excused to the extent required to prevent forfeiture." RESTATEMENT (SECOND) OF CONTRACTS § 229 cmt. b (1981). But room for disagreement about the exact nature of that risk does not mean that the parties left a gap to be filled by speculation about what arrangements fully rational bargainers would prefer. *See* Burton & Andersen, *supra* note 270, at 865 (urging contextual interpretive efforts rather than immediate recourse to supplemental gap fillers). If we remember that the task is to ascribe purposes to policy language chosen by the

insureds might choose or expect, and remind us that we need not accept as axiomatic the assumption that each additional condition in an insurance policy makes the coverage, and thus the price, less by assigning to the insured only those costs thereby deflected away from the insurer (and the pool). Most do, but some do not. When our understanding of the purpose(s) of a condition tells us that an insurer is using noncompliance with a condition to impose on the insured costs that are disproportionate to the costs that the insurer would have avoided had there been compliance, nonoccurrence of the condition should be excused to the extent necessary to prevent disproportionate forfeiture.

III. APPLICATION OF THE MODEL TO CLAIMS–MADE LIABILITY FORMATS

Enough! It is time to return at least briefly to deepest claims–made land, there to test our new tools against two of the thorniest problems in the claims–made thicket: the "forfeiture risk" created by "claims–made–and–reported" and "potential–claims–discovered–and–reported" triggers, and the "classification risk" created by triggers that fall so late in the tort liability sequence that the insurer knows of the potential claim before any policy has been triggered. As we have seen, when lawyers first ventured into these precincts, they came ill–equipped to locate the notice–prejudice rule within contract law's larger agenda of policing against opportunism or to debate whether it should be applied to failures of reporting conditions in claims–made policies. On a return trip, might a lawyer with section 229 in his kitbag be able to see distinctions where before none appeared? Would appreciation that most insurance policy conditions are narrowly tailored to allocate commensurate risks between insurer and insurer but that others pose the potential for disproportionate forfeitures prove adequate to the task of identifying which failures of condition might on appropriate facts be excused? Or does the simple classificatory method sketched above falter when asked to do duty beyond tame hypotheticals involving excepted causes,

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insurer, we will find it easier to take the insurer at its word and to use the costs avoided by satisfaction of the condition as the baseline against which to measure the cost of noncompliance to the insurer. The insurer has said that it is content to pay if the notice is on time, the house doesn't remain too long vacant, or the theft is evidenced by visible external marks. By focusing on why the insurer is content to pay under those circumstances, we have a baseline against which to measure the effects of what actually did happen.

loss adjustment conditions, continuing warranties, and evidentiary conditions?

Section 229 invites us to ask questions the neo–classical tradition keeps carefully submerged. Why did the insurer make the provision creating the condition a part of the insurance contract? What insurer purposes(s) does it serve? What costs does compliance with the condition permit the insurer to avoid? Or—the same question—how, exactly, does occurrence of the condition make the policy cheaper?

The conventional explanation for why claims–made policies are less expensive than occurrence policies is that claims–made formats reduce insurers' costs by shielding insurers from some of the uncertainties and expenses associated with intramural disputes about which insurers are to be tagged with responsibility for coverage obligations under difficult–to–apply "occurrence" triggers, and by reducing the need for loadings to compensate insurers for subjecting themselves to the uncertainties associated with longer–tailed occurrence policies. Of course, those explanations, though accurate, are not complete. A fuller answer also would acknowledge that new claims–made policies should be significantly cheaper than occurrence policies because retro dates and "other insurance" clauses mean that claims–made policies take a number of years to mature; in medical malpractice insurance, for example,

> Claims–made policies are lower in cost in the first few years of coverage because the insurer's risk exposure is lower. Claims resulting from medical services rendered during the first year of coverage will likely not be asserted against the physician during that year. The cost of the premium increases, thereafter, on a yearly basis, as the insured's cumulative exposure to claims increases. The yearly increases in premiums are referred to as "steps" and represent the insurer's increasing liability exposure as the physician's period of exposure also increases. . . . The increases in cost level off when the physician reaches a "mature" level, after approximately 5 years of claims–made coverage. After the mature level has been reached, the costs of claims–made and occurrence premiums are generally comparable.[288]

288. Johnson, *supra* note 27, at 1571. *See also* KEETON & WIDISS, *supra* note 9, § 5.10(d)(1) & (3), at 594–96, 598–01 (emphasizing that lower costs of claims–

And, to be truly complete, an explanation for why claims–made policies generally are cheaper also should recognize the contributions of multiple–event triggers and triggers that operate late in the tort liability sequence: in theory, an insurer who anticipates that multiple–event triggers will permit successful failure of condition defenses in some instances even though the denial of compensation to the insured exceeds the costs of noncompliance to the insurer can reflect the expected windfalls worked by those forfeitures in its premium calculations, and an insurer who expects to be able to use renewal underwriting to avoid some idiosyncratic risks after they have become known can be paid a reduced premium to reflect that assignment of classification risk to the insured.

A. Ameliorating the Forfeiture Risk in Claims–Made Policy Formats?

But, of course, section 229 does not ask why claims–made policies in the aggregate are cheaper than occurrence policies, or why a particular claims–made format is cheaper than would be an occurrence policy with otherwise identical coverage provisions, or even how a particular condition in a claims–made policy makes that policy cheaper than it otherwise could be. Section 229 is concerned with when a particular instance of noncompliance with a particular condition might be excused, and thus asks us to explore the extent to which that particular instance of noncompliance added to the insurer's costs. A simple analogy may help with this critical distinction. Just as in misrepresentation litigation we may acknowledge that the insurer's question to the applicant clearly is a material part of the insurer's underwriting efforts but nonetheless conclude that the applicant's misrepresentation was not materially false, so in excuse litigation under section 229 we may concede that each policy condition contributes to controlling insurer costs but nonetheless be interested in the extent to which a particular failure of condition did or did not impose upon the insurer costs the condition was intended to avoid.

Sometimes application of the section 229 template to failure of a condition in a claims–made policy will appear easy. If an insured against whom a claim was made on January 2, 1997 tries to argue that the insurer whose pure claims–made policy lapsed at midnight the preceding December

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made coverage in first years are due in large part to the immaturity of the experience). "Much of the impetus for development of 'claims made' coverage was an interest in deferring a 'crisis' over costs of malpractice coverage. Predictably, 'claims made' coverage temporarily deferred, but did not resolve, the 'crisis' over costs." *Id.* at 598.

31 nonetheless should be obligated to provide coverage for the claim because a January 2 claim is no more costly than a December 30 claim, we will have no difficulty concluding that the failure of condition should not be excused under section 229. Why? Because we understand the policy provision to be a definition of the insured event that shields the insurer from the same costs that it thereby imposes on the insured: it protects the insurer from responsibility for costs of claims made before and after the policy period by leaving a commensurate responsibility—costs of claims made before and after the policy period—with the insured. Such a condition cannot work a disproportionate forfeiture. So too with any single event—negligence, exposure, injury, manifestation, discovery of something by someone, claim by someone against someone, report of something by someone to someone—a policy might establish as a trigger for coverage. There is nothing for section 229 to do with single-event triggers for the same reason there is nothing for section 229 to do with a rodent exception: in each case, we ascribe to the provision the purpose of protecting the insurer from the very costs that the provision allocates to the insured.

Case 1: Failure to Satisfy Single Event Trigger

1996 – INSURER A
CONDITION: Claim Made in 96
FACTS: Claim Made in 97

What if an insured under a policy with a "reported potential claim" trigger makes a timely report to the insurer of an injury to a third party caused by the insured's negligence, but fails to satisfy the policy condition requiring that the report include the "name and address of any witness?" Is that the kind of nonoccurrence of a condition that might be excused under section 229? Indeed it is. But why? We would not be prepared to excuse failure to report a potential claim during the policy period no matter how minimal the delay. Why should we contemplate excusing failure to make the report in the prescribed fashion? The answer must be that we understand the report of a potential claim to be a single-event trigger of coverage that necessarily

Case 2: Failure to Satisfy Loss Adjustment Condition

1996 – INSURER A
CONDITIONS: Report in 96 of Potential Claim Witnesses fully identified
FACTS: Report in 96 of Potential Claim Witnesses not fully identified

allocates to the insured costs commensurate with the protections it provides the insurer, but we understand the purpose of the requirement that witnesses be identified to be to cabin the juridical hazards associated with adjusting the claim. Because the insurer's legitimate interest in controlling that juridical hazard is expressed in a policy condition that puts the insured's entire coverage at risk, and because the costs that failure of condition may impose on the insurer can range from zero to well in excess of the value of the insured's claim, we recognize that failure of the condition could in some scenarios work a disproportionate forfeiture. Thus, the section 229 inquiry should proceed as it does with any loss adjustment condition.

But why, we might wonder, do we understand the single–event trigger in Case 2 to be "report of potential claim" rather than "report–of–potential–claim–including–names–and–addresses–of–witnesses?" Why cannot the complementarity of burden avoided and burden retained that we assume for single–event triggers insulate the failure to comply with the fuller description of what the report should include? The answer is implicit in section 229's functional focus on the additional protections each additional condition provides the insurer, but the English language is slippery, and the term "condition" is one of most difficult to keep in hand. When we ask what additional protections "the condition" affords the insurer, our focus should not be on the policy provision but rather on the circumstance or action that the policy provision insists must occur if the insurer is to have a duty to perform. Section 229 does not contemplate excuse of nonoccurrence of a policy provision; it contemplates excuse of nonoccurrence of a state of affairs identified by a policy provision as a condition. To accept the argument that the state of affairs that did not happen in Case 2 was "report–of–potential–claim–including–names–and–addresses–of–witnesses" would be to exalt form over function. We are not likely to allow a homeowner's insurer to convert notice requirements currently subject to the notice–prejudice rule into immune triggers of coverage by defining the triggering event in that occurrence policy as "physical injury to person or property . . . of which notice to the insurer is given in timely fashion." And we should not think that a claims–made insurer can through creative drafting make identification of the witnesses an indivisible part of a "report of circumstances" trigger of coverage.

Of course, this threshold question of how to identify the "condition" nonoccurrence of which might or might not be excused is not free from difficulty. Even if we conclude that a single event—for example, a "claim" made by the victim against the insured, or a "report of potential claim" by the

insured to the insurer—is the relevant trigger, we must still determine whether the essential constituent elements of that event in fact occurred. When does a billing dispute with a client ripen into a "claim" against the insured? Will identification of a potential claim in a renewal application satisfy the "report of potential claim" condition in the current policy? Will a blanket notification to the insurer that some of the financial institution's employees made improper loans be enough to satisfy that condition? If we conclude that a communication from insured to insurer can be a "report of potential claim" even though it does not identify every witness with particularity, but that it cannot be a "report of potential claim" unless it is in a form that differentiates it from the paper generated by normal renewal underwriting and unless it identifies a particular incident with some particularity, we are ascribing a purpose to the "report of potential claim" provision and declaring that the purpose has been satisfied in the first instance but not in the second and third. Of course, both the identification of purpose, and the determination of whether that purpose was satisfied in the particular case, may be hotly contested. But once we determine that identification of a particular incident is a necessary constituent element of a "report of potential claim," we entail the conclusion that failure to identify a particular incident is a failure of condition that is not subject to excuse.

Multiple–event triggers add another level of complexity to the process of ascribing purposes to policy provisions. What if an insured with a "claims–made–and–reported" policy for 1996 is the subject of a claim during the 1996 policy year, but does not report the claim to the insurer until 1997? Should we regard the tardy report as the kind of nonoccurrence of condition that might be excused under section 229? Or should we treat it as part of an indivisible "claims–made–and–reported" definition of the insured event both parts of which must be satisfied in 1996 if the insurer is to be liable? Or might there be other alternatives?

Case 3: Claims–Made–and Reported Trigger

1996 – INSURER A	
CONDITIONS:	**Claim in 96** **Report in 96**
FACTS:	**Claim in 96** **Report in 97**

Here, for the first time, we confront directly the special problems posed by multiple–event triggers of coverage. By itself, a claims–made trigger involves no overbreadth and poses no potential for disproportionate forfeitures. By itself, a reporting trigger involves no overbreadth and poses no potential for disproportionate forfeitures. But linked together in a

multiple–event "claims–made–and–reported" trigger, they may pose the potential for the sort of disproportionate forfeiture that we normally associate with warranties, loss adjustment conditions, and evidentiary conditions. Why is that?

The explanation is implicit in section 229's focus on identifying the *additional* protections each new condition affords the insurer. With single–event triggers, we necessarily start from a baseline of zero. Because we cannot imagine an insurance policy without a trigger of coverage to tell us whether or not a particular policy is applicable to a particular insurance story, we have no difficulty ascribing to any single–event trigger the insurer may choose to employ the function of protecting the insurer from the very costs that the provision thereby assigns to the insured.[289] But with a multiple–event "claims–made–and–reported" trigger like that in Case 3, an insured might argue, we do not start with a baseline of zero. By making it a condition of the coverage that the insured be the subject of a claim during the policy year, the policy insulates the insurer from responsibility for costs of claims not made within the policy period, and does so by assigning those costs to the insured. What *additional* protections, section 229 tells us to ask, does the insurer get by insisting that the report also be made within the policy period?

As we have seen, insurers and the courts are ready with an answer—the insurer cannot be truly free from the "incurred but not reported" (IBNR) exposure that is said to have prompted the move to claims–made formats unless its coverage obligations are limited to claims that have been reported to the insurer by the end of the policy period. Changing from an occurrence trigger to a single–event, claims–made trigger frees the insurer from some but not all of the IBNR problem: requiring that the claim first be made during the policy period shields the insurer from the portion of the IBNR exposure

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289. So long as the trigger is conceptualized as a single event, it can—at least in the philosophical systems in which most of us work—be an event which occurs in one and only one policy period. *Cf.* Fischer, *supra* note 11, at 676 ("[A] claim is either made or it is not."). If the "report of potential claim" was not made in 1996 because there was not sufficient detail for us to treat it as a "report of potential claim," then it can still be made in the future when there is sufficient detail. But if the trigger is conceptualized as involving two different events—for example, a claim first made against the insured and a report of that claim by the insured to the insurer—then the first logically can fall in one and only one period and the second in one and only one period. By the terms of such dual–event triggers, if both events fall in the same policy period, that policy is triggered; if they fall in different policy periods, neither policy is triggered.

attributable to claims incurred but not made (IBNM) by the end of the policy year, but it leaves the insurer to bear the remainder of the IBNR exposure—claims made but not reported (MBNR) by the end of the policy year. Thus, the purpose for requiring report of the claim within the policy year is to free the insurer from the MBNR as well, and the reporting condition trigger accomplishes that by assigning the MBNR to the insured. And so, the argument would go, refusing to excuse a failure to satisfy the reporting condition cannot involve a disproportionate forfeiture.

But that is an explanation for why the insurer would choose to make a reporting condition the trigger of coverage, not an explanation for why an insurer would choose to employ a multiple–event trigger requiring both that the claim first be made against the insured during the policy period and that the claim be reported to the insurer during the policy period. If the insurer can be shielded from the entire IBNR exposure by a single–event reporting condition trigger that would allocate that IBNR exposure to the insured, isn't use of a multiple–event "claims–made–and–reported" trigger the same sort of failure to tailor means narrowly that we encountered with loss adjustment conditions, continuing warranties, and evidentiary conditions?

Indeed it is. Multiple–event triggers remind us of Kent and his flashlight, and one obvious possible response to the overbreadth of the "claims–made–and–reported" triggers would be to treat the claim as the trigger and to put the reporting condition on the section 229 scales. So long as challenges to late–report claims denials were framed as efforts to apply the "notice–prejudice rule" to reporting requirements in claims–made–and–reported formats, it was easy enough for courts to conclude that late reports must necessarily prejudice the insurer's pricing efforts. Section 229's requirement that the prejudice be proportionate to the amount of the insured's forfeiture would force us to confront the realities of claims–made pricing to determine how, exactly, a late report interferes with the insurers loss adjustment and pricing efforts, and under that standard insurers would be much less likely to prevail.

Still, recognizing that multiple–event triggers pose problems similar to those presented by loss adjustment conditions, warranties, and evidentiary conditions does not necessarily mean that section 229 should put courts in the business of weighing the extent of the harm to an insurer caused by late reports. There is another alternative. Rather than interpreting "claims–made–and–reported" formats as establishing the "claim" as the baseline trigger and then asking what additional protections the reporting condition trigger provides, might we instead interpret the "report" as the baseline trigger and

ask what additional protections the insurer gains by also insisting that the "claim" be made in the same policy period?

Consider Case 4. The facts are the same as those in Case 3, with one addition: the insured bought identical "claims–made–and–reported" coverage from the same insurer in both 1996 and 1997. For a lawyer with only the

Case 4: "Claims–Made–and–Reported" Triggers; Same Insurer

1996 – INSURER A		1997 – INSURER A	
CONDITIONS:	**Claim in 96** **Report in 96**	**CONDITIONS:**	**Claim in 97** **Report in 97**
FACTS:	**Claim in 96; Report in 97**		

"notice–prejudice rule" to bring to bear on behalf of the insured, nothing has changed. Success still depends on convincing the court that the claim triggered the 1996 policy and that the late report did not prejudice the insurer. But section 229 opens up another alternative. Why, it invites us to wonder, should we automatically assume that a "claims–made–and–reported" insured who satisfies the "claim" condition of the 1996 policy and the "report" condition of the 1997 policy will be seeking to excuse the reporting condition of the first policy in order to trigger its coverages? Might not an insured take seriously the rhetoric that declares that "the essence of claims–made policies is a report to the insurer" and seek to invoke coverage under the second policy on the grounds that the failure to have a claim in that policy year should be excused? Why not conclude that in a claims–made–and–reported format the report is the trigger and that the failure to have a claim during the policy period is the condition non–occurrence of which might be excused?

This way of interpreting "claims–made–and–reported" formats—by ascribing to the reporting condition the function of identifying the essential trigger of coverage—is not as strange as it first might appear. Insurer insistence that the report is "essential" has always seemed elusive. Understood as an assertion that insurers cannot run a claims–made insurance program without making report of a claim during the policy period a condition of coverage, it is clearly nonsense; many claims–made policies do not require that the report be made during the policy year. Understood as an assertion that a late report necessarily prejudices the insurer because it interferes with the insurer's pricing efforts, it is clearly suspect both because it is difficult to credit the contention that a single late report can much affect

the insurer's pricing[290] and because it provides no way to distinguish the prejudice a late report causes a claims–made–and–reported insurer from the prejudice late reports cause other insurers—both "occurrence" and "claims–made"—that do not insist that the report be made during the policy period. But understood as an assertion that we should interpret a claims–made–and–reported policy as making the report the trigger of coverage, it makes sense. We can concede the insurers' premise that the move to claims–made formats was prompted by a desire to reduce the insurers' IBNR exposure, and grant also that the exposure cannot totally be eliminated if a policy can be triggered before the claim has been reported, but still point out that multiple–event triggers are an unnecessarily unnuanced way to accomplish that goal. Faced with a choice of interpreting a claims–made–and–reported policy as making the claim, or the report, or both, the trigger, we should follow Cardozo and section 229 and choose the interpretation that minimizes the chances for forfeitures without denying the insurer the essential protections we believe the language was intended to provide. And that, it might appear, could mean treating the report as the condition which must happen within the policy period if a "claims–made–and–reported" policy is to be triggered, thus putting courts in the business of weighing the harm to the insurer caused by the fact that the claim was early![291]

The possibility that the "report" could be regarded as the baseline trigger of coverage would appear to fit dual–event "potential–claim–discovered–and–reported" formats at least as well. The promiscuity with which courts

Case 5: "Potential–Claim–Discovered–and–Reported" Trigger

1996 – INSURER A	1997 – INSURER A
CONDITIONS: Discovery in 96 Report in 96	CONDITIONS: Discovery in 97 Report in 97
FACTS: Discovery in 96; Report in 97	

290. *See generally* notes 22, 81–82, and accompanying text.

291. If the insured is in its first year with the claims–made–and–reported insured, it might seem obvious that the failure of the claim to occur during the policy year should not be subject to excuse. Any other result would open the insurer to adverse selection. But, of course, the inquiry into the impact on the insurer of a failure of the "claim" condition would require examination of the other underwriting and risk control mechanisms being employed by the insurer, and if those mechanisms include a retro date, the objection could lose much of its force. *See generally infra* cases 7–10.

and commentators use "discovery" and "claims–made" and "reporting" as labels for all manner of claims–made formats might lead the incautious to flirt with the idea of treating "discovery" of circumstances that might ripen into a future claim as the trigger for coverage and subjecting failure to report that discovery to the section 229 calculus, but that interpretation would deny the insurer almost all of the advantage of the move to "claims–made" triggers. Here, at least, the industry rhetoric complaining that application of the notice–prejudice rule to reporting conditions in claims–made formats would convert claims–made coverage into occurrence coverage is closer to the mark. Excusing the failure to make a report in a potential–claim–discovered policy would have the effect of making the trigger—discovery of a potential claim —something very much like the trigger in an occurrence policy applicable to professional negligence. Might we instead treat the report as the essential trigger and contemplate on some circumstances excusing the fact that the discovery of the claim did not occur in the policy year?[292]

Of course, these speculations do not mean that we would be compelled to indulge the suggestion that a report is essential to the functioning of every claims–made format. Many claims–made policies contemplate that some claims that ultimately will be associated with a particular policy period will not be reported during the policy period. Some require only that notice of a claim be given "as soon as practicable," others that the notice be given within 60 days of the claim, still others that the notice be given as soon as practicable but in no event more than 60 days after the end of the policy period. For such formats, there seems to be no reason not to take the insurer at its word. The policy does not try to achieve complete elimination of the

Case 6: Failure to Satisfy Non–Trigger Notice Provision

1996 – INSURER A	1997 – INSURER B
CONDITIONS: **Claim in 96** **Notice "as soon as practicable"**	**CONDITIONS:** **Claim in 97** **Notice "as soon as practicable"**
FACTS: **Claim in 96; Notice Tardy and in 97**	

292. Policies with alternative "claims–made–and–reported" and "potential–claims–discovered–and–reported" triggers appear to pose no new challenges. Either the claim or the report of claim should be treated as the single–event trigger for the first prong, and either the discovery of potential claim or the report of potential claim the single–event trigger for the second prong. Of course, the window for insurer opportunism is smaller when a claims–made–and–reported trigger is joined by an alternative "potential–claim–discovered–and–reported" trigger.

IBNR exposure from the insurer's portfolio. The policy says that a claim first made within the policy year is the single–event trigger. In such policies, the provision requiring a "report" or "notice" of the claim to the insurer should be understood to function just as it does in occurrence formats: it provides the insurer with protections for both its claims–adjustment and its pricing efforts. And under both occurrence and claims–made policies in which the claim in the trigger of coverage, section 229 authorizes an inquiry into whether in the particular case the loss of those protections due to the tardiness of the notice is enough to keep the forfeiture from being disproportionate.

Thus, when the policy is a pure "claims–made" policy, we should regard the claim as the trigger that is necessarily immune from excuse arguments. When confronted with a dual "claims–made–and–reported" policy, we should treat either the claim or the report, but not both, as the immune trigger; when faced with a dual "potential–claim–discovered–and–reported" policy, we should treat either the discovery, or the report, but not both as the immune trigger. But how should we regard "retro date" provisions? What if a "pure"

Case 7: Pure Claims–Made Trigger with Retro Date

1996 – INSURER A	
CONDITIONS:	**Negligence after 1/1/96** **Claim in 96**
FACTS:	**Negligence in 95** **Claim in 96**

claims–made policy promising that the insurer will respond to a claim made against the insured during calendar year 1996 also makes it a condition of the insurer's obligation that the negligence precipitating the claim have taken place after January 1, 1996? Do our concerns about multiple–event triggers mean that section 229 should be available to an insured wanting to argue that it is not significantly more difficult to adjust a 1996 claim based on 1995 negligence than to adjust a 1996 claim precipitated by 1996 negligence? She should not, for the retro date shields the insurer from costs—of claims precipitated by pre–1996 negligence—that are commensurate to the costs—of claims precipitated by pre–1996 negligence—thereby assigned to the insured, just as the claims–made condition in the same policy allocates commensurate costs away from the insurer to the insured. The combination of a retro date with another trigger does not involve the overbreadth encountered in claims–made–and–reported and potential–claim–discovered–and–reported policies because we ascribe different and independent timing purposes to the retro

date and to the single–event trigger. With claims–made–and–reported and potential–claim–discovered–and–reported formats, one of the multiple–event triggers appeared to be redundant. But a retro date cannot guarantee the insurer freedom from claims first made after 1996, and the claims–made condition cannot guarantee the insurer freedom from negligence occurring before 1996, and thus in Case 7 we are not presented with that sort of timing redundancy.

The distinction is easier to see if we assume that the same insurer renews the policy for calendar 1997, with the retro date remaining January 1, 1996.

Case 8: Pure Claims–Made Trigger with Retro Date Fixed at Inception of Relationship

1996 – INSURER A	1997 – INSURER A
CONDITIONS: Neg after 1/1/96 Claim in 96	CONDITIONS: Neg after 1/1/96 Claim in 97
FACTS: Neg in 96; Claim in 97	

The retro date condition continues to allocate consequences of pre–1996 negligence away from the insurer and to the insured, and the claims–made condition allocates the costs of pre–1997 and post–1997 claims away from the insurer and to the insured. Consequently, each should be classified as immune from section 229 scrutiny.

What is more, this conclusion does not change if we assume that the insured moves to a new insurer in calendar 1997 and that the new insurer employs a January 1, 1997, retro date. The purpose of the retro date provision in Insurer B's policy is to shield the insurer from liability for claims

Case 9: Pure Claims–Made Trigger with Retro Date; Different Insurers

1996 – INSURER A	1997 – INSURER B
CONDITIONS: Neg after 1/1/96 Claim in 96	CONDITIONS: Neg after 1/1/97 Claim in 97
FACTS: Negligence in 96; Claim in 97	

arising out of negligence prior to the inception of its relationship with the insured, and that is precisely the risk that thereby is assigned to the insured. True, the insured now faces a potential gap in coverage because claims after January 1, 1997, precipitated by negligence before 1997 will not be covered by any policy, but that is not a problem to which section 229 can respond.

The forfeiture which the insured will suffer is not disproportionate to the protections the provisions provide the insurer.

But what if we imagine that the insured does not change insurers, but at renewal the insurer nonetheless "advances the retro date" in the 1997 policy to January 1, 1997? In form, the provision operates as did retro dates in the preceding three hypotheticals. But in context we may be tempted to regard the insurer's reasons for employing this retro date condition quite differently. In Case 7, Insurer A established the retro date at the inception of the relationship; in Case 8, Insurer A kept the retro date at the inception of the relationship even in its renewal policy; in Case 9, Insurer B established a new retro date at the inception of its relationship with the insured. In each of those cases the insurer plausibly could contend that the purpose of the retro date provision was to protect the insurer against adverse selection; in those cases we have no difficulty understanding the use of the retro date provision to be an unexceptional exercise of the insurer's underwriting discretion to choose with whom and on what terms it will do business.

Case 10: Pure Claims–made Trigger with Retro Date Advanced; Same Insurer

1996 – INSURER A	1997 – INSURER A
CONDITIONS: Neg after 1/1/96 Claim in 96	**CONDITIONS: Neg after 1/1/97 Claim in 97**
FACTS: Negligence in 96; Claim in 97	

With Case 10, however, that explanation will not do. In 1996, the insurer was willing to assume the risk of claims made and reported in 1996 based on negligence in 1996; in 1997, it is willing to assume the risk of claims made and reported in 1997, but not if they are based on negligence during 1996. Why not? Would it affect our understanding of the situation to be told that the insurer advanced the retro date for the individual insured because it had learned of negligence by the insured in 1996 that had not yet triggered any policy? And if so, in which direction does that bit of context cut? Is there a difference between employing a retro date in order to avoid adverse selection at the beginning of what may become a multi–year relationship and employing a retro date in order to avoid known risks at the beginning of a renewal policy? Would it be more or less troubling to learn that the insurer was not reacting to known circumstances but merely advancing the retro date for all renewal insureds in order to keep its claims–made exposures

immature? Clearly, there is something about an insurer advancing the retro date that nags, and it should not surprise us to learn that the practice is one against which regulators inveigh.[293] But that does not mean the retro date provision is overly–broad. The insured's problem is not one for which section 229 provides an answer.[294]

What do these ten cases tell us about section 229 and the sensibilities it seeks to express? Three things in particular seem worth emphasizing. First,

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293. *See, e.g.*, ARK. CODE § 23–79–306 (g) (1987):

> (1) A retroactive date may only be advanced with the written consent of the first named insured and upon one (1) or more of the following conditions:
>
> (A) If there is a change in insurer other than another insurer within the same insurer holding company or group;
>
> (B) If there is a substantial change in the insured's operations which would have been a material factor in the insurer's acceptance or declination of the risk; or
>
> (C) At the request of the first–named insured.
>
> (2) Prior to the advancement of the retroactive date under subdivisions (1)(A), (B), or (C) of this subsection, the insured must receive a disclosure form for his signature which acknowledges that he has been advised of his right to purchase an extended reporting period endorsement.

In New York, the minimum standards for claims–made policies include the following: "A retroactive date may not be changed during the term of the claims–made relationship and any new extended reporting period." Regulation No. 121, N.Y. COMP. CODES R. & REGS. tit. 11, § 73.3 (b) (1993). Such formal regulatory restrictions remain relatively rare.

294. This treatment of retro dates might suggest that we should revisit the suggestion that the "claim" condition in a "claim–made–and–reported" or a "discovery" condition in a "potential–claim–discovered–and–reported" policy might be subject to excuse arguments under § 227. On facts like those in Case 7, Insurer B plausibly might contend that the requirement that the claim first be made after the inception of the policy year should be ascribed a function it lacks in a renewal policy: it operates as a de facto retro date protecting the insurer from claims made prior to the inception of the relationship and allocating responsibility for those claims to the insured. Thus, the argument might go, it deserves to be treated as immune from excuse arguments for the same reason that retro dates fixed at the outset of the relationship deserve to be treated as immune.

the process of ascribing purposes is not easy. Exploding the positivist conceit that we can determine the meaning of a policy provision without regard to its consequences helps make the project more tractable; so too does shifting the focus away from vestigal will–theory fictions that pretend to be searching for a joint intent and away from the overcompensations of insurance law's fatal fascination with the "objective reasonable expectations" of the insured. But even cast as a problem of ascribing purposes to the insurer, the project will not be easy. Context matters. Even if we are asking the correct question, ascribing appropriate purposes will require many return trips to different parts of the claims–made thicket.

The second thing these cases tell us is that classifying policy provisions as vulnerable to section 229 oversight or as immune from such review is only the first step. Even if we have correctly isolated the purpose(s) that should be ascribed to the particular policy condition, we still must determine to what extent those purpose(s) have been satisfied. In this first survey of claims–made conditions we have not attempted to confront those questions directly, but we have seen enough of the complexity that waits once we move beyond hothouse hypotheticals to warn us that section 229's authorization to courts to engage in a fine–tuning of the burden avoided and burdened assumed may well be beyond what we reasonably can ask lawyers and courts to do. If the issue is not whether the insurer was prejudiced, but how much it was prejudiced, the inquiry will be much more difficult and the allocation of burdens of proof and persuasion will be much more important. Australia currrently is trying to apply a statutory rheostat that requires courts to calibrate with precision the harm done to an insurer by a failure of condition,[295] and the early experience there suggests that other alternatives to the strict common law rule that do not require such fine–tuning should be explored.[296] But details of how the standard should be framed can be worked out through experience if we keep our eye on the point of the exercise: ameliorating forfeitures that are not necessary to protect the insurer from the costs it sought to avoid.

The third and most significant reason that section 229 may seem to come up short as a way of dealing with the problems posed by claims–made formats is that section 229 is an attempt to deal with only one specific manifestation—overbreadth—of the larger problem of how to determine the

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295. *See* authority cited *supra* note 201.

296. I explore the Australian experience in Bob Works, *Excuse of Failure of Insurance Conditions Turned Upside Down: The View from Down Under* (forthcoming).

mix of contractual and regulatory institutions best suited to police the potential for insurer opportunism created by the combination of bounded rationality and transaction–specific investments. Section 229 insists that discretion created by unnuanced insurance policy conditions should be exercised only to guarantee to the insurer the protections the provision was inserted to provide, and should not be employed to create windfalls for the insurer even if those windfalls ultimately redound to the benefit of policyholders. But that "forfeiture risk"—though it has dominated this essay —is only one part of the larger problem of how to police the potential for opportunism that goes with bounded rationality and sunk investments. As these last examples make clear, pushing coverage triggers later into the tort liability insurance sequence makes it more likely that an insurer will be able to employ its underwriting discretion—through cancellation of an existing contract, refusal to renew at the end of the term, or renewal with advanced retro dates, laser exclusions, or dramatic price effects—after the insurer knows a particular insured is likely to be subject to a claim but before any policy has been triggered. The problem posed by late triggers is not a problem of overbreadth; the uncertainties that claims–made insurers avoid by pushing the trigger for coverage later into the tort liability claim sequence are commensurate with the uncertainties thereby assigned to insureds. But late triggers nonetheless are a concern because they can be used to subject individual insureds, perhaps unnecessarily, to classification risk.

B. Ameliorating the Classification Risk in Claims–Made Policy Formats?

What do we mean by "classification risk?" When insurance is written for a specific term, the choice of whether to trade a premium for a transfer of risk can be revisited by both parties at the end of each policy period. If things have changed since the last underwriting review, then the price/coverage relationship also is likely to change. What sort of things may have changed? Some involve the expected value of the loss: what might change is the probability of loss, or the potential amount of loss, or the insurer's faith in its ability to make appropriate predictions about those risk factors. But other factors that may influence the insurer's willingness to assume the risk transfer have nothing to do with changes in the perceived riskiness of prospective insureds; rather the insurer may be more or less willing to write a renewal contract due to different capacity constraints, changes in its agency force, different projected overhead costs, better or worse investment returns, or alterations in its business philosophies. By keeping the term of the insurance contract short, the insurer limits its exposure to the risk of changes; by

lengthening the term, or—the same thing—by providing some guarantee of renewability, the insurer increases its share of the risk of changes. Risk of change not assumed by the insurer stays with insureds.

The market offers several different models of how parties to insurance contracts can assign the risk that circumstances will change during the term.[297] At one end of the spectrum are the fixed term policies that predominate in most of the property–casualty industry. The insurer assumes the risk of changes in the desirability of the exchange during that term, but limits its exposure to that risk by keeping the term short. At the other end of the spectrum is the "perpetual policy"; in exchange for a single pre–paid premium, the insurer undertakes to insure the property for so long as the insured desires.[298] Between these two extremes fall a variety of "guaranteed

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297. For a sophisticated effort to model the possibilities, see Mark V. Pauly, Howard Kunreuther & Richard Hirth, *Guaranteed Renewability in Insurance*, 10 J. RISK & UNCERTAINTY 143 (1995). *See also* Kevin D. Cotter & Gail A. Jensen, *Choice of Purchasing Arrangements in Insurance Markets*, 2 J. RISK & UNCERTAINTY 405 (1989):

> Most health insurance, as well as a substantial portion of life and disability insurance, is purchased on a risk–pooling basis. [statistics] . . . Virtually all group contracts pool risks, in which all members of the group have identical premiums and benefits regardless of their loss experience or risk factors. Individually purchased life insurance is usually either whole–life, renewable term, or extended–period term, all of which guarantee coverage over an extended period with no change in premium other than for age. . . . This contrasts with the purchase of automobile, personal property, and personal liability insurance. Contracts in these lines are typically short–term (one year or less), renewal is rarely guaranteed, and premiums are based on loss experience.

Other studies of multi–period contracting in the presence of classification risk include Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care,* 53 AM. EC. REV. 941 (1963); Thomas R. Palfrey & Chester S. Spatt, *Repeated Insurance Contracts and Learning*, 16 RAND J. EC. 356 (1985); Mark Pauly, *The Welfare Economics of Community Rating*, 37 J. RISK & INS. 407 (1970).

298. The Philadelphia Contributionship for the Insurance of Houses from Loss by Fire, the nation's oldest property insurance company (1752), still offers homeowners perpetual policies, paid off with single deposit, with full premium refunded when policy is canceled. Terrence Samuel & Duane Winner, *Historic*

renewable" contracts that provide a pre–commitment from the insurer, but with no enforceable obligation for the insured to renew.[299]

Simple enough. The complication lies in this question: when we say that a policy provision limiting coverage to a particular term protects the insurer from some of the risk of changes, do we mean that it assigns that risk to the pool of insureds, or to the individual insured? Some hazards are correlated for all members of the insured pool; others are not. Some contributors to adverse changes in an insured's risk profile will affect all members of the insured pool: inflation, new technologies, new environmental exposures, epidemics. Some will be idiosyncratic to an individual insured: although there has been no change in the likelihood that members of the insured pool will develop multiple sclerosis, and no increase in the costs of treating multiple sclerosis, this insured did develop multiple sclerosis. Every insured for a term assumes the risk that correlated risk factors may change before the end of the term, making the pool of risks less desirable in future terms. The "classification risk" is the additional risk that idiosyncratic, uncorrelated risk

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Insurance Company Makes Another Historic Move, PHIL. INQ., Aug. 12, 1996, at C2, col. 3.

299. *See* Cotter & Jensen, *supra* note 297 (explaining why long–term pooling contracts are possible in health, life, and disability insurance but difficult to sustain in property and liability insurance):

> One possible reason for these differences in purchasing arrangements is that the classification risk of future uncertain changes in one's risk type provides an incentive for long–term risk pooling contracts. . . . Such contracts are feasible, however, only when the loss probabilities increase with age. When loss probabilities decrease with age, it is generally not possible to write a long–term pooling contract that discourages older individuals with a favorable loss history from leaving the contract in lieu of coverage on more favorable terms. Consequently, sequential short–term pooling contracts arise as a second–best arrangement when neither group nor individual long–term pooling contracts are feasible. Property and liability insurance do not involve loss probabilities related to age, but a lack of classification risk in these lines of insurance decreases the incentive for long–term arrangements.

Id. at 406. As we shall see, when liability policies do involve classification risk the same imperatives apply.

factors may change for an individual insured before the end of the term, thus adversely affecting the individual insured's desirability for the next term when compared to the rest of the pool.

How do claims–made formats allocate the classification risk? In the academic models that grace the finance literature, the answer is clear: the risk of idiosyncratic changes in an insured's desirability continues to be diversified across the pool of insureds.[300] Of course, this answer is driven by the assumptions of the model. Working from the initial premise that the insurer's role in traditional commercial insurance arrangements stems from its comparative advantage in dealing with uncorrelated risks, the finance literature explains claims–made formats as an effort to decompose risk into two categories—correlated risk, which cannot be diversified in an insurance pool and which therefore should not be transferred to the insurer, and uncorrelated idiosyncratic risk, for which the magic of the law of large numbers still operates. Needless to say, such models do not confront the possibility that reporting requirements, renewal applications, laser exclusions, or mobile retro date provisions may be used to force the individual insured to bear the costs of idiosyncratic risks that have ripened into known preexisting circumstances before any policy has been triggered. By assuming that all claims are paid when made, that all claims–made policies automatically are renewed, and that retrospective rating makes the pool of insureds bear its own costs, such models take the insurer out of the risk assumption business almost entirely, and collapse almost completely any distinction between a reciprocal mutual pooling arrangement administered by an insurer and claims–made policy formats marketed by a commercial insurer.[301] In such a world, the

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300. *See, e.g.*, Doherty, *supra* note 8; Luc Grillet, *Corporate Insurance and Corporate Stakeholders: Limits of Insurability and Public Policy*, 11 J. INS. REG. 291 (1993); Anne E. Kleffner & Neil A. Doherty, *Costly Risk Bearing and the Supply of Catastrophic Insurance*, 63 J. RISK & INS. 657 (1996).

301. As Grillet summarizes:

> The movement from constant to random premium contracts can be illustrated with Doherty's framework. In essence, the insurance market employs constant premium contracts if risks are easily diversifiable, or in other words, if the risk–pooling properties of the Law of Large Numbers hold. If a segment of the insurance market is plagued by substantial event and/or information correlation, risk–spreading for these undiversifiable risks will be achieved through random premium or risk–sharing contracts. . . . The insurer will offer random premium contracts, which in the extreme case means

costs of both correlated and uncorrelated risks are borne by the insured pool. In such a world, it makes sense to say that "the claims–made form represents a preferred form of contracting under conditions of non independence between insurable risks."[302]

Of course, within the orthodox intellectual traditions of insurance law, a different answer is equally clear: the classification risk is borne by the individual insured. In insurance, as elsewhere, freedom of contract finds its "first and most important application . . . in the right to choose one's trading partners,"[303] and unless the insurer has promised to renew regardless of changes in the desirability of the insured, it matters not whether that underwriting discretion is manifested as an initial refusal to deal, as a refusal to renew, or as a renewal that carves known potential claims out of the renewal coverage. Because an insurer can choose to reject the application of a new prospective insured, it can choose to limit the coverage it does write on a new applicant by a laser exclusion of idiosyncratic circumstances known to the insurer or by a retro date that excludes later claims based on circumstances known to the insured at the inception of the contract. As Judge Posner correctly notes:

> Like the exclusion of a known preexisting condition from a health insurance policy, the exclusion from a claims–only policy of claims based on conduct that occurred before the

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> that he base[d] the premium [charge] to the policyholder on the information available *after* the loss has been realized. This enables him to remove the event and information correlation from his portfolio. . . . The policyholder still achieves partial risk–shifting. Why? The policyholder shares his loss with the losses of the other pool members. He can insure his idiosyncratic risk, because his retroactively calculated premium is not based on his individual loss but on his individual share in the realized collective loss of the insurance pool.

Grillet, *supra* note 300, at 310. Professor Doherty makes the same point: "The intention is not to nullify the effects of insurance against the policyholder's idiosyncratic risk, but to remove insurer risk. Thus the retroactive correction to the individual's premium is not based on his or her individual loss but on the collective loss in the pool." Doherty, *supra* note 8, at 232.

302. *Id.* at 243.

303. RICHARD EPSTEIN, ANTIDISCRIMINATION IN HEALTH CARE: COMMUNITY RATINGS AND PREEXISTING CONDITIONS 1 (1996).

> policy was issued and that was known to have claim potential is uncontroversially proper.[304]

But is it also "uncontroversially proper" for an insurer that was providing claims–made coverage when the conduct took place and became known—to the insured, to the insurer, or to both[305]—to employ its renewal underwriting discretion to make certain that it will assume no responsibility for known circumstances under future policies? Within a spot–market paradigm that understands insurance contracts as short–term relations that must be formed, and then performed, after which they cease to exist, there is no reason to distinguish between Case 7, where the retro date protects the insurer from adverse selection at the inception of its relationship with the insured, and Case 10, where the advanced retro date seeks to protect the insurer from potential claims based on conduct that occurred and became known while the same insurer was on the risk. So long as each insurance contract is seen as a simple transfer of risk for a term, the question will be whether the insurer agreed to assume any of the classification risk to which the insured otherwise would be subject. Posed that way, the answer usually will appear to be "no."

Thus, in the still–dominant insurance law way of thinking, a ten–year history of renewals with the same insurer is just a history of ten different contracts, and preexisting conditions that became known before the first contract takes effect should be treated no differently than conditions that became known between the sixth and seventh renewal. However, a neo–institutional perspective sensitive to the vulnerabilities that go with relation–

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304. Truck Ins. Exchange v. Ashland Oil, Inc., 951 F.2d 787, 791 (7th Cir. 1992) (citations omitted). Indeed, Judge Posner added, sounding a note we have heard before, there is "nothing exploitive about such limited coverage if the insurance premium were correspondingly small." *Id.* at 790.

305. Insurers may underwrite against "preexisting conditions" directly on the basis of information known to insurer, or indirectly by expressly excluding claims based on information known to the insured at the time the policy was issued or by relying on the implicit "fortuity defense. *See generally* Stephen A. Cozen & Richard C. Bennett, *Fortuity: The Unnamed Exclusion*, 20 FORUM 222 (1985) (summarizing recent developments including growing use of subjective standard focusing on knowledge of insured); Richard L. Fruehauf, *Note, The Cost of Knowledge: Making Sense of "Nonfortuity" Defenses in Environmental Liability Insurance Coverage Disputes*, 84 VA. L. REV. 107 (1998) (contending that "nonfortuity" arguments add little to existing policy and misrepresentation and concealment defenses, but that actual knowledge of legal liability variant of "nonfortuity" arguments may function as per se concealment defense).

specific investments might see a distinction between Case 7 and Case 10. Claims–made contracts conceived, not as a simple transfer of risk from an insured to an insurer, but as a reciprocal undertaking by members of an insured pool with the commercial insurer functioning as their agent for administering the pool, might carry quite a different set of implications about whether the costs of idiosyncratic risk that becomes known after the inception of the relationship is to be shared among members of the pool or whether instead it is to be visited upon the individual insured in order to reduce costs to the pool.

Of course, the reality necessarily is more complex than either the reciprocal pooling arrangements of the financial models or the spot market exchanges between strangers with no common history and no common future that so dominate conventional insurance law thinking. Claims–made policies can not effect a complete mutualization of correlated and uncorrelated risks without the very strong assumptions of the financial models; the commercial claims–made insurer has a stake in the claims costs of the pool of insureds, and those claims costs can be affected by preventing known potential sources of claims from being admitted or readmitted to pool. Moreover, Judge Posner's analogy to medical expense insurance is double–edged, and not just because federal COBRA[306] and HIPAA[307] legislation and their state complements now trump the common law assumption that refusal to insure known medical expense risks "is uncontroversially proper" even for individuals who have managed to gain initial access to an insured pool.[308] Some claims–made insureds will find unrestricted renewal coverage at the pool price even after their idiosyncratic sources of potential claims have become known, just as in group medical expense insurance before COBRA and HIPAA, because the classification risk has been mutualized by their membership in a community–rated pool. But others will not, and the later trigger of claims–made formats means that a greater number of insureds

306. 29 U.S.C. §§ 1161–1168 (Supp. 1995).

307. The Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104–191, 110 Stat. 1936 (1996).

308. For insureds who have once gained admission to medical expense insurance through an employee group plan, COBRA guarantees continuing coverage from that group plan for a period after the loss of eligibility; HIPAA allows qualifying members of a group health plan to apply credit earned by participation in their old group plan against waiting periods and preexisting condition limitations if they move to a new group or individual plan. *See generally* JOSEPH A. SNOE, AMERICAN HEALTH CARE DELIVERY SYSTEMS 80–123 (1998).

under liability policies will be exposed to the application of renewal underwriting discretion after their idiosyncratic risk potential has become known, just as the later trigger of medical expense insurance imposes a greater exposure to the classification risk on medical expense insureds not sheltered by a community–rated pool or ameliorating federal legislation.

A few examples may help to highlight how the classification risk imposed by claims–made formats can differ from the classification risk borne by insureds covered by policies with more traditional triggers. When my daughter turns sixteen and begins driving, we expect that the increase in risk will be reflected in an increase in the price charged for the family's auto coverage. We have no reason to be offended by such efforts at risk classification; in a competitive insurance market, classification of exposures on the basis of perceived contributions to the expected losses of the pool is necessary for rate equity and to prevent the insured pool from unraveling. But expected loss is a prediction about the average loss of the pool of risks being combined. Actual losses of individual members of the pool still are largely a function of chance. When my daughter backs the family car into the neighbors' recreational vehicle, we may worry that her negligence may be a precursor to further price hikes or even a refusal by the insurer to provide further coverage, but we do not worry about whether the damage to the recreational vehicle will be covered. The occurrence trigger of the auto policy guarantees that the policy will have been triggered before anyone has any opportunity to know that she has distinguished herself from the majority of insureds who will not be making a claim. The classification risk to which we are subject includes the risk that my daughter may signal to the insurer that she is a poorer risk than the ordinary sixteen–year–old driver, and that the new information may be used by the insurer in its renewal underwriting, but it does not include the risk that damage she causes while insured will not be covered. Or, to put the matter yet another way, at the end of a policy period we expect that insurer concerns about any "known risks" may be reflected in price or underwriting effects, but we expect any "known losses" already will have triggered a policy.

In the abstract, and with simple examples, the assumption that the classification risk borne by an individual insured includes "known risk"—the chance that during the policy term the insured will discover idiosyncratic risk factors that so far have not triggered any policy and that legitimately may affect an insurer's willingness to accept a future risk transfer—but not "known losses"—events that simultaneously trigger any policy then in effect and make the loss no longer insurable because no longer "fortuitous"—can

seem obvious and uncontroversial. A fire loss in 1996 triggers a 1996 property insurance policy insuring against the perils of fire; when renewal time arrives, the 1996 fire is relevant to the 1997 renewal decision only to the extent that it supports inferences about potential losses that could trigger the 1997 policy. And messier facts need not destroy that fundamental complementarity. Thus, no one would doubt that a fire started by New Year's Eve revelers that destroys part of the insured house before the midnight expiration of the 1996 policy, and the rest after the ball has dropped, will be treated as a fire that occurred in the 1996 policy period. Under the "loss–in–progress" rubric, efforts by the 1996 fire insurer to argue that its liability is limited to damage that occurred before midnight simply should fail; efforts to tag the 1997 fire insurer with responsibility for damage that occurred after midnight should be equally unavailing.[309] Indeed, we expect the same complementarity to prevail when occurrence triggers in liability policies must be applied to progressive personal injuries or property damage. As two recent authors capture the conventional understanding:

> The fortuity principle and trigger analysis are distinctly different but complementary. When applied in the context of a continuous or cumulative personal injury or property damage case, these interrelated concepts provide that coverage would be triggered under the policy in effect when damage or injury first occurs (or becomes manifest). Liability for the CGL carrier on the risk at that time is contractually fixed, whether or not all resulting injury or damage has occurred during that policy period. Damage or injury caused by the same occurrence but materializing after

309. *See* Snapp v. State Farm Fire & Cas. Co., 24 Cal. Rptr. 44 (Cal. Ct. App. 1962) (if contingent event insured against occurred during policy period, insurer is liable for full loss even if extent of damage cannot be ascertained at end of policy period). Other contexts beget other rubrics. Thus, in accident and disability insurance settings, the "process of nature" rule is used to justify the conclusion that complications and intensification of injury that result from an accident should be treated as occurring on the watch of the insurer at the time of the accident even if they are experienced in later policy periods. *See, e.g.,* National Life & Acc. Ins. Co. v. Edwards, 174 Cal. Rptr. 31 (Cal. App. 1981). *See generally* Fischer, *supra* note 11, at 627, 664–65, 677–86. *Cf.* James F. Hogg, *The Tale of a Tail,* 24 WM. MITCHELL L. REV. 515 (1998) (challenging argument that responsibility of occurrence insurer for progressive injury losses should be reduced if losses continue during years in which insured had untriggered claims–made coverage).

termination of the triggered policy is not insured under subsequent policies due to the loss–in–progress rule.[310]

Such examples, though useful, can obscure a fundamental point: the comforting complementarity on display in these familiar stories is dependent upon the policy triggers being employed. In these cases, the very event that triggers one policy is the event that renders the damage no longer fortuitous and thus not insurable under a subsequent policy. And, in these cases, the trigger usually is satisfied before the insurer gains knowledge of the idiosyncratic circumstances that distinguish this insured from other insureds and that might prompt a negative underwriting decision. But as another look at our exploded liability insurance claim sequence should remind us, a policy trigger set late in the tort liability insurance claims sequence sometimes will not be satisfied until after the loss has become certain or after the insurer has learned of an idiosyncratic risk factor that seems certain to produce a loss.

Potential Stages in the Evolution of Liability Insurance Claims

allegedly tortious act or omission by insured
exposure of potential victims
injury in fact
manifestation of victim's injury
insured should have discovered circumstances that may give rise to a claim
insured discovers circumstances that may give rise to a claim
insured discovers specific acts or omissions that may give rise to a claim
insured reports to insurer circumstances that may give rise to a claim
insured reports to insurer specific acts that may give rise to a claim
insured reports to insurer circumstances that may give rise to a claim
claim for compensation by victim against insured
insured reports claim to insurer
victim files suit against insured
investigation by insurer
defense and reserving decisions by insurer
negotiations between insured and victim
judgment or settlement
payment to victim

310. Harold M. Provizer & Noel F. Beck, *Making Sense of the Fortuity Doctrine*, FOR THE DEFENSE, February 1996, at 20, 25. *See also* Richard L. Antognini, *When Will My Troubles End? The Loss in Progress Defense in Progressive Loss Insurance Cases*, 25 LOY. L.A. L. Rev. 419 (1992).

What if an explosion during the term of a pure claims–made policy has leveled adjoining buildings and sent numerous victims to hospitals and morgues, but by the end of the policy period no claims have yet been filed? Can the claims–made insurer simply walk away at the end of the term? Or consider the situation of a lawyer continuously insured under pure claims–made policies issued by the same insurer from 1986 through 1996 who realizes in September, 1996, that he negligently missed a July 1, 1996, statute of limitations filing deadline. Had the lawyer been insured under old–fashioned professional liability formats once in vogue, the lawyer's negligence during the 1996 policy year would have triggered the 1996 policy and would be relevant to the 1997 renewal decision only to the extent that it supports inferences about the lawyer's riskiness in the future. But with a pure claims–made trigger, not only is the 1996 policy not triggered, but now the insured knows of the potential claim, and if the insured truthfully answers the questions on his renewal application, soon the insurer will know as well. In these cases the comforting complementarity usually worked by occurrence triggers is absent. Not only have the explosion and missed filing deadline failed to trigger any policies, but we may wonder whether renewal underwriting by insurers and the fortuity requirement will permit any subsequent policy to be triggered.

Well, might be the response, so what?[311] That is the nature of claims–made formats. They are cheaper because less risk is being transferred. Academic models and appellate opinions may emphasize that claims–made formats protect the insurer from the risk of correlated changes in liability rules, inflation, medical technology, and the like by assigning those risks to insureds. But another part of the risk being assigned to the insured is the risk that the renewal insurer will choose to exercise its underwriting discretion to keep known idiosyncratic risk factors—including "known losses" that have not triggered earlier policies—from becoming a burden to the insurer and ultimately to the pool of insureds. Policy triggers that operate at the same time or before losses become known do not create opportunities for insurers to underwrite in order to avoid a "known loss"; there the classification risk includes only the possibility that known risk factors will influence the

311. *See, e.g.*, Jaap Spier, *Long Tail (Liability) Risks and Claims Made Policies*, 23 GENEVA PAPERS ON RISK & INS. 152 (1998) (claims–made formats designed to shift risks to insureds). However, even in the course of a spirited defense of claims–made formats, Professor Spier acknowledges room for possible concern "in the case of 'classical damage', occurring just before the elapsing of the contract, if the damage would not be covered under any policy." *Id.* at 166.

willingness of the renewal insurer to assume responsibility for future losses, but it does not include the possibility that the insurer will choose to duck responsibility for losses that have already become inevitable. With policy triggers that operate later in the sequence, the insurer's discretion is not so obviously limited, and in the conventional understanding there is no reason to think that the claims–made insurer is obligated to react any differently to knowledge of explosion–caused death and destruction or a missed statute of limitations deadline than it does to knowledge that a factory lacks a sprinkler system or that a lawyer has new clients in the savings and loan industry or no longer maintains a formal docket control system. Once a policy term ends with the policy still untriggered, both idiosyncratic "known risks" and idiosyncratic "known losses" that might trigger a subsequent policy will be factors to be considered when a renewal insurer makes underwriting and pricing decisions for subsequent terms. In the orthodox understanding, that is part of the classification risk to which the claims–made insured is subject, just as it is part of the classification risk to which some medical expense insureds still are exposed.[312]

312. As we have seen, in the positive analysis of institutional economics, one of the chief determinants of long–term contractual commitments is the presence of relation–specific investments; long–term commitments may be necessary to induce a party to make the relation–specific investment that creates the vulnerability to hold–ups at the end of short–term contract. *See generally* WILLIAMSON, *supra* note 95, at 71–84. Applied to insurance, that means that we should expect fully–informed, fully–rational insureds to react to the vulnerabilities to classification risk that go with late–operating triggers by demanding that insurers make long–term commitments or allow the trigger to be pulled earlier in the tort liability sequence. And sometimes insureds do react in that way. The practice literature addressed to insurance–buying professionals routinely suggests that the only real protection against classification risk is to establish long–term relations with an insurer. *See, e.g.*, Thomas A. Konopka, *The Advantage of Claims–Made Forms for Insurance Buyers*, RISK MANAGEMENT REPORTS, July/Aug., 1991, at 11, 16 (chief protection against classification risk is "selecting a carrier with a demonstrable commitment to meeting the insured's long–term–liability protection needs"). Consequently, there is significant resistance to claims–made formats and, when occurrence policies are not available, insistence that nominally "claims–made" formats include extended reporting periods, "circumstances discovered and reported" triggers, and guarantees that retro dates not be advanced. But such protections are far from universal, they provide only limited protections against opportunism at renewal, and they constitute a fundamental retreat from the implications of pure "claims–made" and "claims–made–and–reported" triggers.

But is it really so obvious that the classification risk to which insureds are exposed by late triggers must include not only "known risks" but also "known losses?" Imagine the polar example of a late trigger, a "claims–paid" policy trigger providing that the insurer's obligation to pay will not be triggered until a claim against the insured actually had been paid—and the insurer, as under most mainstream liability insurance policies, asserts a right to control the defense. How would we react to a policy trigger that cannot be satisfied unless the insurer permits it to be satisfied? The choice will seem familiar to those whose memories of first–year contracts include Cardozo and Lady Duff–Gordon:[313] either we say the insurer's control of the timing of the

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However, the institutional implications of the claims–made insured's vulnerability to classification risk may be even more fundamental. As Brent Clark has noted: "as loss situations become known, claims–made insurance has a tendency to 'evaporate' as it becomes increasingly difficult to transfer the risk of a known loss to an insurer. Thus, the purchase of claims–made insurance may create the illusion of risk transfer that could involve firms in extremely damaging situations later on." Brent M. Clark, *The Broad Implications of Claims–Made Insurance,* RISK MANAGEMENT REPORTS, Vol. XIII, No. 4, at 9, 23 (1986). Recognition of this reality means that, for some corporate buyers, what is nominally liability insurance becomes a mechanism by which the individual insured employs claims–made coverage with paid–loss retrospective rating to smooth the impact of at least some of the losses that it ultimately will bear itself. "Thus, the broad implication of claims–made insurance may be a decreasing reliance on commercial insurance to finance risk." *Id.* at 31.

Doubtless concern about these vulnerabilities has been one important contributor to the proliferation in recent decades of a variety of captives, reciprocals, risk retention groups, and other forms of mutual organization distinguished from commercial liability insurance enterprises by the fact that "[r]isk is pooled amongst those who are commonly exposed rather than transferred to external risk bearers." Neil A. Doherty & Georges Dionne, *Insurance with Undiversifiable Risk: Contract Structure and Organizational Form of Insurance Firms*, 6 J. RISK & UNCERTAINTY 187, 188 (1993) (mutual organizational forms and claims–made policies modeled as giving policyholders stake in the residual value of the insurer; thus are alternative responses to correlated uncertainties about liability insurance payouts). *See also* John M. Marshall, *Insurance Theory: Reserves versus Mutuality*, 12 ECON. INQ. 476 (1974) (reserve principle appropriate where law of large numbers can provide acceptable predictability; mutualization where it cannot). The same point has been applied to the recent history of liability insurance by Doherty, *supra* note 300, at 239–240; Grillet, *supra* note 300, at 308–311.

313. Wood v. Lucy, Lady Duff–Gordon, 118 N.E. 214, 214 (N.Y. 1917):

triggering event makes the putative risk transfer illusory, or we say the risk transfer is not illusory because the insurer's discretion is "instinct with an obligation" to make its decisions in good faith[314] —and then we worry about what the flexible standard of good faith might be made to mean in this setting.

In fact, we are unlikely to encounter such a brazen effort to preserve underwriting discretion until after both the fact and the magnitude of a loss have been determined. But we will encounter many instances in which the liability insurer gains knowledge of irremediable idiosyncratic circumstances before a policy has been triggered, and not only when the format is some variation of "claims–made." Occurrence triggers too can operate after a known loss.[315] Thus, for example, recognition of the vulnerability that goes with late triggers was an important factor in judicial rejection of "manifestation" as the sole trigger of coverage for claims involving asbestosis and other "progressive loss" claims. As the opinion in *Keene Corp. v. Insurance Company of North America*[316] explained:

> To demonstrate why the policies require that both exposure and manifestation trigger coverage, we begin by positing a rule in which manifestation is the *sole* trigger of coverage. If that interpretation were adopted, . . . [the insured] Keene would not be covered for diseases manifesting themselves

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> The law has outgrown its primitive stage of formalism when the precise word was the sovereign talisman, and every slip was fatal . . . A promise may be lacking, and yet the whole writing may be 'instinct with an obligation,' imperfectly expressed. . . We are not to suppose that one party was to be placed at the mercy of the other.

314. *See* Robert A. Hillman, *"Instinct with an Obligation" and the "Normative Ambiguity of Rhetorical Power,"* 56 OHIO ST. L.J. 775 (1995).

315. *See generally* Geert Schoorens & Caroline Van Schoubroeck, *Insuring the Uninsurable? The Appeal of the Circumstances Clause,* 23 GENEVA PAPERS ON RISK & INS. 169 (1998) (urging use of circumstances–reported triggers to avoid classification risk posed by both occurrence and claims–made formats); Gerhard Wagner, *Comments on the Appeal of the Circumstances Clause and the Uninsurability of Long Tail Risks*, 23 GENEVA PAPERS ON RISK & INS. 178 (1998) (questioning costs of such an approach).

316. 667 F.2d 1034 (D.C. Cir. 1981). *See also* Insurance Co. of N. Am. v. Forty–Eight Insulations, Inc., 633 F.2d 1212, 1230 (6th Cir. 1980) (Merritt, J., dissenting).

> after 1976. By that time it was widely known that prolonged inhalation of asbestos has a high probability of causing disease. From about then on, insurance companies ceased issuing policies that adequately cover asbestos–related disease. Yet we can still expect thousands of cases of those diseases to manifest themeselves throughout the rest of the century. If we were to hold that only the manifestation of disease can trigger coverage, the insurance companies would have to bear only a fraction of Keene's total liability for asbestos–related diseases.[317]

In *Keene* and other "triple trigger" and "continuous trigger" decisions, the courts are able to avoid leaving insureds to bear the costs of known exposures that have not yet triggered a policy by saying that what would be a preexisting condition for a renewal policy with a manifestation trigger—the known exposure—also is enough to trigger the earlier policy. Of course, other interpretive moves sometimes may accomplish the same result. For example, in *Chemstar, Inc. v. Liberty Mutual Insurance Co.*,[318] faced with twenty–eight different product liability claims for damage to twenty–eight different properties over a four–year period based on plaster pitting that manifested itself in different policy periods, the court rejected the continuous trigger interpretation but still was able to "protect the insured's access to insurance" by holding that coverage was triggered for all claims when the problem first manifested itself in the first claimant's house.[319] In such decisions, the

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317. Keene Corp., 667 F.2d at 1045–46.

318. 797 F. Supp. 1541 (C.D. Cal. 1992), *aff'd*, 41 F.3d 429 (9th Cir. 1994).

319. *Id.* at 1552. As the court explained:

> [U]nlike the continuous injury trigger, the manifestation trigger avoids a conflict with the loss–in–progress rule. The loss–in–progress rule is based on the principle that insurance is designed to protect against contingent or unknown risks of harm, rather than harm that is certain or expected. Accordingly, the loss–in–progress rule precludes coverage for losses that were known before the policy period, even if the damage progresses during the policy period.
>
> The loss–in–progress rule and the manifestation trigger complement one another and protect the insured's access to insurance: To use the current case as an example, even after

vulnerability to renewal underwriting that would result from a trigger that might not be satisfied until after an injurious process has become known is a powerful argument for interpreting the occurrence trigger as satisfied by events that fall early in the sequence.[320] Indeed, in *Montrose Chemical Corp.*

> plaster–pitting manifested in the first home, subsequent insurers would be willing to issue policies to Chemstar because they could rely on the loss–in–progress rule to preclude coverage for progressive plaster–pitting. By contrast, the continuous injury trigger risks exposing the insured to gaps in coverage: Once plaster–pitting manifests in the first home, a potential insurer that is aware of the heightened risk of further plaster–pitting in other homes would be unwilling to issue policies to Chemstar because the insurer would be held liable for plaster–pitting that occurs during its policy period.

Id. at 550–51 (citations omitted).

320. *See, e.g.,* Keene Corp. v. Ins. Co. of N. Am., 667 F.2d 1034 (D.C. Cir. 1981).

> This conclusion is consistent with the law involving insurance coverage of losses that begin during a period of coverage but continue to develop after a policy's expiration. For example, Snapp v. State Farm Fire & Casualty. Co., 206 Cal. App. 2d 827, 24 Cal. Rptr. 44 (1962), . . . stated that "[t]o permit the insurer to terminate its liability while the fortuitous peril which materialized during the term of the policy was still active would not be in accord either with applicable precedents or with the common understanding of the nature and purpose of insurance."
>
> These cases illustrate the principle that when it becomes known that an occurrence has set in motion a process that has a significant probability of resulting in a covered loss, the insurer on the risk at that time is liable for the full loss. It does not matter whether the insurer learns of a progressing loss through direct observation, as in Snapp, or through statistical inference, as in asbestos–injury cases. It is the use of that knowledge to shift a covered risk back to the insured that is not permitted.

Id. at 1046–47.

v. Admiral Ins.Co.,[321] in rejecting an interpretation of an occurrence policy that would have created just that vulnerability, the court seemed to make the preexisting condition problem the synecdoche for the distinction between occurrence and claims–made policies: "To read an occurrence policy to afford coverage only when the injury or damage becomes manifest during the policy period . . . unfairly transforms the more expensive occurrence policy into a cheaper claims made policy."[322]

With claims–made formats, such interpretive moves usually will not be available. Explosions and missed statutes of limitations are not "claims made" against the insured, and there is no point in trying to argue that they should be enough to trigger a "claims–made" or "claims–made–and–reported" policy in effect when they happened. But acknowledging that claims–made triggers subject insureds to discretionary renewal underwriting decisions, and that sometimes that discretion will be exercised after losses become both inevitable and known, need not mean that the exercise of that discretion must be unconstrained. Perhaps there is a middle ground between insurance law's traditional assumption that the insured bears the full burden of classification risk no matter how many policy renewals he's been through and the finance literature's assumption that the idiosyncratic portion of classification risk is fully mutualized in the pool. Might we take our lead

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321. 5 Cal. Rptr. 2d 358 (Cal. Ct. App. 1992). *See also* Harford County v. Harford Mut. Ins. Co., 610 A.2d 286, 294 (Md. 1992) (quoting *Montrose* with approval).

322. Montrose Chemical Corp. v. Admiral Ins. Co., 5 Cal. Rptr. 2d 358, 368 (Cal. Ct. App. 1992). The opinion of the Court of Appeals later was displaced by the opinion of the Supreme Court, but not without this confirmation of the characterization: "We agree with the conclusion of the Court of Appeal below that to apply a manifestation trigger of coverage to Admiral's occurrence–based CGL policies would be to effectively rewrite Admiral's contracts of insurance with Montrose, transforming the broader and more expensive occurrence–based CGL policy into a claims made policy." Montrose Chemical Corp. v. Admiral Ins. Co., 913 P.2d 878 (Cal. 1995).

Note that the vulnerability to renewal underwriting after a loss has become inevitable can arise even with earlier occurrence triggers. For example, on the *Chemstar* facts it would be possible for the insured and the insurer to learn of potential for plaster–pitting even before some ultimate users were exposed; of course, in theory alternative measures—an aggressive recall campaign, for example—might still prevent the risk from coming to fruition with respect to those future end users. *See also* Fischer, *supra* note 13, at 675–76 (noting that breast implants pose similar potential).

from the assumptions of the finance literature and its less formal echoes in some appellate opinions and conclude that the purpose of even pure claims–made formats is to insulate the insurer from uncertainties about correlated risks, but to continue to allow idiosyncratic risks to be combined and diversified through the pool, and that therefore it is bad faith for an insurer to exercise its underwriting discretion to force the occasional individual insureds whose idiosyncratic circumstances become known before renewal to bear the full costs of their own misadventures? There are interesting potential parallels in the law and literature of employment law, where the obligation of good faith and fair dealing may on appropriate facts provide some protections against opportunistic efforts by employers to terminate employees at will,[323] and in the law of lender liability, where good faith may sometimes set limits on a lender's discretion to decide whether to renew a financing arrangement with a debtor.[324] In each of these arenas, judicial use of the good faith standard is more likely after sunk investments have rendered the other party vulnerable to opportunistic exercise of discretion granted or permitted by the contract. In the employment setting, the fundamental transformation comes

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323. *See, e.g.,* Schwab, *supra* note 148 ("courts have been boldest" in protecting nominally at will employees where protection is most needed, i.e., at the beginning and end of employees' careers, where employees' investments in firm–specific skills trap workers in their present jobs and render them vulnerable to employer opportunism). *See also* WEILER, *supra* note 148, at 63–67; Kenneth G. Dau–Schmidt, *Employment Security: A Comparative Institutional Debate*, 74 TEX. L. REV. 1645 (1996). *Contra* Edward B. Rock & Michael L. Wachter, *The Enforceability of Norms and the Employment Relationship*, 144 U. PA. L. REV. 1913 (1996) (sunk investments and potential for opportunism prompt "internal labor markets" to develop informal practices and norms that provide just cause protections in fact even where legal rule is employment at will).

324. *See, e.g.,* Gillette, *supra* note 109 (advocating thick contextual inquiries to determine whether a lender who refuses to renew is acting in good faith, while acknowledging difficulties of trying to determine whether a particular relationship is straight loan with both lender and borrower engaged in egoistic gambles about what the future may hold, or whether the lender has tied up the borrower's collateral so as to create a monopoly with respect to future extensions of credit). In lender liability litigation, the sunk investments may take the form of grants of security to a lending institution that effectively prevent the borrower from seeking secured loans elsewhere. *See* Gillette, *supra* note 109, at 565–74. *See also* Daniel R. Fischel, *The Economics of Lender Liability*, 99 YALE L.J. 131, 139 (1989) (lack of access to new lenders likely when lender has acquired costly information about borrower, and where the market cost of credit has risen).

in the form of relationship specific investments that cannot be transferred to other employers; in the lender liability setting, the fundamental transformation occurs when security arrangements effectively prevent the borrower from gaining access to other credit markets. Might we conclude that in claims–made insurance, the fundamental transformation occurs and thus the obligation to exercise renewal underwriting discretion in good faith arises when an idiosyncratic loss becomes inevitable during the term of a claims–made policy?

Still, analogies to the ways in which flexible standards of good faith can be used to police discretion in employment contracts and lending arrangements, though easily asserted, may prove too facile. Exercise of renewal underwriting discretion is not opportunism unless it is offends the letter or spirit of the agreement, and the news that claims–made formats are sold subject to a tacit understanding that the insurer will not visit the costs of an irremediable idiosyncratic risk on an individual member of the pool when it could be diversified through the pool likely will come as a surprise to anyone accustomed to viewing insurance transactions as involving but two parties, the insurer and the insured, and insurance contracts as transfers of discrete risks for a term. But might we look to the models of claims–made contracting in the finance literature, not as part of an orthodox ex ante perspective asking if assumptions of those models somehow have become incorporated into the expectations of the parties to claims–made contracts, but instead as Schwab uses the assumptions of the life–cycle model of employment contracts[325] and Gillette employs alternative understandings of lending relationships,[326] as a guide to where the occasions for opportunism are most pronounced and where the expenditure of judicial resources in an effort to prevent bad faith is most likely to prove productive?

Of course, finding a doctrinal handle is not the only problem. Difficulties of application will prove daunting. We can opine with confidence that an insured should not be able to row through flood waters threatening his house in order to buy flood insurance for the first time,[327] and that an insurer that

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325. *See* Schwab, *supra* note 148, at 38–51 (arguing that courts intervene despite at–will presumption in portions of life–cycle when dangers of employer opportunism are high).

326. *See* Gillette, *supra* note 109, at 552–74 (discussing spectrum of commercial relationships).

327. "A homeowner could not insure his house against flood damage when the rising waters were already in his front yard." Bartholomew v. Appalachian Ins. Co., 655 F.2d 27, 29 (1st Cir. 1981). *See* Summers v. Harris, 573 F.2d 869 (5th Cir.

has written flood insurance should not be permitted to cancel or nonrenew when the flood waters begin lapping at the door.[328] But beyond such obvious examples, our efforts to find something in the relationship to tell us whether the insurer or the insured should bear a particular portion of the classification risk will be very difficult. Insurance opinions are full of unsatisfactory efforts to explain the line of demarcation between "known loss" and "known risk" when the issue is whether the risk has become so certain that it is no longer a fortuity. Can we expect any better when the issue is whether the loss has become so certain that it should be bad faith not to renew?

Perhaps not, but our understanding of both issues would be advanced by explicit recognition of the vulnerabilities worked by the "fundamental transformation." Underwriting discretion that is unexceptionable when employed in a competitive setting, before the fundamental transformation has occurred, may be inappropriate when employed after the insured has been locked in by an irremediable change in circumstances. Thus, if I negligently leave a boulder perched on the precipice at the edge of my property, and the insurer learns of that idiosyncratic potential for causing damage to my neighbor in the valley below, I will have no reason to object if the insurer reacts by raising my rates, incorporating a laser exclusion of damage caused by rolling rocks, or refusing to insure me at all—either initially or at renewal. The rock is still but a potential cause of loss; I can still take other measures to eliminate or ameliorate the risk. But once the boulder begins to roll and damage to neighboring persons and property becomes inevitable, I am locked in and it should be too late for the insurer to price or to underwrite against that loss even if as yet no perambulators have been crushed and no lives ruined.[329]

That simple intuition can, on appropriate facts, survive the trip to the claims–made setting. If the factory already has exploded, it should be too late for even a claims–made liability insurer to walk away. In *Heen & Flint Associates v. Travelers Indemnity Co.*,[330] the court vindicated that instinct by

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1978) ("loss in progress" rule prevents coverage for damage by flood water that entered house during policy period; flood was continuation of flooding process "in progress" at policy inception).

328. Fire, not flood, was featured in the most–familiar aphorism: "Of what avail would it be, to take a policy against fire, to permit its cancellation when the fire is approaching." Home Insurance. Co. v. Heck, 65 Ill. 111, 114 (1872).

329. *See generally* Schoorens & Van Schoubroeck, *supra* note 315 (urging use of potential claims reported triggers to help ameliorate vulnerabilities of lock–in).

330. 400 N.Y.S.2d 994 (N.Y. S. Ct. 1977).

declaring the claims–made trigger unconscionable because it appeared to permit the insurer to refuse to renew for future years in order to avoid future claims certain to ensue.[331] In *Helfand v. National Union Fire Insurance Co.*,[332] faced with an attempt by National Union to cancel the third year of a claims–made policy when it learned that "that there were significant law suits pending against the directors and officers and more were expected to be filed,"[333] the court chose to attack the exercise of the discretion granted by the absolute cancellation clause rather than the substance of the clause itself. The traditional understanding that cancellation provisions in an insurance policy are not contrary to public policy and need not be exercised for cause did not mean that the insurer was free to cancel after knowledge of imminent legal action make it impossible for insureds to seek alternative coverage elsewhere in the market.

> Liability carriers do not have an unfettered right to cancel coverage, notwithstanding mutual cancellation clauses to that effect. Cancellation provisions in an insurance contract are subject to the implied covenant of good faith and fair dealing just like any other clause.
>
> . . . .

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331. *Id.* at 998–99:

> It is my determination that a provision in a "claims made" policy that permits an insurer, where it has notice of a potential claim, to refuse to renew that policy, is unconscionable. Such a provision allows an insurer to avoid the risk of serious potential claims arising from accidents committed within the policy period, and leaves the insured without coverage after the expiration of the policy, since no other insurer will be willing to accept the known risk and thus buy its way into a potential lawsuit.
>
> I, therefore, limit the provision of the Travelers' policy that requires a claim to be made against the insured during the policy period, to instances where continued coverage is available from the same or from some other insurer . . . .

332. 13 Cal. Rptr. 2d 295 (Cal. Ct. App. 1992), *cert. denied,* 510 U.S. 824 (1993).

333. *Id.* at 315–16.

> An arbitrary cancellation is a breach of the covenant of good faith and fair dealing. "Where a contract confers on one party a discretionary power affecting the rights of the other, a duty is imposed to exercise that discretion in good faith and in accordance with fair dealing." To exercise that power arbitrarily and to the detriment of the other party is inconsistent with that party's justified expectations.[334]

Of course, within the inherited traditions of the private insurance enterprise, cancellation is one thing, nonrenewal quite another.[335] Should the obligation to exercise underwriting discretion in good faith apply there as well? "Yes," the Colorado Supreme Court recently held. In *Yasuzawa v. PHICO Insurance Co.*,[336] the insurer's argument "that it does not have a duty of good faith toward its insureds in the nonrenewal or negotiation context"[337] was flatly rejected.

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334. *Id.* at 315–17. The *Helfand* court invoked the old saw from *Home Ins. v, Heck,* 65 Ill. 111, 114 (1872) (quoted *supra* note 328). 13 Cal. Rptr 2d at 317. *See also* Murphy v. Seed–Roberts Agency, Inc., 261 N.W.22d 198 (Mich. Ct. App. 1977) (bad faith to exercise cancellation clause in medical malpractice policy in order to offer reinstatement at much higher premium); L'Orange v. Medical Protective Co., 394 F.2d 57 (6th Cir. 1968) (violation of public policy to cancel malpractice policy in effort to affect conduct of insured in pending malpractice suit). The scant authority and commentary is collected in Johnathan M. Purver, Annot., *Liability Insurer's Unconditional Right to Cancel Policy as Affected by Considerations of Public Policy*, 40 A.L.R.3d 1439 (1971). Of course, efforts to analogize to the understandings in other kinds of insurance can cut both ways; in medical expense insurance, for example, there is no similar practice of treating cancellation as impermissible once medical expenses become inevitable.

335. *See, e.g.*, STATE OF NEW YORK INS. DEP'T, THE PUBLIC INTEREST NOW IN PROPERTY AND LIABILITY INSURANCE REGULATION 49 (1969) (elaborating reasons for traditional pattern of regulatory restrictions on cancellations but not nonrewals); Robert Works, *Whatever's FAIR—Adequacy, Equity, and the Underwriting Prerogative in Property Insurance Markets* , 56 NEB. L. REV. 445, 487–90 (1977) (same). For an indication of just how firmly entrenched the prerogative not to renew has been, see Martin J. McMahon, Annot., *Insured's Right of Action for Arbitrary Nonrenewal of Policy, Where Insurer Has Option Not to Renew,* 37 A.L.R.4th 862 (1985).

336. 875 P.2d 1354 (Colo. 1993) (citations omitted), *rev'g* Ballow v. PHICO Ins. Co., 841 P.2d 344 (Colo. Ct. App. 1992).

337. *Id.* at 1362.

> As a general principle, we agree than an insurer may choose to nonrenew an insured for any reason. However, an insurer is required to act in good faith when carrying out its decision not to renew either a single insured or entire blocks of business. In this setting, we believe that good faith should be measured according to the legal standard used in the first–party context: unreasonable conduct and either knowledge or reckless disregard of the unreasonableness of the conduct.[338]

As the court's elaborate recitation of the facts made clear, the insurer's bad faith in PHICO lay in assuaging insureds' fears about the classification risk problem that is intrinsic to claims–made formats, then leaving them in the lurch with accumulated practice histories and no access to tail or replacement nose coverage. The concurring opinion thought the majority opinion should have taken even greater pains to tie the renewal obligation of good faith to the peculiar lock–in worked by claims–made formats: "[Claims–made coverage] makes the policyholder a virtual economic captive of the insurer. The unique nature of claims–made insurance gives rise to heightened duties during renewal negotiations because claims–made insurance contemplates a continuing relationship between the parties."[339]

That, ultimately, is the question. Should we continue to assume that each liability insurance arrangement can be modeled as a discrete purchase of a risk transfer for a term, and thus continue to sweep claims–made formats within the general rule that treats the distinction between cancellation and

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338. *Id.* at 1363 (citations omitted).

> PHICO enticed the doctors to purchase claims–made coverage through promises of longevity and assurances that the terms and method of calculating the premium for a tail policy would be fixed. It then undermined these promises by unilaterally changing the terms of the tail policy to discourage renewal by the doctors, and without disclosing its plan to nonrenew them. Instead, PHICO continued to reassure doctors that it had no intention of leaving the state in the several months prior to its withdrawal from the Colorado market. Rather than dealing with the doctors in good faith once it decided not to renew them, PHICO concealed its intention and actively misled the doctors to their detriment.

Id.

339. *Id.* at 1372–73.

nonrenewal as inviolate?[340] Or should our appreciation of the fundamental transformation suggest a more complex and interdependent relationship?

CONCLUSION

Within the neo–classical habits of thought still dominant in insurance law, "the coverage is less, but so, therefore, is the cost" is a conversation–stopper, reassurance that—even with bounded rationality and mass marketed standard insurance policy forms—the disciplines of competitive insurance markets still provide the best answers to most questions concerning the quantity, quality, and price of insurance products. As redeployed in this essay, however, it is but the beginning of a further conversation, a reminder of the vulnerability to opportunism worked by the fundamental transformation, and thus an invitation to ask how—exactly, as applied in the individual case—the policy provision makes the coverage less.

The still–unfamiliar ways in which claims–made insurance policy formats allocate "forfeiture risk" and "classification risk" are a useful place to begin these discussions. Recognition that competitive markets at the inception of insurance relationships cannot guarantee freedom from opportunism ex post will do much to remedy the inadequate descriptions of claims–made formats that first prompted this extended meditation, and will help to identify the practices that should attract special attention, but it does not entail any particular institutional response. Deciding what combination of contract terms, market developments, and legislative and judicial initiatives can best cabin exercise of the discretion claims–made formats confer will require many more forays into the claims–made thicket.

Of course, the habit of asking how, exactly, a policy condition makes the coverage less should prove helpful well beyond the problems posed by multiple–event and late–operating triggers in liability policies. The difficulties with claims–made formats, though real and relatively intransigent, in time will wane. Increased understanding of the claims–made forfeiture risk and classification risk will yield more circumstances–discovered–and reported triggers, more long–term contracts, more mutualization, more careful compliance with conditions, and, where they do not, better bases for

340. *See, e.g.*, Gahres v. PHICO Ins. Co., 672 F. Supp. 249 (E.D. Va.1987); Travelers Ins. Co. v. Lesher, 231 Cal. Rptr. 791 (Cal. Ct. App. 1986)); Coira v. Florida Medical Ass'n, 429 So. 2d 23 (Fla. App. 1983); Egnatz v. Medical Protective Co., 581 N.E.2d 438 (Ind. App. 1991); Armstrong v. Safeco Ins. Co., 765 P.2d 276 (Wash. 1988).

assessing assertions that legislative or judicial amelioration is appropriate. But the broader issues will remain. A century ago proof–of–loss conditions in fire policies required a signature of the local magistrate, and lawyers and judges of the day wondered how to frame their resistance to the disproportionate forfeitures that would have resulted from blind enforcement of those conditions.[341] `Today we wonder how we should respond to a reporting condition in medical malpractice policies that purports to require the names and addresses of all potential witnesses, and whether the notice–prejudice rule should apply to other post–loss failure of conditions[342] and beyond liability insurance.[343] A century ago, insurance law was wrestling with what to do with good health clauses and affirmative warranties that purported to shift classification risk to insureds;[344] today we worry about late–operating liability and medical expense insurance triggers; tomorrow classification risk concerns will surface in other settings.

The methodological uncertainty that has prevented insurance law from adequately acknowledging the challenges of claims–made policy formats is the same methodological uncertainty that for most of the twentieth century has left insurance law unsure of where to find its conceptual bearings. "What do they know of the law of insurance, who only the law of contracts know?"[345] was a good question when Professor Woodruff first posed it, and it is a good question now, but both the question and the responsory judicial mantra reassuring that "a contract of insurance is no different from any other contract" fudge a fundamental question. Is the contract law that insurance law is—or is not—like the abstract conceptualism of classical contract, with its foundational belief in individualism and freedom of contract and its methodological preference for treating legal categories acontextually and language as objective? Or is it the contract law of standard forms and contracts of adhesion, where recognition of the lack of actual assent to many of the provisions found in standard forms can produce a judicial finger on the

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341. *See, e.g.,* German–American Ins. Co. v. Etherton, 41 N.W. 406 (Neb. 1889); Works, *supra* note 222, at 241–43.

342. *See, e.g.,* Anderson et al., *supra* note 232, at 842–45.

343. *See, e.g.,* Michael E. Brown, *Property and Prejudice: Must Insurers Show Prejudice When Denying Coverage Based on Conditions in the Property Policy?*, TIPS COMMITTEE NEWS, INSURANCE COVERAGE LITIGATION COMMITTEE, Summer, 1997, at 1.

344. *See generally* Vance, *supra* note 265.

345. EDWIN H. WOODRUFF, SELECTION OF CASES ON THE LAW OF INSURANCE 5 (2d ed. 1924).

interpretive scales or the substitution of gap–filling default rules said to vindicate the hypothetical "objective reasonable expectations" of insureds? Or is it the contract law of modern neo–institutional thought, with its attention both to bounded rationality and to the potential for opportunism and its concern to identify both private and public devices for policing against opportunism?

The answer matters, for recognizing the aridity of the acontextual, formalistic approaches still ascendant in much of insurance law is only the first challenge; the second, and more difficult, question for modern insurance law remains what part of the insurance context makes insurance different, and what reactions those differences should suggest. "Situation sense" works only if we are confident we know what it is about the situation that should interest us. Efforts to capture contextual concerns about insurance contracting in the "Doctrine of Reasonable Expectations" are radically incomplete because they focus on ex ante—formation—difficulties and ignore ex post—performance and enforcement—difficulties. Often the relevant contextual detail in insurance disputes is not that the insured did not understand what was in the policy, or lacked any practical alternative to what was in the policy, but that the policy creates occasions for opportunism which are being exploited in the particular case. Insurance law needs to acknowledge that not all questions can be answered by reference to the actual or assumed intent of the parties, and to recognize explicitly that for some cases an ex post perspective will be an appropriate complement to more familiar ways of looking at insurance questions. By raising "Excusing Nonoccurrence of a Condition to Avoid Disproportionate Forfeiture" to the same level of explicit principle as "Vindicating Objective Reasonable Expectations," we will come closer to having the tools we need to wrestle effectively with insurance law's enduring puzzles.

IMAGINING INSURANCE
RISK, THRIFT AND INDUSTRIAL LIFE INSURANCE IN BRITAIN

*Pat O'Malley**

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INTRODUCTION

Recent developments in French social theory suggest that rather than thinking of the nature of insurance as driven primarily by actuarial advances, by "what the market demands," or by the narrow interests of pressure groups, emphasis needs to be placed on the role of "insurantial imaginaries."[1] These are ways in which abstract techniques of insurance are given novel institutional forms by imaginatively linking them to practicable projects of government (incorporating but not restricted to government by the state).[2]

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1. *See, e.g.*, Daniel Defert, *Popular Life and Insurance Technology*, *in* THE FOUCAULT EFFECT: STUDIES IN GOVERNMENTALITY 211 (George Burchell et al. eds., 1991); Francois Ewald, *Insurance and Risks*, *in* THE FOUCAULT EFFECT: STUDIES IN GOVERNMENTALITY 197 (George Burchell et al. eds., 1991).

2. *See id.* at 198–9. Ewald developed the concept of "insurantial imaginary" and defined it thus: "the ways in which, in a given social context, profitable, useful and necessary uses can be found for the insurance technology." This takes its place in an analytic division of insurance into an abstract technology, an institution, and a form. The definitions of these are rather vague, but each is distanced from the simple idea of the straightforward application of certain natural principles. First, insurance technology, as a technology of risk is not a general kind of event "occurring in reality" but rather is "a specific mode of treatment of certain events capable of happening to a group of individuals...Nothing is risk in itself, there is no risk in reality. But on the other hand anything *can* be risk, it all depends on how one analyzes the danger, considers the event." *Id.* (emphasis added). Insurance is thus a particular form of rationality, part of a systematic way of *thinking* about the world. The elaboration of the abstract technology is seen to be the work of the actuary. The abstract technology is distanced from the specific institutions of insurance (for example marine insurance, life insurance, socialized unemployment insurance), by the fact that "[i]nsurance institutions are not *the* application of a technology of risk; they are always just *one* of its possible applications." The history of insurance is thus open and contingent for this reason. But in addition it is open because the particular application is formed on the basis of its own contingent history:

> Insurance technology and actuarial science did not fall from the mathematical skies to incarnate themselves in institutions. They were built up gradually out of multiple practices which they reflected and rationalized, practices of which they were more effects than causes, and it would be wrong to imagine that they have now assumed a definite shape. Existing in economic, moral and political conjunctures which continually alter, the practice of insurance is always reshaping its techniques.

Id. at 198.

Institutions, in turn, however, are the sites of insurance *forms*. These are the products of the "insurantial imaginary." They represent the "shape" insurance technology takes "in a given institution at a given moment," they are the specific ways in which the insurance institutions "utilize" the technique of risk. "So, one has an insurance technology which takes a certain form in certain institutions, thanks to the contribution of a certain imaginary." *Id.* at 198. (In

Such an approach does not deny the value of other ways of investigation, but focuses attention onto the intellectual and imaginative work carried out in rendering problems for government "thinkable and calculable" in new ways.[3] For example, one familiar way of understanding the emergence of an insurance category (such as "moral hazard") is in terms of the ways it reflects the interests of the powerful[4], or can be seen as "naturally" arising from the development of actuarial techniques or technologies.[5] However, the approach

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the present study, examples of the insurance form would include the particular modes of setting and collecting the premiums that gave shape to Industrial Life Insurance). The imaginary, of course, is not thought to operate without limits. As Ewald stresses, much depends on the context within which insurance is to work. But again, these contexts are fluid and variable, and are capable of being interpreted in different ways to provide opportunities as well as constraints.

Thus, the net effect of all of this is a very open and contingent way of approaching the question of the emergence and development of insurance that, nevertheless, does not dispense with the contribution of actuarial technique and its mathematical trajectories, nor ignores the constraints of economic conditions and considerations.

3. Peter Miller & Nikolas Rose, *Governing Economic Life*, 19 ECON. AND SOC'Y 1, 3 (1990).

4. *See* Carl J. Cuneo, *Comment: Restoring Class to State Unemployment Insurance*, 19 CAN. J. OF POL. SCI. 93 (1986).

5. *See* Leslie A. Pal, *Relative Autonomy Revisited: The Origins of Canadian Unemployment*, 19 CAN. J. OF POL. SCI. 71, 77-9 (1986); Jonathan Simon, *The Emergence of a Risk Society: Insurance, Law, and the State*, 95 SOCIALIST REV. 61 (1987); Jonathan Simon, *The Ideological Effects of Actuarial Practices*, 22 L. AND SOC'Y 772 (1988). One of the more influential of such accounts has focused on the emergence of "actuarialism" – the application of actuarial techniques to the government of social problems. In turn, this has been argued to underlie a broader move toward a "risk society," that is a society governed primarily in terms of risk management. A rapidly growing body of such socio–legal literature is focusing on the nature and development of insurance and other actuarial technologies of governance (*See, e.g.*, Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395 (1994); Tom Baker & Karen McElrath, *Whose Safety Net? Home Insurance and Inequality*, 21 L. & SOC. INQUIRY 229 (1996); Kevin Carriere & Richard Ericson, *Fragmentary Criminologies*, *in* THE FUTURES OF CRIMINOLOGY 89 (D. Nelken ed., 1994); Robert Castel, *From Dangerousness to Risk*, *in* THE FOUCAULT EFFECT: STUDIES IN GOVERNMENTALITY 281 (George Burchell et al. eds., 1991); Defert, *supra* note 1; Ewald, *supra* note 1; Malcolm Feeley & Jonathan Simon, *The New Penology. Notes on the Emerging Strategy of Corrections and its Implications*, 30 (4) CRIMINOLOGY 449 (1992); Malcolm Feeley & Jonathan Simon, *Actuarial Justice. The Emerging New Criminal Law*, *in* THE FUTURES OF CRIMINOLOGY 173 (1994); Pat O'Malley, *Legal Networks and Domestic Security*, 11 STUD. IN L. POL. & SOC'Y 171 (1991); Pat O'Malley, *Risk, Power, and Crime Prevention*, 21 (3) ECON. AND SOC'Y 252 (1992); Nancy Reichman, *Managing Crime Risks: Toward an Insurance–Based Model of Social Control*, 8 RES. IN L. & SOC. CONTROL 151 (1986); Deborah Stone, *The Rhetoric of Insurance Law: The Debate over AIDS Testing*, 15 L. & SOC. INQUIRY 385 (1990). In much of this work, technical characteristics of insurance and

adopted in this article asks different questions of its material, questions such as the following: What assumptions were made about human nature and action in the formulation of this insurance arrangement? What understandings about the nature of insurance were taken for granted or given shape by this development? How was the matter that was to be governed given its specific shape as a "problem"? How was it thought of as a problem governable through insurance techniques? What means were assembled together, out of those available, in order to translate the idealized model of government into practice? How, in short, did it come to be that such an insurance *invention* could be thought of as possible, necessary and practicable in a given setting?

Such questions tend to disrupt the "naturalness" of the development of insurance. Looking backward, it may seem that the rise of certain forms or elements of insurance was more or less inevitable, or had taken the only possible and effective route. But those who formulated insurance technologies had no such benefit of hindsight. True, the course they took was partly constrained—for inventions must be made using the intellectual and material resources at hand. But each development was to some degree a foray into the unknown and followed no prescribed course. The emergence of "insurable interest" in its present form, for example, was the product of considerable inventiveness required to steer insurance past the problems created by those who devised schemes for turning the institutions of life and marine insurance into forms of gambling, and who thereby exposed the industry both to moral opposition and moral hazard.[6] It is precisely for such reasons that terms such as "imagination" and "invention" are deployed in this account—in order to

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actuarial technique are held to explain the rise of risk management to the role of the key governmental technology over the past few decades. For example Jonathan Simon's path–breaking work suggested that insurance techniques have been developed into their key place because they are less socially visible in their role as governmental instruments. *See* Simon, *supra* note 5. Primarily this is held to follow from the fact that they appear statistical in their nature and form, and thus technical, rather than driven by political or moral values. Further, because they create risk categories shaped by actuarial rather than moral considerations, the categories used for targeting people for intervention are less likely to coincide with familiar ways of thinking about government, and so are less likely to be recognised. Furthermore, their lesser visibility is said to follow from the fact that actuarial techniques deal with statistical distributions rather than "aberrant" individuals, and tend not to isolate such individuals for attention (in contrast to social work, criminal justice or psychiatric techniques). Because of this lesser visibility, actuarial and insurance techniques will generate less resistance to rule than do approaches that attempt to change individuals. *See also* STANLEY COHEN, VISIONS OF SOCIAL CONTROL 139-60 (1985). They will thus appear more tolerant, and be less politically and economically costly to implement.

6. *See, e.g.*, ROBERT H. JERRY, UNDERSTANDING INSURANCE LAW 233-36 (2d ed. 1996).

stress the open and contingent development of that which may now be taken for granted.[7]

This paper will examine the history of British working class life insurance (and especially the form known as Industrial Life Assurance) through such a lens.[8] In this history, the category of "thrift" takes a central role. In the 19th century, thrift appears as a personal, risk–avoiding, moral attribute or habit, thought to be indispensable to insurance for working people. Life insurance techniques and politics at the time were never able to break free from its intellectual hold. But it was later imaginatively distinguished by welfare liberal planners into two forms—"compulsory" and "voluntary" thrift—a distinction that might very well have been meaningless

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7. There is a considerable literature exploring and developing this approach, that can only be alluded briefly to in an essay such as this. Such work has been influenced strongly by the thinking of Michel Foucault (*see particularly* Michel Foucault, *Governmentality*, *in* THE FOUCAULT EFFECT: STUDIES IN GOVERNMENTALITY 87 (Burchell et al. eds., 1991)) but has been advanced primarily in recent years by British and Australian scholars (*See, e.g.*, THE FOUCAULT EFFECT: STUDIES IN GOVERNMENTALITY (Graham Burchell et al. eds., 1991); GOVERNING AUSTRALIA (Mitchell Deane & Barry Hindess, 1998); FOUCAULT AND POLITICAL REASON (Andrew Barry et al. eds., 1996); MITCHELL DEAN, CRITICAL AND EFFECTIVE HISTORIES (1995); ALAN HUNT & GARY WICKHAM, FOUCAULT AND LAW (1995); Miller & Rose, *supra* note 3;. The journal *Economy and Society* has been a principal site for the development of this approach, which is frequently referred to as the "governmentality" literature. While "governmentality" refers to a particular technology of government that emerges in the eighteenth century, the term is more generally used to refer to the approach adopted in its study. The approach is characterised by two primary characteristics. The first is a stress on the dispersal of "government," that is, on the idea that government is not a preserve of "the state" but is carried out at all levels and sites in societies – including the self government of individuals. Thus it will be seen in this paper that the manner in which insurance agents govern the thrift of their policyholders is regarded as continuous with (and not necessarily subsumed by) attempts by the Executive to govern thrift more generally in the polity. The second is the deployment of an analytic stance that favors "how" questions over "why" questions. In other words it favours accounts in terms of how government of a certain kind becomes possible: in what manner it is thought up by planners, using what concepts; how it is intended to be translated into practice, using what combination of means? Only secondarily is it concerned with accounts that seek to *explain* government - in the sense of understanding the nature of government as the effect of certain other events. *See* Miller & Rose, *supra* note 3 (providing an extended discussion of this distinction) (*especially* p. 3-4). The work of Ewald, *supra* note 1, and Defert, *supra* note 1, on insurance, referred to above, falls squarely within this tradition.

8. The term "assurance" here is synonymous with "insurance." The former is strictly speaking the correct term in this history, as the term "industrial life assurance" is used by virtually all parties in Britain concerned with its operation and its critique. However, for ease of comprehension I will refer throughout to "industrial life insurance" - except of course in direct quotations using the original term. "Industrial Life Insurance" is the American name for the equivalent institution.

to 19th century liberals. Each of these constructs subsequently is used to rethink working class security and to invent specific forms of social ("compulsory") and individually based ("voluntary") life insurance. Later still, in the 1980s and 1990s, and paradoxically under the umbrella of restoring the Victorian virtues, thrift was turned on its head. People came to be imagined as too cautious and risk averse, rather than insufficiently so. In this process, working class insurance was reinvented as a fully commodified "investment product" with a strong speculative, *risk–taking*, element.

As this suggests, thrift, risk and insurance are governmental constructs whose natures and forms vary through time, but which exist in a triangular relationship—so that variations in each has had implications for how the others are imagined and practiced. These processes, in turn, it will be argued are strongly influenced by the prevailing political rationality, in such a manner that rethinking the meaning, nature and place of thrift and risk in terms of political rationalities has been central to the process of imagining insurance.[9] Broadly speaking, this history can be divided into three phases each characterized by the dominance of a different form of political rationality—classical liberalism, welfare liberalism and neo–liberalism.

I. CLASSICAL LIBERALISM: POLICING THRIFT

In Britain, insurance as a governing technology for instilling and institutionalizing thrift among the working classes emerged with the activities of the Friendly Societies. Despite some liberal suspicions of the Friendly Societies as a form of combination in restraint of market relations, successive administrations during the early part of the 19th century legislated to encourage the Societies' role in providing insurance for the working class. This was regarded not only as fostering "Habits of Industry and Frugality" but also as a means to reduce pressure of the Poor Law.[10] This state facilitation

9. Political rationalities are here thought of not as the relatively narrow band of policies promoted by a particular political party, but rather as the broad and fairly abstract formulae for thinking about government that often are accepted by most political parties at a given time. *See* Jacques Donzelot, *The Poverty of Political Culture*, 5 IDEOLOGY & CONSCIOUSNESS 71 (1979); Colin Gordon, *Government Rationality: Introduction*, *in* THE FOUCAULT EFFECT: STUDIES IN GOVERNMENTALITY 1 (George Burchell et al. eds., 1991). Typical examples are classical liberalism, neo–liberalism, Keynesianism and so on. Because of their abstraction, there is always a considerable volume of work to be done to negotiate to the level of specific political programs, leaving space for the political struggles that characterise state politics even in times when a political rationality is hegemonic.

10. For example, the Friendly Societies Act of 1819, 59 Geo.III, ch.128, and the Acts of 1793, 1829 and 1834, respectively, 33 Geo.III, ch. 54, 10 Geo.IV, ch. 56, and 5 Wm. IV, ch.

encouraged the Friendly Societies to replace traditional emphases on fraternalism and benevolence with actuarially based principles of fund management. The instability and high failure rates of funds managed on fraternal principles were matters of considerable government concern, for they failed to deliver a degree of security to members (and concomitant protection to the Poor Rates) commensurate with the workers' efforts at self–help.

Fraternal societies were characterized by "intentionally organizing themselves around notions of 'friendship, brotherly–love, charity'" in which "any self–understanding in terms of 'risk' or 'insurance' [was] largely absent."[11] It was clear at the time that the frequent failures of these funds followed from an inability of the fund managers to predict liabilities and to balance these against contributions and funds in hand. The reason for this lay in the benevolent principles of the early Societies, that implied payment of benefits to members according to their need rather than in proportion to their premiums or levels of risk.[12] As a precaution against such "failures," from

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40). The preamble of the Act of 1793 referred approvingly to the Societies' role in "diminishing the public burthens." *See also* SIR ARNOLD WILSON & HAROLD LEVY, INDUSTRIAL LIFE ASSURANCE: AN HISTORICAL AND CRITICAL STUDY 18 (1937). Here, Wilson and Levy refer to support from William Pitt in 1796, in which he argued that through "the operation of the Friendly Societies individuals would be rescued from becoming a burden upon the public and, if necessary, be enabled to subsist upon a fund which their own industry contributed to raise."

11. Nob Doran, *Risky Business: Codifying Embodied Experience in the Manchester Unity of Oddfellows*, 7 J. OF HIST. SOC. 131, 134 (1994).

12. SELECT COMMITTEE, REPORT OF THE SELECT COMMITTEE OF THE HOUSE OF COMMONS ON LAWS RESPECTING FRIENDLY SOCIETIES 12-13 (1825). *See also* Bentley Gilbert, *The Decay of Nineteenth Century Provident Institutions and the Coming of Old Age Pensions in Great Britain*, 17 (4) ECON. HIST. REV. (Series 2) 550 (1965). Gilbert notes one form taken by this problem:

> the nature of the societies, their emphasis on brotherhood, and their preoccupation with respectability and self–help, forbade them to cut adrift a brother so long as a penny of reserve was left to help him. Normally, there was no age limit to membership and older members could and did live on friendly society sick pay year after year. In doing so, they forced the society to provide for them what was in fact an old age pension, which the societies' reserves had never been calculated to carry.

Id. at 556.

It should be noted that terms such as "fraternal" usually need to be taken literally, at least in the sense that they refer to all–male organizations. There were few benevolent societies that allowed women as members, and the principal examples were those run by and for women –

1819 onward statutes required that the tables and rules of societies applying for registration be approved by "two persons known to be professional actuaries or persons skilled in calculations."[13] The uneven contest between the representatives of these competing principles – the workers on the one hand, and on the other the government and the actuaries, resulted in the displacement of a horizontal, fraternally based and essentially amateur organization by a hierarchical, actuarial and managerial form of insurance which distanced the rank and file members from the professionals who operated the funds. Thereby, control of the business of insurance was taken from the hands of policyholders.[14] The monthly society meeting in the local inn, which was simultaneously a convivial social gathering and a business committee, largely disappeared during the middle years of the nineteenth century.[15] In its place there emerged the domination of this field by large scale Fraternal Orders, operating out of centralized offices and holding annual meetings at which the membership was rarely able to wield effective power. More than that, actuarial methods that were set in place further eroded benevolent ideas and introduced a "disciplinary element into membership."[16] In particular, graduated contributions were imposed, and members became divided and ordered according to their levels of contribution and risk categorizations. The old solidarity that characterized the Fraternal Orders was thus fragmented and transformed. While the resulting insurance arrangements were still collective, this collectivity was increasingly abstract, fiscal and mediated by third parties.

Hand in hand with these shifts came new relationships that were involved in the collection of premiums. In the fraternally organized Friendly Societies, premiums had been paid either at the monthly meetings, or had been collected by members themselves in their spare time. The larger, actuarially based Societies (the Friendly Collecting, or more simply, the "Collecting Societies" or "Collecting Orders"), however, substituted a model based on the deployment of salaried or commission–funded collectors. By the 1870s, the

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usually in relation to providing for the post–birth "laying–in" month. *See* P. H. J. H. GOSDEN, SELF–HELP: VOLUNTARY ASSOCIATIONS IN THE 19TH CENTURY 26-27 (1973).

13. 59 Geo. III , ch. 128 §2 (Eng.).

14. *See, e.g.*, SELECT COMMITTEE, REPORT FROM THE SELECT COMMITTEE ON THE FRIENDLY SOCIETIES ACT 1875 vi-vii (1889).

15. GOSDEN, *supra* note 12, at 23.

16. Doran, *supra* note 11, at 145.

Royal Commission into Friendly and Benefit Building Societies reported that full–time paid collectors were the "pivot of the whole system."[17]

In this arrangement, the working class insured were increasingly ordered around a regime of contributions which was subject to the pressures of collecting agents working to a formally actuarial, hierarchic and bureaucratic routine. The relations of actuarially–driven discipline in the Friendly Societies were magnified in scale and intensity by the rise of industrial life assurance companies, which made a commercial principle out of the emergent form of insurance relation.[18] Life insurance for the working class had changed dramatically under the impact of actuarial techniques, but the emergence of these collectors was not simply an outgrowth of actuarial science or technology. Rather, it reflected a way of *doing business* in a particular social and class context. As the Fabian critics Wilson and Levy lamented, a "new class of intermediary strangers had come into existence, replacing the old bond of personal faith and friendship by commercial instincts scarcely hidden behind a veil of demonstrative humanity and friendliness." [19]

The pivotal place of these collectors stemmed from the changed entrepreneurial trajectory of industrial life assurance. Dominated throughout the next hundred years by firms such as *The Prudential*, it came to focus on the poorer sections of the working class—whereas the Friendly Societies had been the providers for the skilled aristocracy of labor:

> The grey, faceless, lower one–third of the British working population lay altogether outside their province. The dock worker, the railroad navvy, the carter, the hawker, the crossing sweeper, the casual city labourer of any sort, was shunned and distrusted. Friendly society membership was traditionally the badge of the artisan. It indicated that within his own social level he was clubbable. [20]

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17. ROYAL COMMISSION, ROYAL COMMISSION TO INQUIRE INTO FRIENDLY AND BENEFIT BUILDING SOCIETIES: FOURTH REPORT (THE NORTHCOTE REPORT) (HMSO Cmd 961, 1874).

18. It may be noted in passing that actuarial techniques and disciplinary practices are not – as is implied by some commentators - at odds with each other. *Cf.*, Simon, *supra* note 5. Clearly, when practiced as an actuarial technique, insurance is founded upon the disciplined collection of data concerning mortality and morbidity rates. In this sense it is almost impossible to think of actuarial techniques as displacing disciplinary techniques – for the growth of the former implies the growth of the latter.

19. WILSON & LEVY, *supra* note 10, at 25.

20. Gilbert, *supra* note 10, at 552.

The development of the "commercial industrial insurance" thus extended the reach of life insurance to the "the poor" as well as to the majority of the working classes. By the early part of this century, industrial life insurance had become the principal institution for the governance of working class thrift and few households were not enlisted in this regime of insurance.[21] The success of these companies, especially in the nineteenth and early twentieth centuries was partly due to the stress placed on burial insurance to which endowment policies linked, for burial insurance exploited the working class' fear and shame associated with the pauper's funeral.[22] However, of greater importance still, was the disciplinary nature of the collecting strategies of industrial life assurance that came to be regarded as crucial to its command of the field. Sale of policies and collection of premiums was characterized by the deployment of an army of collectors who took small weekly premiums, normally of only a few pence, at the policyholder's home. The detailed reviews of the collectors' techniques undertaken by a series of governmental inquiries and committees from the mid 19th to the mid 20th centuries, map out a strategy of infiltration into the fabric of working class domestic life, aimed at maximizing the sale of insurance.[23] The collector's regular call was timed to coincide with pay day, for it was recognized that the "thriftlessness"

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21. By 1911, Lloyd George estimated that there existed 42 million industrial life assurance policies, and that "(t)here is scarcely a household in this country where there is not a policy of insurance against death." 31 PARL. DEB., H.C. 1181 (1911).

22. *See* PAUL JOHNSON, SAVING AND SPENDING: THE WORKING CLASS ECONOMY IN BRITAIN 1870-1939 42-46 (1985) (for discussions of the place of the pauper's funeral in the life and consciousness of the poor); VIVIANA ZELIZER, PRICING THE PRICELESS CHILD: THE CHANGING VALUE OF CHILDREN 113-119 (1985) (discussing the parallel phenomenon in the United States). In Britain, burial insurance was combined with sickness insurance, but the advent of the larger insurance businesses during the 1860s and 1870s resulted in burial insurance becoming a distinct business. In their work on burial reform, Wilson and Levy argued that

> though a pauper funeral may be "decent," it is still felt to be a slur on the dead and their relatives...The feelings of shame aroused by the common grave are enhanced by the idea that such interment represents the loneliness of the corpse for whom nobody cares but the Poor Law Authorities who are simply fulfilling a statutory obligation...The poorer the individual, the lower in the social scale, the deeper his sense of guilt and shame if he cannot promise a decent burial for his relatives.

ARNOLD WILSON & H. J. LEVY, BURIAL REFORM 63-64 (1938).

23. *See, e.g.,* ROYAL COMMISSION, *supra* note 17, at cx-cxx; Lord Passfield, *Special Supplement on Industrial Insurance*, 13 NEW STATESMAN 1, 12 (1915).

of the poor and the unpredictable pressures on their vulnerable domestic economy meant that available cash may have been spent within twenty four hours. The collector was advised to be "a ladies' man," in the most respectable sense, for collections occurred during weekdays, when the male breadwinner was at work. As well, it was recognized that in most households the wife was delegated the role of domestic treasurer, and this was to be exploited. Tactics for the manipulation of individual family dynamics were disseminated among collectors through training manuals and articles in the insurance press.[24] Collectors were instructed to pay detailed attention to the state of the home and its contents. They were to look for additions to household furnishings which would indicate an ability to purchase increased insurance, and to watch for the disappearance of items of furniture—which would indicate their sale or pawn to tide the household over hard times. Collectors thereby developed a biographical knowledge of each family, its history, composition, resources, fears and ambitions. Each change in family fortunes or redistribution of membership (the arrival of babies, children leaving home, unemployment etc.) was to be known and linked with advice on the appropriate value of insurance taken out. Informal neighborhood networks were exploited in a process of utilizing status comparisons to sell insurance, for contributions to life insurance became a matter of pride and respectability among many families.[25]

From the industry's point of view, this form and level of disciplinary intervention was not exploitative. Rather, it represented both a necessary way of doing business and a disciplinary strategy for ensuring the thrift and prudence of the poor policyholders in their own interests. Without such interventions, it was argued, the poor would not take out life insurance or

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24. *See* WILSON & LEVY, *supra* note 10, at 136.

25. Here again, the status issues around burial were crucial. Many critics of Industrial Life Insurance, among them William Beveridge, argued years later that the insurance industry's focus on burial was counterproductive to nurturing thrift. It was argued that the poor arranged "extravagant" funerals based on the benefits received from their burial insurance policies. *See* WILLIAM BEVERIDGE, SOCIAL INSURANCE AND ALLIED SERVICES 270 (1942). Such money, it was argued, would be better spent elsewhere. These criticisms arose in part from the patronizing and censorious attitudes of the middle classes toward poor people's values and customs, and were by no means restricted to expenditure on funerals. They also arose from a belief that insurance companies encouraged such "excess" in order to increase income from premiums. Observations and claims about such alleged insurance premium collectors' practices are mapped out in detail in the reports of inquiries referred to throughout this paper. Further detail may be gleaned from the publications of the insurance industry such as the *Insurance Monitor* and from "collectors' manuals," and some insights into this are provided by Johnson and Wilson and Levy. *See* JOHNSON, *supra* note 22, at 33-46; WILSON & LEVY, *supra* note 10, at 165-75.

would grossly under–insure themselves. They did not have the social and moral resources to sustain, unassisted, the long–term commitment required to maintain insurance policies. The industry represented its activity in terms of providing a necessary *discipline of thrift*. It envisaged its role as one that included "educating" people about the need to insure for the future, "ensuring payments," generating "security" for the family, and providing "moral" support when other temptations were more alluring, or competing necessities more demanding. Even some critical historians still share this view:

> The importance of the agent was in putting external pressure on the housewife in those weeks of hardship to induce her to save even when there was scarcely enough money to feed the family. It was his role to remind the policyholder of long–run goals when immediate financial pressures seemed overwhelming—he imposed the sort of discipline for saving that many people could not exercise on their own, and without this discipline lapsing rates would certainly have been higher.[26]

While there can be little doubt that the practices were disciplinary, and often bordered on compulsion, from an early date the question of the collectors' contribution to the task of inculcating thrift among the poor became the center of political contest between the industry and the government. This debate served only to cement the assumption by all parties, that insurance and thrift were necessary adjuncts of one another. However, it should be recognized, of course, that there was nothing necessary about this way of thinking about insurance. In the previous century, major forms of insurance had involved wagers on the lives of others, until proscribed by the Life Insurance Act of 1774 (known more widely as the "Gambling Act").[27] The principal commentators of the day regarded gambling as "an offence of the most alarming nature; tending by necessary consequence to promote public idleness, theft and debauchery among those of the lower class,"[28] a view retained through and into the present century.[29] Distinguishing

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26. JOHNSON, *supra* note 22, at 38-39.

27. 14 Geo. III, ch. 48 (1774).

28. Blackstone, in 3 SIR WILLIAM HOLDSWORTH, A HISTORY OF ENGLISH LAW 539 (1969).

29. DAVID DIXON, FROM PROHIBITION TO REGULATION 330 (1991). Dixon provides an excellent discussion of the history of gambling and governmental attitudes toward it. The view that gambling is the antithesis of thrift, reason and character is well illustrated by the remarks of John Hobson, who in 1905 wrote that

insurance from gambling and rendering it an instrument of thrift was no mean feat and the place of *risk–taking* in the genealogy of insurance should not be forgotten. While the story of this process cannot be provided here, it is also important to note that this remained a constant concern of legislators and of the judiciary until well into the twentieth century.[30]

> Gambling involves the denial of all systems in the apportionment of property; it plunges the mind in a world of anarchy, when things come upon one and pass from one miraculously. It does not so manifestly sin against the canons of justice as do other bad modes of transfer – theft, fraud, sweating – for everything is said to have an equal chance; but it inflicts a grave damage to the intellect. Based as it is upon an organised rejection of all reason as a factor, it removes its devotees into a positive atmosphere of miracle, and generates an emotional excitement that inhibits those checks which reason more or less contrives to place on emotional extravagancies...The essence of gambling consists in an abandonment of reason, and inhibition of the factors of human control... A practice so corrupting to the intelligence not only of the habitue, but even of the casual spectator, stands condemned as a formidable enemy of education and intellectual order.

JOHN HOBSON, THE ETHICS OF GAMBLING 12 (1905). *See also* D. Knights & T. Vurdubakis, *Calculation of Risk: Toward an Understanding of Insurance as a Moral and Political Technology*, 18 ACCT. ORG. & SOC'Y 729, 738-40 (1993) (for a more detailed discussion of the separation of gambling and insurance).

30. Robert Merkin, *Gambling by Insurance: A Study of the Life Assurance Act 1774*, 9 ANGLO–AMERICAN L. REV. 331, 340-60 (1980). There have been many attempts to make the distinction between gambling, insurance and speculation. *See* REUVEN BRENNER & GABRIELLE BRENNER, GAMBLING AND SPECULATION: A THEORY, A HISTORY AND A FUTURE OF SOME HUMAN DECISIONS 90-112 (1990) (supplying a review of some of these attempts). The central legal innovation developed in order to distinguish wagering and gaming from insurance contracts, was that of the "insurable interest." With respect to life insurance, in Britain at least, this was based either on a relationship of natural affection between spouses, or on ties of dependence. *See* MALCOLM CLARKE, BRITISH INSURANCE 23-4 (1997). In the latter case, this effectively required the rule that applies to indemnity insurance (i.e. that the beneficiary must be able to establish financial loss on the death of the person on whose life the policy is taken out (the benefit being limited to the extent of said loss)). Yet, the deployment of "insurable interest" in this fashion was never without difficulties, and continued to be so during this period as indicated by the number of key cases dealing with the matter in English common law around this time. *See* Halford v. Kymer, 10 B&C 724 (1830); 4 Barber v. Morris, 1 M & Rob 62 (1831); Henson v Blackwell, Hare 434 (1845); Shilling v. Accidental Death, H&N42 (1857); Hebden v. West, 3 B&S 579 (1863). However, an important issue to note is that Industrial Life Assurance was allowed exceptions to some of the restrictions that applied to other life insurance forms arising from the insurable interest requirement. In particular, the proscription against parents insuring the lives of their children was not applied to this form of insurance, despite repeated qualms about the risks this presented to small children, on whose lives several

A. The State Versus Business: The Critique of "Useless Thrift"

While the moral role of insurance in promoting thrift and reducing reliance on the Poor Law had dominated early British debates on life insurance, by the 1860s new issues were arising, concerned with the efficiency and justice of governing thrift through industrial life insurance. It was argued, most notably by government commissions and parliamentary leaders, that two major *systematic* problems involved in this model of insurance undermined its privileged status as a moral technology.

First, and most significant was the problem of the *expense ratio*. For the middle classes, life insurance premiums were paid once or twice yearly at the office of the company. Making large individual outlays of this sort was beyond most working people—who relied instead on frequent "penny payments." Such collection procedures were labor intensive and costly. The payment of commissions to the "army of collectors" generated a drain of between 25 per cent and 50 per cent of the value of premiums collected. Accordingly, the rate of return for poor people's thrift was recognized by all to be much lower than for the middle classes, and effectively involved "useless thrift" on the part of the poor.[31]

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policies might be taken out. *See* SELECT COMMITTEE, *supra* note 14, at 17. Despite their Fabian sympathy for "the poor," Wilson and Levy nevertheless argued that this constituted a form of speculation, based on the high mortality rate among working class young children at that time. In such cases, they felt, "the object of insurance is falsified; insurance becomes a gamble or speculation instead of a means of alleviating the losses and premature calamities incurred by a few, by the 'cooperative' effort of as many persons as possible." *See* WILSON & LEVY, *supra* note 10, at 148-9. *See* Viviana Zelizer, *The Price and Value of Children: The Case of Young Childrens' Insurance*, 86 AM. J. OF SOC., at 113-137 (for a discussion of the parallel struggles over child insurance in the United States); *see generally supra* note 22.

31. The term "useless thrift" was coined at the end of the nineteenth century by the anonymous author of *Useless Thrift or How People are Robbed. See* JOHNSON, *supra* note 22, at 32 (discussing the text and its importance). It is worth noting that some contemporary critics regarded both the cost of collection and the mode of collection as working *against* the inculcation of thrift, rather than producing useless or even useful thrift – for thrift had to be undertaken as a result of the will rather than of the routine compulsion of collectors:

> Some men argue that the fact of such large sums of money being collected from the working classes, for the purposes of providing assistance in the hour of need, goes far to prove what a hold provident habits has (sic) taken upon them. This is an error. There is nothing that shows so much indifference, inconsideration, utter want of thought, reckless mode of wasting means, as the mode in which these contributions are generally paid.

Second were the twinned problems of *lapses* and *overselling*. As the collectors benefited directly from the value of premiums collected, there were systematic pressures to increase sales. This "overselling" led to a high rate of lapsed policies among the poor. As early as the 1860s, the rate of lapses was seen by government officials as a deterrent to thrift among the poor, for holders of lapsing industrial insurance policies received nothing by way of return from their savings.[32] Ten years later Northcote's Royal Commission made the claim that it was in the agents' and companies' interests to sell policies to people whom they knew were unlikely to be able to sustain them because the lapsing of policies amounted to windfall profits through "confiscation of the premiums of its members."[33] Thus, while the importance of thrift as a means for governing the poor was never brought into question, and indeed was the driving concern of parliamentary critics, a contest emerged that focused on whether the lack of adequate provision for security was the result of the absence of thrift among the poor, or the unsatisfactory institutional means for converting their thrift into security.

The government's concern over the need to encourage habits of self reliance, and the even more pressing, the need to make the poor less reliant on poor relief, brought it to challenge the "inefficiency" of industrial insurance. In 1865, Prime Minister Gladstone set up a state–run fully contributory life insurance system in order to drive the industrial insurance companies from the market. In the Government Annuities Act of that year, a scheme was introduced which retained the practice of small premiums paid weekly, but dispensed with collectors. Instead, it required contributions to be

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Paul Johnson, *Credit and Thrift and the British Working Class 1870-1939*, *in* THE WORKING CLASS IN MODERN BRITISH HISTORY 140, 162 (J. Winter ed., 1983). One implication that not leaving prudence to the operation of the will destroys thrift, which must be achieved by the exercise of the will. As will be seen, William Beveridge's rethinking of thrift turned such ideas upon their head.

32. *See generally* 173 PARL. DEB. H.C. 1575 (1864). Gladstone pointed out the specific injustice to the poor in this respect:

> among the higher classes the holder of a policy who is unable to continue his payments has a certain proportion, generally about one third of his premiums, repaid to him, but no such right is conceded in the case of the industrial classes... If the poor man fails...to pay one premium, the policy drops and he loses everything.

Id. at 1575.

33. ROYAL COMMISSION, *supra* note 17, at cx-cxxxiii. Note that almost identical arguments were presented forty years later by Sydney Webb. *See* Passfield, *supra* note 23, at 15.

made at the local Post Office. The expectation was that the thrifty poor would be attracted away from the industrial insurance companies because the Post Office's reduced collecting costs and would result in a much higher rate of return to the policyholder. Moreover, because the officials of the Post Office would have no financial interest in overselling policies, the plan would eliminate another of the evils afflicting insurance.

Within a decade, however, Post Office insurance appeared to have failed, with few people entering the scheme or sustaining payment of their premiums. The Northcote Royal Commission concluded from such evidence that the insurance industry was correct in its views. The Poor would not practice thrift unless "specially invited and urged to do so by personal application from the collectors; nor will they keep up their payments unless the collector calls for them."[34] Accordingly, the inquiry recommended that for any scheme of life insurance directed at the poor, "house to house collection will be required."[35] Otherwise, it supported the continued operation of the Post Office scheme. Because this model worked through the fair "competition of the government," it was felt by the Commission that insurance companies could not claim state interference in the market. Moreover, as the Post Office scheme was fully contributory, it "did not carry with it something of the appearance of a relief system."[36] The unanimous recommendation of the Commissioners, therefore, was that the system of Government Insurance, newly armed with insurance collectors, should be extended to more effectively compete in the field of industrial insurance.

By implication, government collectors would now enter the field in direct competition with those of the companies and societies. However, this proposal was never enacted, not because of liberal fears about the state entering the market, but because it created the image of government postal agents—or "special postmen" —acting inappropriately. In particular it was felt unacceptable that officers of the state would be constrained to act like common commercial salesmen. As Brabrook, the Chief Registrar of Friendly Societies noted, if the private insurance collector supports himself

> by the arts of persuasion which he uses upon poor mothers to induce them to effect insurances; ...(then) the special

34. ROYAL COMMISSION, *supra* note 17, at cxxi-cxxx. See also the comments of the critics of the Post Office scheme who testified before the Parmoor Committee in 1920 (Departmental Inquiry 1920. Q.7098).

35. *Id.* at paragraph 850

36. ROYAL COMMISSION, *supra* note 17, at paragraph 848.

> postman, if he is to be a success, would have to learn to use the same arts of persuasion, and would thus become as unlike the ordinary Government Officer as could be.[37]

There was also concern that the commercial nature of such "special postmen" would blur the distinction of the private and the public, taking the government into private homes in a way that was still a concern to classical liberalism. Indeed, Gladstone had adverted to this very danger when setting up the Post Office scheme in 1864, stressing that "the House of Commons is not going to vote money to enable us to go into every cottage in the country."[38] Finally, as Brabrook pressed, if an army of state collectors entered the field, then this would eliminate one of the main justifications for state involvement—the lowering of expense ratios.[39]

Available technologies of insurance for the poor thus appeared to be intrinsically compromised. First, the volitional basis of moral virtues such as thrift (which ultimately had to be exercised freely and habitually), was compromised by the necessity for some form compulsion. Second, the apparent impossibility of avoiding high collection costs meant that the institution of industrial life insurance generated wasted thrift. Thrift, as a moral virtue, thus was *problematically* embodied in specific institutional forms of insurance. The tensions now set up, in turn, were to transform thrift itself as a way of thinking about, and thus governing, working class security.

II. WELFARE LIBERALISM: SOCIAL INSURANCE AND "THE CONSUMER"

Into the twentieth century, continuing critiques of industrial life insurance condemned its inefficiencies and injustices.[40] Despite this, Prime Minister

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37. SIR EDWARD BRABROOK, PROVIDENT SOCIETIES AND INDUSTRIAL WELFARE 78-9 (1898).

38. 173 PARL. DEB., H.C. (3rd Ses.) 1566 (1864).

39. *See* Brabrook, *supra* note 36, at 78. Without collectors, the Post Office scheme continued to function in a marginal fashion. Ironically, Sydney Webb – one of the most trenchant critics of industrial life insurance – was one of those who foresaw that its end would be due to the failure to employ collectors. *See* Passfield, *supra* note 23, at 20. The scheme eventually folded in 1928.

40. This critique was unabated despite the fact that after the turn of the century there was, as Johnson notes, a marked change away from burial insurance (in the form of assurance maturing on the death of the nominated person). *See* JOHNSON, *supra* note 22, at 41. Beginning in the 1880s, industrial assurance offices began to offer endowment policies (i.e., maturing after a set number of years rather than only on the death of the assured), and by the time of the Cohen Report of 1930, the latter represented over a quarter of industrial life insurance business.

Lloyd George decided against incorporating industrial life insurance into his nationalized insurance scheme in 1911. Ostensibly this was because "there is hardly a household in this country where there is not a policy of insurance against death... (and) the ground has been very thoroughly covered."[41] Almost certainly, this decision was made to minimize industry resistance to other developments (notably social health insurance), and out of a pragmatic desire to deploy the insurance companies and their collectors as convenient agents for state insurance schemes. But the upshot nevertheless was that industrial insurance survived—albeit to remain the target of repeated and severe criticisms, first by Sydney Webb[42] and later by further government reviews—the Parmoor inquiry[43] and the Cohen committee.[44] None of these reports did very much more than reiterate at length and painstakingly document the problems already identified in the nineteenth century. However, developments during World War II that foreshadowed the formation of the postwar welfare state not only brought to bear new pressures on industrial life insurance, but re–conceptualized the whole framework of governing security through thrift, discipline and insurance on which it was founded.

A. The Invention of "Socially Desirable Thrift"

The proposals of successive inquiries, between 1879 and 1930, had more or less taken for granted the market–based delivery of life insurance.

By the time of the Beveridge report, endowment policies represented three quarters of such business.

41. 31 PARL. DEB., H.C. (5th Ses.) 1181 (1911).

42. Passfield castigated alleged overselling (and consequent lapses) in the strongest terms:

> We do not see how it is possible for an all–pervading army of professional canvassers, paid to enrol the largest number of recruits, on a method of remuneration that makes loss of livelihood the penalty for every failure of persuasiveness, invariably to abstain from a magnification of the advantages and of slurring over of the shortcomings and of the cost of a policy which the public absolutely refuse to read, and which is couched in language not as clear as it might be, and certainly incomprehensible by the vast majority of those concerned. The system amounts, to say the least, to a standing temptation to deceit.

Passfield, *supra* note 23, at 29.

43. DEPARTMENTAL COMMITTEE, REPORT OF THE DEPARTMENTAL COMMITTEE ON THE BUSINESS OF INDUSTRIAL ASSURANCE COMPANIES (1920) (The "Parmoor Report").

44. SELECT COMMITTEE, COMMITTEE ON INDUSTRIAL ASSURANCE AND ASSURANCE ON THE LIVES OF CHILDREN UNDER TEN YEARS OF AGE: REPORT, 1933, Cmd. 4376 (The "Cohen Report")

Northcote had recommended that the state enter as a competing supplier, Cohen urged that it expand its role as a competitor, and Parmoor had advised increasing regulation of the industry. However, in his report on *Social Insurance and Allied Services*—in many ways the blueprint for postwar British welfare institutions—Beveridge shifted the debate into the realm of welfare liberalism. He argued, in short, that "(t)he criticisms made upon life assurance in the past have not been met, and cannot be met while the system remains, as at present, a competitive business."[45] The problems with industrial insurance noted by Beveridge in his report were virtually identical to those located by each of the previous inquiries. However, he cut through their inability to resolve the problems of industrial insurance by arguing that

> The proposal that life assurance among persons of limited means should be a public service rather than a competitive private business is based upon the special character of industrial assurance, as a business in which competition leads to overselling and as a business in which the seller's interest presents special danger to the consumer. Life assurance is not like other commodities because those who insure make their choice once and for all when they take out a policy. They cannot buy less insurance or another form of insurance next day or change their assurance company without loss, as next day they can substitute bacon for beef or change their grocer without loss. Industrial assurance, that is to say *life assurance among people of limited means, is so different from most other commodities that it cannot be safely treated as an article of commerce.*[46]

Note that Beveridge achieved this position, initially at least, not by focusing on the moral problematic of thrift. Rather he moved directly to imagining insurance in terms of the nature and behavior not of people but of commodities. He then moves on to distinguish two kinds of insurance commodity, those that behave like normal commodities (i.e., luxuries) and those that behave like exceptional commodities (i.e., necessities). In the case of the latter, market distribution presents "special dangers to the consumer." For the moment, analysis must pass by the highly significant re–imagining of people as "consumers," for at this point, Beveridge reintroduces the idea of

45. BEVERIDGE, *supra* note 25, at 274.

46. *Id.* at 275 (emphasis added).

thrift. But it is a thrift transformed, for he argues that in the light of this analysis, that it is necessary for the state to create new, *"socially desirable forms of insurance and thrift."*[47]

This distinction between "normal" commodities and those of "special character" allowed Beveridge to defend the importance of private competition against total nationalization, for "there is a place for each of these models in its appropriate sphere according to the character of the work to be done."[48] The market was the site for the production and distribution of normal commodities. The state was to be the site for dealing with exceptional commodities, for which market distribution presented "special dangers to the consumer." This general argument was then applied to the two areas of "burial insurance" (i.e., whole–life policies, the traditional mainstay of industrial life assurance), and endowment or investment policies (which was the majority of business by the 1940s), in slightly different ways.

Burial insurance was deemed to warrant incorporation in the system of compulsory social insurance schemes, *in part,* because in market terms "burial insurance behaves like a necessity—bread or rent—not a luxury" (i.e., people with less than the means of subsistence continued to purchase the commodity). Overselling produced a characteristic problem, namely that more of the income of the poor was allocated to this purpose than was required and this excess interfered with the purchase of other essentials:

> on the occurrence of a death, money may be paid and undoubtedly is in a large number of cases paid, for which there is no obvious need either in meeting direct funeral expenses...or in meeting personal expenditure of relatives... Insurance money for funeral expenses may fall due at a death in such amounts that there is no choice between extravagant spending and making a profit out of assurance on life–of–another. [49]

In addition, insurance money "may be spent in other ways leaving the funeral unpaid for," leaving the state still to cover the essential expenses. The elimination of both these problems could be achieved by distinguishing between those aspects of the burial that could be seen as necessities, and those which were optional extras. Beveridge proposed the introduction of

47. *Id.*
48. *Id.* at 274-5.
49. *Id.* at 270.

compulsory burial insurance for "the essential universal need for direct funeral expenses." Expenses over and above the provision of what he referred to as "a decent burial," being "less uniform and less universal" were to be subjects for "voluntary action rather than compulsion."[50]

The problem of workers' "excessive" expenditure on funerals had exercised Beveridge's nineteenth century forebears, who interpreted it as sign that the poor were extravagant and had no proper conception of thrift.[51] Beveridge however translated the issue out of the domain of individual morality into the realm of social policy, by locating a level of *"universal need"* in relation to burial costs, and defining the market as an inescapably flawed apparatus for dealing with it. The market's role lay in the field of individual choice and discretion beyond this level of "needs." The role of the state was thus to intervene in the market, and generate its own "socially desirable forms of insurance and thrift." [52]

B. Commodifying Insurance Under Welfare Liberalism

In analyses of insurance under welfare liberalism, the compulsory and state–based nature of social insurance schemes has normally monopolized the attention of theorists of insurance.[53] However, with respect to life insurance in this period Beveridge's focus on voluntarism and choice, and his analytical starting point of commodities and consumption, are equally fundamental issues. In subjecting thrift to a regime of social liberalism, Beveridge was by no means absolving individuals from the responsibility for self–help, even with respect to social insurance schemes.[54] Nevertheless, by creating a domain of compulsory insurance, he simultaneously created the possibility of a new conception of thrift. Voluntary thrift was dislocated from necessity, and thus disarticulated from the provision of security which could reasonably become a charge on the public purse. Forms of thrift among the poor could now be assigned to the sphere of personal discretion.[55] Once it

50. *Id.* at 271-5.

51. *See, e.g,* Knights and Vurdubakis, *supra* note 29, at 758 (referring to Samuel Smiles' views about this "ruinous and altogether unjustifiable" habit).

52. BEVERIDGE, *supra* note 25, at 275.

53. *See, e.g.*, Defert, *supra* note 1; Ewald, *supra* note 1.

54. Thus he was clear that "citizens as insured persons should realize that they cannot get more than certain benefits for certain contributions" and "should not be taught to regard the state as the dispenser of gifts for which no one needs to pay." BEVERIDGE, *supra* note 25, at 108. Moreover, he stressed that for the state "to give by compulsory insurance more than is needed in subsistence is an unnecessary interference with individual responsibilities." *Id.* at 118.

55. *See* BEVERIDGE, *supra* note 25, at 275.

became possible to think of the thrift of the poor in this way, then the moral governance of "voluntary thrift," at least, was attenuated. Certainly it could be removed from that domain of moral compulsion sustained by institutional reinforcement.[56] The question remaining was how, practicably, to achieve this. As long as the industrial assurance companies remained, then—as generations of inquiries had shown—collection and its attendant evils were impossible to eradicate. The solution was to nationalize the industry under an Industrial Insurance Board, which "would work steadily to substitute direct payment of premiums for collection."[57] But why should this work when its precursor under Gladstone had failed?

Beveridge proposed to remove the grounds justifying the market forms of disciplinary compulsion by creating both a field of "universal needs" in which state compulsion created security, and a field of "personal needs" in which the moral grounds for compulsion were exhausted. If "voluntary thrift" would have been a meaningless redundancy to Victorian moralists—for how could a moral virtue be other than voluntary—the term represented a precise and socially generated field for the programmers of the new insurance form.[58] For the latter, *voluntary* no longer meant "disciplined," and

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56. The term "voluntary thrift" was given formal political status in the Labour Party's postwar policy documents. LABOUR PARTY, LABOUR BELIEVES IN BRITAIN (1949) & LABOUR PARTY, THE FUTURE OF INDUSTRIAL INSURANCE (1950).

57. BEVERIDGE, *supra* note 25, at 275.

58. Thus, it is worth remarking that a common 19th and early 20th century criticism of Industrial Life Insurance was that its mode of collection and organization were such that *true* thrift could never develop – because the impetus to save came from "above" rather than from within. The contrast, of course, was always the self help model of the fraternal societies. Thus in 1875, Sir Stafford Northcote is reported as stating that his Royal Commission had taken

> a deliberate view that the only and true way of bringing about a development of a virtue of providence amongst the people was to make them work it out for themselves, and that our great desire ought to be to give fair play, and full play, to those institutions that have sprung from the people themselves.

WILSON & LEVY, *supra* note 10, at 57.

Nearly forty years later, Passfield was concerned that

> The power, even in those Societies where the delegate system has been adopted, is practically in the hands of the management, subject to the remarkable influence which the collectors are able to bring to bear on the members. The members never have any real control over the business...The Committee are (*sic*) compelled to look upon the methods of Collecting Societies as of no value toward education of thrift.

thus morally compelled. Instead it took on connotations of choice. Indeed, and more precisely, the shift in Beveridge's language, toward that of commodities and consumption informs the distinction between compulsion and volition. For Beveridge, the latter begins to imply a rather distinct model of the subject of liberal rule: the citizen as consumer, for whom technologies of negative discipline would no longer be necessary or fitting.

Beveridge's focus on consumption and commodities should not be seen as either totally contingent, or simply as an effect of the influence of economics "in general." The economic discourse that shaped and provided the foundation for his thinking was that of John Maynard Keynes, which, in turn, may be distinguished from the classical economics of the previous century, *inter alia,* by its prioritizing of consumption.[59] Beveridge also was quite clear that the reforms he proposed were to be understood in this framework, as being an expression of this shift in focus away from a framework of production:

> [c]orrect distribution does not mean what it has often been taken to mean in the past–distribution between the different agents of production, between land, capital, management and labour. Better distribution of *purchasing power* is required among wage earners themselves, as between times of earning and not earning and between times of heavy family responsibilities and times of light or no family responsibilities.[60]

The further consideration underlying Beveridge's thinking was the view that the distribution of poverty had changed radically. Beveridge observed that in contrast to the situation prevailing at the turn of the century the surplus income of those workers above the poverty line was eight times as great of the deficiency of those below it. Real living standards had increased by 30%, and, viewing predictions of post war growth, he was confident that this trend would continue for the foreseeable future.[61] In other words, the problem Beveridge identified as confronting government through insurance was no longer in the existence of a mass of low paid workers. It was this that made

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Passfield, *supra* note 23, at 7,

59. *See* TONY CUTLER ET AL., KEYNES, BEVERIDGE AND BEYOND 6-13 (1986).

60. BEVERIDGE, *supra* note 25, at 167 (emphasis added)

61. *See* JOSE HARRIS, WILLIAM BEVERIDGE: A BIOGRAPHY 393 (1977).

possible his observation that poverty could be eliminated by redistributing incomes within the working class.[62] This was to be the role of compulsory insurance. But even more important for our concerns, is that this reading of the relieving of economic pressure on domestic economies, coupled with compulsory insurance to cover necessities, made it possible to propose that door to door collection of "voluntary" insurance premiums could now be dispensed with. Thrift, in the sense of self denial to cover against future want, and thus a virtue or habit in need of constant policing, was on the verge of being doubly dissolved: on the one hand by the reconceptualizing of saving and insurance as the consumption of commodities, on the other, by the *rethinking* of working class incomes as providing a real *surplus* for discretionary spending.

This is not intended to imply that Beveridge had simply imagined the improvement in living standards. Rather, the point is that to see this change in terms of providing something thinkable as a "surplus" is a very specific way of thinking about money.[63] It is a way that carries connotations that this money is liberated for free expenditure. Nothing necessary has to be gone without, and thus expenditure is less subject to moral constraint. It is rendered, as Beveridge termed it, "voluntary" in a sense that could not readily have been applied fifty years before.[64]

More generally, the rethinking of insurance, thrift and surplus in this period took its place in what May and Cooper regard as part of a broader reconstitution of citizenship in which individuals and groups are increasingly seen not as *citizens* but as *consumers*.[65] As seen above, this rethinking of the subjects of insurance as "consumers" was quite explicit in Beveridge's work. While this partly is explained by his focus on Keynesian economics, it is also linked to new ways of thinking about liberalism that Beveridge saw emerging. As Judith Brett has noted, in the liberal political discourses of the 1940s, the categories of "choice," "freedom" and "liberty" scarcely appeared, whereas

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62. Beveridge notes that "want could have been abolished before the present war by a redistribution *within* the wage earning classes." BEVERIDGE, *supra* note 25, at 165.

63. *See* VIVIANA ZELIZER, THE SOCIAL MEANING OF MONEY 157-62 (1994).

64. *See* WILLIAM BEVERIDGE, VOLUNTARY ACTION (1948) (for the author's complex position of the nature of the "voluntary sector"). This work clearly linked Beveridge to certain key political traditions of liberalism, despite his emphasis on social mechanisms. Compulsory insurance was not to take over all insurance precisely because he felt there should be "room and encouragement for voluntary action by each individual to provide more...for himself and his family." BEVERIDGE, *supra* note 25, at 7.

65. *See* Colin May & Anthony Cooper, *Personal Identity and Social Change*, in 38 (1) ACTA SOCIOLOGICA 75 (1995)

concepts such as "frugality," "thrift" and "savings" still held center stage.[66] Individualism "took its primary meaning from Protestantism and its ethic of hard work, personal responsibility, thrift and community service."[67] By contrast, whereas the key characteristic of the individual was thus *independence,* "[t]oday it is *freedom,* most generally understood as freedom of choice in everything ranging from the colour of a new stove to sexuality."[68]

III. NEO–LIBERALISM: PUTTING THE RISK BACK INTO INSURANCE

Beveridge proposed that the only way to rid the life insurance industry of its coercive and expensive collectors was to nationalize industrial life insurance, and displace it with a state Industrial Insurance Board that "would work steadily to substitute direct payment of premiums for collection."[69] However, while social insurance on this model subsequently absorbed such areas as burial insurance soon after the war (in 1948), the political muscle of the industry, and failures of political will by the British Labour Party, allowed the industry to survive. The field allocated to voluntary thrift remained in the hands of industrial life insurance and its collectors. Nevertheless, writing in 1955, still in the shadow of Beveridge and under some threat of nationalization of the insurance industry by Labour, one of the last apologists of industrial life insurance foresaw the conditions of its demise. It was possible, but unlikely, Morrah argued, that industrial life insurance could be ousted by the victory of a more determined socialist regime. In practice, however,

> [a] slighter revolution than that would suffice to make it superfluous. If the great mass of the people possessed bank accounts, and could habitually maintain credit balances substantially exceeding the annual amount they thought reasonable to set aside for future needs, then they could provide against emergency by the methods of ordinary life assurance with its premiums paid at long intervals, and industrial assurance (paid) by weekly or monthly

66. Judith Brett, *The Party on the Road to Nowhere,* THE AGE (MELBOURNE), 17 July 1993, at C1.

67. *Id.*

68. *Id.*; *see also* NIKOLAS ROSE, GOVERNING THE SOUL 213-28 (1989).

69. BEVERIDGE, *supra* note 25, at 275.

> contributions, which is necessarily less economical, could not compete.[70]

In Morrah's view, the survival of industrial life insurance was assured because it was still the case that the mass of the populace "have neither bank accounts nor substantial capital resources," and that "weekly wages. . .so little exceed the necessary domestic outgoings of the week that thrift is always an effort." In such a setting, echoing his Victorian predecessors, Morrah saw that "pressure and even strong pressure is therefore essential" to effect adequate insurance against emergencies.[71] Yet within a decade, industrial life insurance had become a minor aspect of the life insurance industry.[72] It continued declining by degrees until by the late 1980s it accounted for less that 3% of new life insurance business.

As far as the insurance industry and its commentators are concerned, Beveridge and Morrah had made correct predictions: the long boom of the 1950s and 1960s created the surplus income that made ordinary life insurance feasible for the working class, and the better return this offered, attracted the market away.[73] This interpretation of the mass of the population as now positively enlisted, rather than morally coerced, into the institutions of fiscal security is characteristic of current discourses of life insurance. In this framework, life insurance no longer is about preventing poverty through regular little acts of sacrifice, but rather is envisioned as the creation of wealth through the active ("voluntary") investment of disposable ("surplus") income—a vision of life insurance as fully commodified. This insurance language speaks of "investment and pension products." Life insurance is "viewed as an alternative investment vehicle" which "no longer sits alone but forms part of the retail services sector."[74] Current discourses of "freedom of service," prominent in the insurance literature—and unwittingly polarizing the imagery of contemporary insurance from that of industrial life insurance—reflect the enterprise culture's valorization of the sovereign consumer.[75] As Clayton indicates, the insurance commodity now is provided

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70. DANIEL MORRAH, A HISTORY OF INDUSTRIAL LIFE ASSURANCE 171 (1955).

71. *Id.* at 174.

72. *See* PRICE WATERHOUSE, A GUIDE TO THE UK INSURANCE INDUSTRY 1 (1990).

73. *See id.* at 11.

74. *Id.* at 5-10

75. *See* Russell Keats, *Introduction: Starship Britain or Universal Enterprise?*, *in* ENTERPRISE CULTURE 7 (R. Keat & N. Abercrombie eds., 1991).

(in its own understanding, at least) not in terms of what "is good for" the insured party, but in terms of "what the consumer wants."[76]

If "thrift" gives way to "investment," it is in part because risk itself is being more positively evaluated in contemporary liberal political rationality. Previous generations of classical and welfare liberals regarded the minimization of risk as essential for the security of working people, respectively fostered thrift and frugality, and established social insurance to minimize risk. To neo–liberals, however, risk also has its positive side that must be valued and made salient, as the source of profit, and the root of enterprise and self reliance.[77] It is also, in the post–welfare era, seen as a potent weapon against the "welfare dependency" that Beveridge's social insurance schemes are now believed to have created.[78]

This positive vision of risk is now beginning to generate a further restructuring of insurance regimes of the working classes. Increasingly, the "voluntary," commodified sector of insurance is being expanded into the "compulsory" field of social insurance. Successive regimes of government in Britain have been involved in a program of restricting access to, and diminishing the attractiveness of, welfare and compulsory social insurance schemes, and of regulating and encouraging their substitution by "private welfare."[79] In this environment, life insurance takes on a changing role. "Encouraged" by legislation such as the Social Security Act of 1986, consumers are exhorted to purchase "investment products which allow the public to gain additional benefits to supplement those gained from the state" or to "contract out of the state scheme altogether in exchange for incentives." Rather than being thought as a contraction of social insurance and social

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76. GEORGE CLAYTON, BRITISH INSURANCE 185 (1985).

77. *See* Pat O'Malley, *Regulating Enterprise Culture*, 9 CAN. J. OF LAW AND SOC'Y 205, 212 (1994).

78. *See* MARGARET THATCHER, THE DOWNING STREET YEARS 625-7 (1993). Margaret Thatcher's accounts of her own political beliefs along these lines, and the ways in which they have shaped government policy since the early 1980s, are clearly outlined in her recent autobiography. *Id.* at 626-8. For the most recent political expression of such a view, see Prime Minister John Major's eulogising of "the risk takers of Great Britain," whom he contrasts with those who take the prudent, cautious line. The latter, by implication, are at the root of any instances of economic under–performance (*The Guardian* 21-25 October 1995). Earlier views of a similar nature have been expressed throughout the literature of the New Right. See in particular Aharoni's deriding of the welfare state as "The No–Risk Society". *See* YAIR AHARONI, THE NO–RISK SOCIETY (1981)

79. *See* Pete Alcock, *A Better Partnership between the State and Individual Provision: Social Security into the* 1990s, 16 (1) J. OF LAW AND SOC'Y 97 (1989).

welfare institutions, this process is represented as an "expanding market for pension products."[80]

Yet in practice, the development of the "personal pension" scheme in the wake of the 1986 legislation represents a still more far–reaching development than this implies. In many respects, the commodification of insurance for workers that occurred during the 1960s and 1970s, was no more than the extension of Beveridge and the Labour Party's version of consumerism, in which consumers exercised freedom of choice among the offerings of the market. Thatcher's neo–liberalism, however, was establishing a program of "worker capitalism" in which it was imagined that making every worker a shareholder would erode the "dependency"[81] that neo–liberals imagined to be an effect of the welfare state.[82] The "activated" worker thus moves beyond being a mere consumer to becoming an entrepreneur:

> the vast majority of British adults own investments in bank accounts, life insurance, unit trusts, and pension funds; and they thereby, though unknowingly, possess indirect claims on shares owned by such financial intermediaries. But. . .however rewarding such investments are financially, they do not and cannot give their owners a sense of enjoying a rightful and potentially active voice in determining the policies of the nation's enterprises. [83]

In the personal pension schemes this "defect" is remedied. While the contribution levels are set at the time of the contract, instead of this delivering an actuarially calculated benefit upon realization, the final amount of the benefit will depend upon the performance of the individual investment portfolio or package selected by the investor. This insurance, then, is not about "the taming of chance," the term that has come to be so familiar in risk–minimizing or risk spreading readings of insurance. Rather, risk is to be given its head. Insurance innovations now are to exploit risk and to expose the policyholder to the risk that is the source of enterprise and gain. Ironically,

80. PRICE WATERHOUSE, *supra* note 70, at 5.
81. THATCHER, *supra* note 78, at 267.
82. SHIRLEY LETWIN & WILLIAM LETWIN, EVERY ADULT A SHAREOWNER 11 (1986).
83. *Id.* at 6.

the Prudential Corporation, formerly the doyen of industrial life insurance, is the leading company in the personal pensions market.[84]

CONCLUSION: TRANSFORMING INSURANCE?

For Francois Ewald, risk is understood as having two elements.

> Rather than with the notions of danger and peril, the notion of risk goes together with those of chance, hazard, probability, eventuality or randomness on the one hand, and those of loss or damage on the other – the two series coming together in the notion of accident. One insures against accident, against the probability of loss of some good. Insurance, through the category of risk, objectifies every event as an accident. Insurance's general model is the game of chance: a risk, an accident, comes up like a roulette number, a card pulled out of the pack. With insurance, gaming becomes the symbol of the world.[85]

What is remarkable about this passage is that insurance is defined as risk related to loss or damage, while simultaneously it is defined as a *game of chance*, with clear connotations of the possibility of speculative gain. This latter imagery, of course, was an element of insurance that successive generations of government had attempted to eradicate or downplay since the "Gambling Act." While endowment policies long before had come to represent an investment for the future, it was always the solid security of known and guaranteed levels of benefit that were emphasized.[86] Insurance remained the antithesis of gambling and any form of speculative gain, and thus retained its faith with the Victorian Virtues of thrift and frugality until well into the twentieth century.

Ironically, despite the fact that welfare liberalism is assailed for eroding these virtues, the welfare reforms developed by Beveridge preserved them, albeit in a transformed state. Beveridge adhered to the idea that saving to cover future risks with respect to life's necessities, and for insurance to

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84. *See* Barbara Waine, *Workers as Owners: The Ideology and Practice of Social Policy in Thatcher's Britain*, in 21 ECON. AND SOC'Y 27, 41 (1992) (noting that by end of the 1988/89 financial year, the *Prudential* had sold over half a million personal pension contracts).

85. Ewald, *supra* note 1, at 199.

86. *See* BRENNER & BRENNER, *supra* note 30, at 90-112.

provide assured benefits, was absolutely crucial. So much so that it could not be left to inefficient mechanisms such as industrial life assurance. By taking that component of life insurance he regarded as behaving like a "necessity," and transferring its governance from the moral and tactical pressures of collectors to the technocratic management of the state sector, Beveridge also preserved the idea that security should be managed by experts in risk–spreading and risk–minimization. In this way, the welfare state can be seen to be quite a conservative institution. While it transformed thrift from a personal moral virtue to an administrative procedure of the state, by making conservative forms of thrift compulsory it moved even further away from the gaming model that was the skeleton in the closet of life insurance.

Yet Beveridge's reforms were also contradictory, for through the invention of "voluntary thrift" for working people *qua* "consumers"—as we have seen—he helped to pave the way for a neo–liberal revolution in insurance. Of course the revolution went much further than Beveridge imagined. True, the neo–liberals retained the core idea of insurance as a way of spreading risk. They also retained Beveridge's belief that "[b]etter distribution of purchasing power is required among wage earners' across periods of high and low income and expenditure."[87] But they broke through the economically conservative notion that insurance necessarily implied risk aversion as well as risk spreading, by encouraging insurance policyholders to expose their investments to the speculative hazards of the stock market. Effectively, the new insurance regimes restored the old sense of *gaming* to insurance—just as simultaneously they were completing the transformation of gambling itself into an acceptable "industry."[88]

Thus, while leaders such as Margaret Thatcher have made much of the idea that neo–liberals are restoring Victorian Virtues, such as thrift, in some ways nothing could be further from the truth.[89] Thrift and financial speculation, at least in the lives of working class people, were at polar ends of the Victorian moral spectrum. There is thus little that is Victorian, albeit much that is "virtuous" about the current promotion of casinos, mass participation in stock and futures markets, and now, the speculative life insurance market. If these are now institutions of thrift, then indeed its meaning has changed radically since Victorian times, and not for the first time, as we have seen.

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87. BEVERIDGE, *supra* note 25, at 167.

88. *See* DIXON, *supra* note 29, at 320-55.

89. *See* THATCHER, *supra* note 78, at 627.

With these transformations, the triangular relationship between thrift, risk and insurance had also shifted dramatically. Each term has undergone a change in meaning and evaluation, in ways that are articulated with, but cannot be simply "read off" from underlying political rationalities. Much depends on how the problems and elements of government are imagined; the new terms and concepts that are invented to capture these in thought; the ways in which the meanings of these terms drift and are transformed; and the ways in which they come to be "translated" into institutional forms. While more traditional forms of analysis may appear in this process to be the mere working out of changes determined at another level, the specific forms of insurance that exist within such parameters are often immensely diverse, and these diversities are highly consequential. In many ways it is the work of "insurantial imagination," not simply class interest, market pressures or actuarial technique, that gives insurance its diversity.

HOME LIABILITY COVERAGE: DOES THE CRIMINAL ACTS EXCLUSION WORK WHERE THE "EXPECTED OR INTENDED" EXCLUSION FAILED?

Daniel C. Eidsmoe and Pamela K. Edwards***

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INTRODUCTION

The axiom that bad facts make bad law could not have been any truer than in the case of Robert A. Berdella.[1] In 1984, Berdella, a Kansas City, Missouri area resident went on a four-year torture and killing spree. Over that period of time Berdella killed at least six men, all in gruesome fashion.[2] The seventh potential victim was able to escape from Berdella's home and call police after breaking free from a bed in which his hands and feet were tied for a period of five days.[3]

When police investigated Berdella's home, they found human skulls, photographs of men being sodomized and tortured, and journal notes describing the torture. In 1988, Berdella pled guilty to six counts of murder and was sentenced to life in prison without parole.[4]

During the plea stage of the criminal proceeding, Berdella pled guilty to first degree murder for three of the murders, in the other three, to those of Todd Stoops, Jerry Howell, and James Ferris he pled guilty to second-degree murder. With the first-degree murder pleas, Berdella admitted that he intended to kill the victims. In the second-degree murder cases Berdella did not admit that he intended to kill Stoops, Howell or Ferris. Instead, he only admitted that he intended to torture them physically and sexually. He maintained that their deaths were unintentional.

The criminal record indicated that Berdella injected the victims with drugs and kept them alive for his "perverted desires."[5] The victims died as a result of drug injection, asphyxiation from being gagged, bleeding or infection. Berdella died in prison one year after his guilty plea.

Civil suits were filed against Berdella's estate by the victim's families for wrongful death. Although Berdella had only $63,000 in personal assets, he did have a homeowners insurance policy with $100,000 per occurrence limits (arguably each murder could have been a separate occurrence). Berdella was insured by Economy Fire and Casualty Company (Economy). In the wrongful death actions, the plaintiffs attempted to trigger coverage by alleging that Berdella's actions amounted to negligence. In response, Economy filed a separate declaratory judgment action, citing its common

1. Economy Fire & Cas. Co. v. Haste, 824 S.W.2d 41 (Mo. Ct. App. 1991).

2. One of the more graphic accounts (in addition to the Economy case cited above) is contained in the article *Wrongful Death*, NAT'L L. J., January 25, 1993, at S16.

3. Toni Cardarella, *Berdella Pleads Guilty in Sodomy Case*, U.P.I., Aug. 24, 1988, at 2.

4. *See* Tom Jackman, *$5 Billion Message*, NAT'L L. J., Jan. 20, 1992, at 6.

5. *See supra* note 1 at 46.

policy language found in all home liability policies (in one form or another) that excludes liability coverage for bodily injury or property damage "expected or intended" from the standpoint of the insured.[6]

In the declaratory judgment action, the trial court agreed with Economy's Motion for Summary Judgment finding that the exclusionary language did bar coverage for the allegations made in the wrongful death action. The victims' families appealed. The Western District of Missouri Court of Appeals granted the appeal.

In its unanimous opinion, the Court of Appeals reversed the trial court's findings as to the claims of Stoops, Howell, and Ferris.[7] The Court of Appeals ruled that the mere fact that Berdella pled guilty to three counts of second degree murder did not establish that he intended to kill the three men for purposes of the civil or the declaratory actions. The court stated: "The record does establish that Berdella intended to harm these individuals, but it does not establish, without genuine issue of material fact, that Berdella . . . expected or intended the result (the deaths) which occurred."[8]

By finding that Berdella intended to torture his victims but did not expect or intend to kill them, the court handed the case back to the jury.[9] This

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6. Although this article refers to the "expected or intended" *exclusion*, the provision at issue is not an exclusion in all liability policies. In some policies this language is incorporated into the definitions section of the policy. For example, Country Mutual's Home Insurance Policy (08/15/91) contains the following definition of an occurrence:

"Occurrence in Section 1 means an accident . . . which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured." This definition is then supported by the following exclusion: "Liability and Medical Payments does not apply to bodily injury or property damage: 1. Caused intentionally by or at the direction of an insured."

In contrast, State Farm Fire and Casualty Company's Homeowners Policy (9/97) incorporates the language in the form of an exclusion. The policy states: "1. Coverage L and Coverage M (Medical) do not apply to: a. bodily injury or property damage: (1) which is either expected or intended by the insured; or (2) which is the result of willful and malicious acts of the insured."

7. As for the three first-degree murder cases, the trial court's opinion on the expected or intended language was affirmed, denying coverage for those claims based upon the exclusion.

8. *See supra* note 1 at 46. *See also* Brian Cox, *Missouri Jury May Find Homeowners Coverage For Murders,* NAT'L UNDERWRITER, Jan. 13, 1992, at 4; Annie Best, *Jury To Decide If Victims' Families Can Tap Killer's Homeowner Policy,* J. COMM., Dec. 23, 1991, at 8A.

9. The Liability Insurance Research Bureau (LIRB) critique of this decision states: "This court incorrectly drew a distinction between an intent to harm and an intent to kill. The definition of "bodily injury" within the policy is inclusive of both harm and death." HOMEOWNERS LIABILITY INS. L. R.EV, Jan. 1992, at 384; David Brummond, assistant vice

decision also placed the case back into the realm of potential coverage under Economy's homeowner's policy.

The rest is history. The resulting jury verdict in the civil case, one year after the Court of Appeals ruling on the declaratory judgment action still stands today as the highest compensatory award in United States legal history.[10] The livid jurors awarded the Stoops family $5 billion ($2.5 billion for wrongful death and $2.5 billion for "aggravating circumstances").[11] Although Economy had planned to appeal the verdict,[12] its policy of insurance also covered pre- and post-judgment interest on the entire judgment. The interest on $5 billion amounted to $600,000 a day![13] Economy was forced to settle the claim rather than appeal and risk insolvency on the outcome of one appeal. Economy paid the Stoops family $2.5 million.[14] The death claims presented by the Howell and Ferris families were settled out of court for undisclosed sums. This decision, although sensational, serves as a blueprint of what can go wrong when an insurer asserts the expected or intended coverage defense. Generally, the expected or intended exclusion is a good coverage defense in the absence of any other grounds upon which to deny coverage.[15] But in the numerous instances where the exclusion is not

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president and assistant general counsel for the National Association of Independent Insurers said it another way: "Commonly, homeowners insurance policy language excludes recovery for harm caused by intentional acts. It does not usually specify 'death' caused by intentional acts," *see supra* note 8.

10. Jury Verdict Research, a Pennsylvania-based database of personal injury verdicts.

11. According to the National Law Journal, "At the trial, [the plaintiff attorney] asked the jurors to award Todd Stoops' parents $1 billion. . . [T]he Kansas City jury raised his bid and awarded $2.5 billion for wrongful death and another $2.5 for aggravating circumstances." In other words, the jury gave the plaintiffs five times more than they were asking for. *Wrongful Death: 1992's Largest Verdicts,* NAT'L L.J., Jan. 25, 1993, at S16.

12. *See* Jon Hilkevitch, *Abuse Not Covered, Insurers Are Saying,* CHI. TRIB., Dec. 24, 1993, at 1 (Following the $5 billion judgment, Kristine Focht, an associate with the Kansas City law firm that defended Berdella in the civil action stated, "No money has yet been exchanged on the cases where (insurance) coverage is being contested, but it's ludicrous that you'd have to go this length. . .It would only seem it's common sense that the kind of things Mr. Berdella did-sexually torturing his victims and injecting them with drugs, tying plastic bags over their heads and watching them die-would not be insurable actions.")

13. A recent article contrasts the *Berdella* verdict to the civil judgments awarded against O.J. Simpson. *See* Debbie Howlett, *Judge Decides Next Week Whether $33.5 Million Is Fair,* USA TODAY, Feb. 12, 1997, at 3A.

14. *See* Jackman, *supra* note 4; and Deborah Hastings, *Big Civil Verdicts Make Headlines-Not-So-Big Collections Don't,* ASSOCIATED PRESS, Feb. 12, 1997.

15. The interpretation of the expected or intended exclusion by the courts is extremely inconsistent. Courts have either found the language inherently ambiguous or seemingly clear.

enforced it can be very costly for the insurer. Missouri is not the only jurisdiction to struggle with a criminal conviction by an insured and still fail to determine that the harm arising out of the act in question was *not* excluded by the expected or intended exclusion of the homeowners policy.[16]

The Berdella decision and decisions like it are shocking to most attorneys and insurance professionals. The frustrating element of those cases is that the intent behind the expected or intended language is seemingly simple to the "average person."[17] As a general rule, liability claims should not be paid on behalf of insureds when the nature of their actions is so inherently harmful that it is against common sense to indemnify them for the consequences of their morally reprehensible acts.[18] Unfortunately, this seemingly clear intent

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For a good summary of the inconsistency see: *Annotation, Construction and Application of Provision of Liability Insurance Policy Expressly Excluding Injuries Intended or Expected by Insured,* 31 A.L.R.4th 957, 978 (1984 & Supp. 1996).

16. *See, e.g.*, State Farm v. Worthington, 405 F.2d 683 (8th Cir. 1968) (Missouri insured pled guilty to manslaughter); Republic Ins. Co. v. Feidler, 875 P.2d 187 (Ariz. 1998) (Arizona insured convicted of aggravated assault); James M. v. Sebesten, 270 Cal. Rptr. 99 (1990) (California insured pled guilty to lewd or lascivious acts upon a minor); Southern Mut. Ins. Co. v. Mason, 445 S.E.2d 569 (Ga. Ct. App. 1994) (Georgia insured pled guilty in juvenile court to involuntary manslaughter); Farmers Ins. Group v. Sessions, 607 P. 2d 422 (Idaho 1980) (Idaho insured pled guilty to assault and battery); Bolin v. State Farm Fire & Cas. Co., 557 N.E. 2d 1084 (Ind. Ct. App. 1990) (Indiana insured pled guilty to criminal recklessness); Hanover Ins. Co. v. Talhouni, 604 N.E. 2d 689 (Mass. 1992) (Massachusetts insured convicted of indecent assault and battery); Burd v. Sussex Mut. Ins. Co., 267 A. 2d 7 (1970) (New Jersey insured convicted of atrocious assault and battery); Public Serv. Mut. Co. v. Saul Goldfarb, et. al., 425 N.E.2d 810 (1981) (New York insured convicted of sexual abuse); General Accident Ins. Co. v. Zazynski, 645 N.Y.S.2d 220 (1996) (New York insured convicted of arson); Aetna Cas. & Sur. Co. v. Gigante, 645 N.Y.S. 2d 386, (1996) (New York insured convicted of reckless manslaughter); R. Stidham v. Millvale Sportsmen's Club, 618 A. 2d 945 (Pa. Super. Ct. 1993) (Pennsylvania insured pled guilty to third degree murder); Long v. Coates, 806 P.2d 1256 (Wash. Ct. App. 1991) (Washington insured convicted of assaulting a police officer).

17. Or, as L. Russ wrote, the standard for insurance contracts is a little higher. The standard is the "reasonably intelligent person." L. RUSS, COUCH ON INSURANCE, 3D § 22.38 at 22 (1995).

18. *See* Michael F. Aylward, *Does Crime Pay? Insurance for Criminal Acts,* 65 DEF. COUN. J., Apr. 1998, 185. Michael Aylward describes this concept in the following fashion:

> One might fairly wonder why there ever should be a question of insurance coverage for criminal acts. After all, the purpose of insurance is to guard against unforeseen events, not to insure conduct that is so heinous that society has imposed special penalties to discourage it. But, as claims professionals can attest, claims for criminal acts are being presented, and in many cases, courts are finding coverage.

by insurers is lost during the policy interpretation stage of many such coverage disputes.[19]

When judges ignore the intent of the language and find fact questions in "expected or intended" declaratory actions the ultimate result is a "loss" for the insurer. The insurer is not faced with just the prospect of the jury finding coverage. The insurer also is faced with the very real possibility of the jury punishing the insured at trial with an excess verdict. Thus, a fact question determination at the summary judgment stage in the declaratory action exposes the carrier to the following dangerous consequences: (1) An excess verdict; (2) Bad faith exposure; (3) Pre- and post-judgment interest on the entire verdict amount; and (4) Mounting transaction costs for coverage counsel, defense counsel, court costs, and in some jurisdictions the cost of independent counsel for the insured.

The creation and addition of a criminal acts liability exclusion by some homeowner carriers is a step in the right direction as far as expressing and clarifying the intent of insurers. How has the exclusion fared in the courts since its inception? What problems and challenges has it faced in the courts and what improvements could be made in its drafting? Those are the issues addressed in this article.

Id. at 185.

19. Professors Robert E. Keeton and Alan I. Widiss stated this simple concept another way: "Losses which are intentionally caused by an insured generally are not covered by liability insurance...this proposition is so clearly sound in principle that it would ordinarily go unchallenged even if there were no insurance policy clause in point." Unfortunately, many jurisdictions follow the general rule that if there is not an exclusion on point in the policy, the assumption is that the act in question is covered. *See* ROBERT E. KEETON AND ALAN I. WIDISS, INSURANCE LAW, A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES (1988) at 493. *See also* Jon Hilkevitch, *Abuse Not Covered, Insurers Are Saying,* CHI. TRIB, Dec. 24, 1993, at 1 (quoting Attorney Ronald Gass, Assistant General Counsel for the American Insurance Association. Gass was interviewed in response to several courts finding coverage for child abuse under homeowners policies. Gass discusses the need for homeowners exclusions in regard to the criminal acts of insureds. Gass stated that the typical homeowners policy is not worded in such a way that would exclude all crimes imaginable. "[I]f you [the insurance company] don't say it specifically, the courts are probably going to rule that there is coverage").

I. THE CRIMINAL ACTS EXCLUSION: ITS ORIGIN AND FORM

A. The Penal Statute or Ordinance Exclusion

An historic review of litigation involving a criminal acts exclusion suggests that the origin of the language can be found in commercial and professional liability lines. A form of criminal acts exclusion was typically found in the personal injury section of most Commercial General Liability policies since at least the mid 1970s.[20] The exclusion, rather than utilizing the words "criminal acts," instead uses the phase "penal statute or ordinance." The exclusion states that the policy does not cover claims:

> Arising out of the willful violation of a penal statute or ordinance committed by or with the consent of the insured.[21]

Although not litigated nearly as often as the criminal acts exclusion, this policy language has been successfully asserted by commercial insurers to deny claims arising out of crimes such as wiretapping.[22] But the courts have consistently refused to enforce the language for claims arising out of less "traditional" crimes involving human rights violations. For example, the courts have refused to enforce the exclusion in situations involving an insured's alleged violation of privacy laws under the Fair Labor Standards Act[23], violations of the Age Discrimination in Employment Act[24], or violation

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20. Insurance Services Organization ("ISO"), Broad Form Comprehensive General Liability Endorsement, GL 0404 (Ed. 07 76).

21. ISO, CGL POLICY FORMS, 1986.

22. *See* Jett v. Monticello Ins. Co., 21 F.3d 1125 (11th Cir. 1994) (Exclusion barred coverage to investigation service that illegally taped conversations of an incumbent politician. The insured violated the state's criminal statutes prohibiting the unauthorized interception and disclosure of telephone conversations); W. Cas. & Sur. Co. v. City of Palmyra, 650 F. Supp. 981 (E.D. Mo. 1987) (Endorsement containing the exclusion barred coverage for claims arising from the insured's wiretap); Reliance Ins. Co. v. Lazzara Oil Co., 601 So. 2d 1241 (Fla. Dist. Ct. App. 1992) (Exclusion barred coverage in case where the insured intercepted wire or oral communications, a third degree felony); MGM, Inc. v. Liberty Mut. Ins. Co., 855 P.2d 77 (Kan. 1993) (Exclusion barred coverage where the insured employer was guilty of illegally tape recording the conversations of employees).

23. Ellis v. Transcontinental Ins. Co., 619 So. 2d 1130 (La. Ct. App. 1993) (Exclusion did not bar coverage for claims filed against employer who illegally forced an employee to submit to a urine drug test. The test did not comply with state and federal guidelines established for urine sampling and drug testing).

of a state human rights law protecting disabled persons.[25] The courts in those cases commonly had difficulty finding the acts in question "willful" violations of the law. The criminal acts exclusion has eliminated the troublesome willful requirement of the penal statute or ordinance exclusion.

B. The Early Criminal Acts Exclusion

One of the first published cases interpreting a "criminal acts" exclusion in a liability policy was the Iowa case of *Ideal Mutual v. Winker*, a 1982 Iowa Supreme Court case.[26] In that case Winker, an off-duty police deputy shot and killed his estranged girl friend. Winker pled guilty to second-degree murder.

The former girl friend's estate then filed a wrongful death action against Winker. At the time of the shooting Winker was insured under a law enforcement officer's comprehensive liability policy issued by Ideal Mutual. In response to the civil suit Ideal filed a declaratory action against Winker to determine whether the policy would cover the incident. Ideal based its declaratory on the following exclusion in its policy: "This insurance policy does not apply . . . (j) to damage assessed against an insured as punitive or exemplary damages or resulting from a criminal act."[27]

On the strength of the exclusion the Iowa Supreme Court had little trouble disposing of the case in favor of the insurer. The court wrote: "Winker contends that the terms 'criminal act' as used in the exclusionary clause are ambiguous . . . we disagree. The term 'criminal act' means exactly what it says—a violation of those laws which are enacted to protect the public and which render the act punishable under the criminal code."[28]

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24. Bensalem Twp. v. West. World Ins. Co., 609 F. Supp. 1343 (E.D. Pa. 1985) (Exclusion did not apply to bar coverage for a civil lawsuit filed by widow of a former police officer who alleged that the insured township forced her husband to retire early).

25. Insurance Co. of N. Am. v. Chinoise Restaurant & Trading Corp., 445 N.Y.S.2d 835 (2nd Dept. 1981) (Exclusion did not apply to bar claims filed against a restaurant owner who allegedly refused to seat handicapped patrons in the main dining room in violation of New York law).

26. Ideal Mut. v. Winker, 319 N.W.2d 289 (Iowa 1982). *See also* St. Paul Fire & Marine Ins. Co. v. Xavier, 365 A.2d 309 (Md. 1976) (This may be the first published case interpreting a criminal acts exclusion. The Maryland Court of Special Appeals had no problem enforcing the exclusion in a case involving a lawyer guilty of embezzlement. At issue was the exclusion in an attorney malpractice policy).

27. *See* Ideal Mut. v. Winker at 290-291.

28. *Id.* at 298.

Nationwide, similar results involving the application of a criminal acts exclusion can be found in commercial policies insuring teachers,[29] doctors,[30] and other professionals.[31] In regard to personal lines coverages, ISO (Insurance Services Organization), as of 1998 still did not have a criminal acts exclusion in their personal lines homeowners policy forms, but they do exclude criminal acts in their Personal Injury endorsement.[32]

II. HOMEOWNERS AND UMBRELLA POLICIES

Based upon published litigation results, Allstate and a few other personal lines carriers have adopted and expanded the commercial lines exclusion for both their homeowners and umbrella policies.[33]

The Allstate criminal acts exclusion varies in form on a state by state basis, although the substance of the exclusion does not vary significantly.[34]

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29. *See* Horace Mann v. Barbara B., 846 P.2d 792 (Cal. Rptr.2d 1993); Durham Board of Education v. Nat'l Union Fire Ins. Co., 426 S.E.2d 451 (N.C. App. 1993).

30. *See* Illinois State Med. Ins. Serv., Inc. v. Cichon, 629 N.E.2d 822 (Ill. App. Ct. 1994); New Mexico Physicians Mut. Liab. Co. v. LaMure, 860 P.2d 734 (N.M. 1993); Podiatry Ins. Co. v. Isham, 828 P.2d 59 (Wash. App. 1992); Princeton Ins. Co. v. Chunmuang, 678 A.2d 1143 (N.J. Super. A.D. 1996); Medical Mut. Liab. Ins. Soc'y v. Azzato, 618 A.2d 274 (Md. 1993); Rivera v. Nevada Med. Liab. Ins. Co., 814 P.2d 71 (Nev. 1991); Govar v. Chicago Ins. Co., 879 F.2d 1581 (8th Cir. 1989).

31. *See* St. Paul Fire & Marine Ins. Co. v. Starr, 651 S.W.2d 517 (Mo. App. 1983) (Attorney guilty of fraud); Continental Cas. Co. v. H.S.I. Financial, 466 S.E.2d 4 (Ga. 1996) (Attorney guilty of theft); Lutheran Benevolent Ins. Co. v. Nat'l Catholic Risk Retention, 939 F. Supp. 1506 (N.D. Okl. 1995) (Priest pled guilty to five counts of forcible sodomy, one count of indecent exposure, and five counts of lewd molestation); St. Paul Fire & Marine Ins. Co. v. Xavier, 365 A.2d 309 (Md. 1976) (Attorney guilty of embezzlement); and All American Ins. Co. v. Burns, 971 F.2d 438 (10th Cir. 1992) (Bus driver, although not a "professional," guilty of lewd molestation of two young girls. Exclusion appeared in a policy of insurance covering the church).

32. The endorsement's coverage for personal injury does not apply to: "(2) injury caused by conscious violation of criminal law (by or with the insured's knowledge or consent)". FC&S Complete Property and Casualty Information Service, the Nat'l Underwriter Co., 1998.

33. *See* Tower Ins. Co., Inc. v. Judge, 840 F. Supp. 679 (D. Minn. 1993); Sledge v. Continental Cas. Co., 639 So. 2d 805 (La. Ct. App. 1994) (Auto policy); Horace Mann Ins. Co. v. Drury, 445 S.E.2d 272 (Ga. App. 1994); Michigan Millers Ins. v. Anspach, 672 N.E.2d 1042 (Ohio App. 1996); Farm. Bur. Mut. Ins. Co. v. Blood, NAII Weekly Law Digest, pg. 2, June 29, 1998 (Mich. App. 1998), No. 197772 (Auto Policy); 20th Century Ins. Co. v. Stewart, 74 Cal. Rptr. 2d 492 (Cal. App. 1998); Metropolitan Prop. & Cas. v. Ham, 930 S.W.2d 5 (Mo. App. 1996).

34. Case law indicates Allstate has added two insanity exclusions in addition to the criminal acts exclusions in some of their policies. Although the insanity exclusion is not the

The following three policy language examples are taken from Allstate litigation in the states of Florida, Illinois, and Tennessee:

Florida policy language

> (1) Losses We Cover
>
> Allstate will pay all sums arising from an accidental loss which an insured person becomes legally obligated to pay as damages because of bodily injury or property damage covered by this part of the policy.
>
> (2) Losses We Do Not Cover
>
> We do not cover any bodily injury or property damage which may reasonably be expected to result from the intentional or criminal acts of an insured person or which are in fact intended by an insured person.[35]

Illinois policy language

> 1. We do not cover bodily injury or property damage intended by, or which may reasonably be expected to result from the intentional or criminal acts or omissions of any insured person. This exclusion applies even if:
>
> a) such bodily injury or property damage is of a different kind or degree than that intended or reasonably expected; or

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subject of this paper it will be interesting to see how litigation involving that provision fairs. The two exclusions state that there is no coverage for bodily injury or property damage from: 1. "an act or omission committed by an insured while insane or while lacking the mental capacity to control his or her conduct or while unable to form an intent to cause bodily injury or property damage;" and 2. "an act or omission which is criminal in nature and committed by an insured person who lacked the mental capacity to appreciate the criminal nature or wrongfulness of the act or omission or to conform his or her conduct to the requirements of the law or to form the necessary intent under the law." Cary v. Allstate Ins. Co., 897 P.2d 409 (Wash. 1995) at 410.

35. Prasad v. Allstate Ins. Co., 644 So. 2d 992 (Fla. Sup. 1994).

b) such bodily injury or property damage is sustained by a different person than intended or reasonably expected.

This exclusion applies regardless of whether such insured person is actually charged with, or convicted of a crime.[36]

Tennessee Policy Language

1. We do not cover bodily injury or property damage resulting from:

(a) An act or omission intended or expected to cause bodily injury or property damage. This exclusion applies even if the bodily injury or property damage is of a different kind or degree, or is sustained by a different person or property than that intended or expected.

2. We do not cover bodily injury or property damage resulting from:

(a) A criminal act or omission; this exclusion applies regardless of whether the insured person is actually charged with or convicted of a crime.[37]

Allstate's policy language in this area is clearly an unending work in progress. The evolution of the language anticipates legal challenges and theories from almost every perceivable angle. In some versions the exclusion applies even if the insured is not charged with or convicted of a crime.

Two other policy examples from other carriers contain a much more concise exclusion. Secura Insurance's homeowners policy simply states that the policy does not apply to bodily injury or property damage which:

36. Allstate's motion, at 3. Allstate Ins. Co. v. Neely, No. 96 CH 6786 (Cook County Chancery Court argued August 6, 1997).

37. Allstate Ins. Co. v. Garth, 1995 WL 593075 (Tenn. Ct. App. 1995).

> (1) is expected or intended by an insured; (2) may reasonably be expected to result from the intentional acts of an insured; or (3) result from the criminal acts of an insured."[38]

Horace Mann Insurance Company has the following exclusion in its homeowners liability coverage:

> [T]his coverage does not apply to liability . . . g. for any act or acts committed by or at the direction of any insured which constitutes a violation of any criminal law or statute.[39]

In each of these exclusions it is clear that the criminal acts exclusion is intentionally broader in scope than the expected or intended language. The criminal acts exclusion excludes coverage for unintentional, as well as intentional criminal acts.[40]

Undoubtedly, the scope of the exclusion is meant to be broad in light of insurers' past negative history with the expected or intended provision. The scope of the exclusion's impact is supported by the general insurance principle that "an insurer may not contract to indemnify an insured against the civil consequences of . . . willful criminal conduct."[41]

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38. Tower Ins. v. Judge, 840 F. Supp. at 683 (D. Minn. 1993). The facts of this case are worth reading, especially if you enjoyed the movie FARGO. The events that unfolded in this case amounted to a true comedy (tragedy) of errors. Five Minnesota men embarked on a weekend drinking spree. Eventually one of the men (Meyer) passed out. Meyer's "friends" decided to see if electrical current would wake their friend. They tied speaker wire around his ankle and wrist and connected the wire to the wall outlet of their trailer. When Meyer did not come to, the friends gave up and left Meyer laying in the room. Unfortunately, when they thought the switch was in the "off" position it was actually in the "on" position. After nearly twenty minutes of electrocution, Meyer was again checked on by his friends. By that time Meyer had turned pale and later was pronounced dead at a local hospital.

Secura had a criminal acts exclusion and its insured pled guilty to reckless homicide. Unfortunately for Secura, the criminal acts exclusion was amended to the policy by an endorsement mailing. The court ruled that the exclusion in the endorsement would have been effective, but for the fact that Secura had failed to explain in the mailing that the amendment reduced coverage. Therefore, the only exclusion that applied was Secura's expected or intended provision, which the court found to be ineffective in this instance.

39. Horace Mann Ins. Co. v. Drury, 445 S.E.2d 272 (Ga. App. 1994).

40. Allstate Ins. Co. v. Norris, 795 F. Supp. 272 (D. Ind. 1992).

41. ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW, A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES, 519-520 (1988).

III. LITIGATION RESULTS: HAS THE EXCLUSION WITHSTOOD THE TEST OF JUDICIAL SCRUTINY?

The exclusion's track record to date is extremely favorable except for a few cases which we will discuss in the next section of this article. As the adjoining chart indicates, at least 31 states have established legal precedent on the exclusion in some form. Allstate, because of the size of its policy-holder base has litigated its exclusion in at least 23 of those 31 states.[42]

Courts across the United States (except for New York) have enforced the policy language for crimes ranging in severity from illegal possession of fireworks[43] to first degree murder,[44] furnishing alcohol to a minor,[45] sexual assault,[46] prescribing drugs without a license,[47] child molestation,[48] and racially motivated hate crimes.[49] Of the 79 cases reviewed in this article most

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42. In addition, at least five states (California, Massachusetts, Montana, North Dakota and Oklahoma) have enacted legislation prohibiting insurers from indemnifying insureds for the civil consequences of their criminal acts. *See* CAL. CIV. CODE § 1668 (Deering 1994), "Certain contracts unlawful" (Insurance contracts are void and against public policy if they are written to "exempt anyone from responsibility for his own fraud or willful injury to the person or property of another, or violation of law, whether willful or negligent."); MASS. GEN. LAWS ANN. Ch. 175, § 47(6)(b) (West 1997)(Insurers cannot insure "any person against legal liability for causing injury, other than bodily injury, by his deliberate or intentional crime or wrongdoing."); MONT. CODE ANN. § 28-2-702 (1997) "Contracts which violate policy of the law." "All contracts which have for their object, directly or indirectly, to exempt anyone from responsibility for his fraud, for willful injury to the person or property of another, or for violation of law, whether willful or negligent, are against the policy of the law."; N.D. CENT. CODE § 9-08-02 (1987) "Contracts against the policy of the law." "All contracts which have for their object, directly or indirectly, the exempting of anyone from responsibility for his own fraud or willful injury to the person or property of another, or violation of law, whether willful or negligent, are against the policy of the law." and OKLA. STAT. ANN. Tit. 15 § 212 (1993) "Certain contracts against policy of law." "All contracts which have for their object, directly or indirectly, to exempt any one from responsibility for his own fraud, or willful injury to the person or property of another or violation of law, whether willful or negligent, are against the policy of the law."

43. *See* Horace Mann Ins. Co. v. Drury, 445 S.E.2d 272 (Ga. App. 1994).

44. *See* Castro v. Allstate Ins. Co., 855 F. Supp. 1152 (S.D. Cal. 1994).

45. *See* Allstate Ins. Co. v. Keillor, 511 N.W.2d 702 (Mich. App. 1993).

46. *See* Allstate Ins. Co. v. Green, 831 F.2d 145 (6th Cir. Mich 1987).

47. *See* Allstate Ins. Co. v. Kabalka, 1997 WL 664926 (Mich. App. 1997).

48. *See* Allstate Ins. Co. v. Talbot, 690 F. Supp. 886 (N.D. Cal. 1988).

49. *See* Allstate Ins. Co. v. Tankovich, 776 F. Supp. 1394 (N.D. Cal. 1991).

have been decided in favor of the insurer based upon some form of the exclusion.[50]

In addition to the litigation success associated with the exclusion, the task before the coverage counsel in these cases has become much clearer. In the vast majority of jurisdictions the exclusion serves as a method for quickly disposing of claims arising out of the criminal activity of insureds. Unlike the all too common "issue of material fact" findings associated with the expected or intended cases, litigation involving the criminal acts exclusion generally does not require any inquiry into the subjective intent or expectation of the insured. On motion the judge in most cases merely needs to conclude that the bodily injury or property damage was (as in Allstate's language) "reasonably expected to result from the criminal acts of an insured."[51]

IV. EXCEPTIONS TO THE APPLICABILITY OF THE CRIMINAL ACTS EXCLUSION

As the criminal acts exclusion becomes more common in personal lines homeowners policies it becomes apparent that the courts will not always apply the language without exception.[52] Although still a relatively "new" exclusion, the courts have been willing to consider the following challenges to its applicability: (1) The intervening acts of a third party; (2) The acts of a minor insured found "delinquent" by the criminal courts; (3) The "New York exception"; and (4) Claims involving an insane insured.

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50. Specifically, 57 of the cases were decided in favor of the insurer based mainly upon a criminal acts exclusion; 19 of the cases appear to represent a judicial struggle to find coverage in spite of an exclusion. The details of the exceptions to the applicability of the criminal acts exclusion are explained in the next section.

51. Prasad v. Allstate Ins. Co., 644 So. 2d 992 (Fla. 1994).

52. Other times, without reason, the courts will refuse to apply the exclusion without any justification. *See, e.g.*, Allstate Ins. Co. v. Brown, 834 F. Supp. 854 (E.D. Pa. 1993). In that case, the insured's son was found guilty of assault against a police officer in a bar room brawl. As a result of the insured's attack the police officer sustained serious facial injuries. Allstate filed a declaratory judgment suit and moved for summary judgment on the basis of its criminal acts exclusion. The trial court denied Allstate's motion and Allstate appealed.

Reminiscent of some courts handling of the expected or intended provision, the U.S. District Court for the Eastern District of Pennsylvania merely reviewed the underlying pleadings and decided that the allegations of negligence against the insured created a fact issue for the jury. No further explanation was provided by the court.

A. The Intervening Acts of A Third Party

On January 28, 1992, when Rita Garth attended a play at the Orpheum Theater in Memphis (with a loaded pistol in her purse) she demonstrated no "intent to harm" Mark Dobbins, another member of the audience, according to the Tennessee Court of Appeals in *Allstate Ins. Co. v. Garth.*[53]

During an intermission from the play, an unknown person brushed against Garth, knocking her purse to the floor. The pistol discharged upon impact and the bullet struck Dobbins in the chest, killing him. Under Tennessee law, Garth, an Allstate insured "committed a criminal act in carrying a concealed pistol."[54] Allstate filed a declaratory action based upon its criminal acts exclusion.

In a two-page opinion, the Court of Appeals refused to enforce the exclusion. At issue in the minds of the court were the terms "resulting from" contained in the following exclusion: "We do not cover bodily injury . . . resulting from: a criminal act or omission."[55]

The court, in refusing to apply the exclusion to the facts of this particular case reasoned:

> "resulting from" should be given its ordinary meaning, that is, that the discharge of the pistol was the consequence or effect of its being dropped on the floor when the insured was jostled by a third party . . . The death of Dobbins did not result from any positive act of the insured, but from the intervening act of a third party.[56]

B. The Acts of a Minor Insured Found "Delinquent" By the Juvenile Courts

Although this challenge to the enforcement of the exclusion has been confronted numerous times in the courts, there appears to be only a single case in which it was successful. In the case of *Allstate Ins. Co. v. Lewis*,[57] 17-year-old Brian Bills, an insured under his grandparent's homeowners policy,

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53. Allstate Ins. Co. v. Garth No. 020A01-9409-CU-00211995 WL 593075 (Tenn. Ct. App.).

54. *Id.* at 19.

55. *Id.* at 20.

56. *Id.*

57. *See id.*

was having difficulty thwarting the amorous advances of a 13-year-old admirer.

Bills decided to confront the girl with a revolver loaded with only one bullet. Bills thought that the gun would not fire when he threatened her with it. He was wrong. The girl suffered serious medical and psychiatric injuries as a result of a gunshot wound.

A delinquency petition was filed and Bills pled guilty to first degree assault. A civil suit was then filed by the girl's parents and Allstate responded by filing a declaratory action based upon its criminal acts exclusion. The United States District Court in Colorado heard Allstate's case and decided against the insurer.

The court found that the state's Children's Code was enacted to protect vulnerable 17-year-olds such as Bills from the "stigma attached to criminal proceedings."[58] Thus the court reasoned that to "characterize (Bills') offense as criminal in the civil case would thwart the clear intent of the Colorado General Assembly."[59] Thus state legislation protecting minors was found to be more important than enforcement of contractual language in an insurance coverage dispute.

The Lewis decision has proven to be the only exception, rather than the rule. At least five other courts, in cases involving five younger juveniles, have ruled in favor of upholding enforcement of the exclusion. All five cases involve Allstate policy language.[60]

C. The "New York Exception"

Two New York cases have given a clear message that the criminal acts exclusion (as it is presently drafted) will not be enforced to bar coverage by the appellate courts of that state. In both cases the courts took issue with

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58. *Id.* at 1115.

59. *Id.* at 1114.

60. *See* Allstate Ins. Co. v. Green, 831 F. 2d 145 (6th Cir. 1987) (sexual assault by the insured's 14-year-old son); Allstate Ins. Co. v. Carmer, 794 F. Supp. 871 (S.D. Ind. 1991)(Insured's 14-year-old son found "delinquent" under Indiana Criminal Code); Allstate Ins. Co. v. Dillard, 859 F. Supp. 1501 (M.D. Ga. 1994) (Insured's 13-year-old grandson shot a friend but was not criminally prosecuted); Allstate Ins. Co. v. Cutcher 920 F. Supp. 796 (N.D. Ohio 1996) (Insured's 15-year-old son found "delinquent" by Juvenile Court as a result of involuntary manslaughter); *see also* Robert Bruss, *Homeowners Insurer Denies Coverage Following Criminal Act*, TAMPA TRIB., Aug. 10, 1996, at 2; and Allstate Ins. Co. v. Burrough, 120 F.3d 834 (8th Cir. 1997) (Insured's 14-year-old son guilty of furnishing a deadly weapon to a minor, criminal charges were never sought).

Allstate's exclusionary language which states that there is no coverage for losses which could "reasonably be expected to result" from a criminal act.[61]

In *Allstate Insurance Company v. Zuk*, Allstate's insured, William Zuk, was cleaning his shotgun while inside his parent's hunting lodge.[62] The gun accidentally discharged, killing Zuk's friend, Michael Smith. Zuk was charged with second degree manslaughter and plead guilty to criminal recklessness.[63]

In the wrongful death action against Zuk, Smith's estate alleged that Zuk was negligent in the way he "operated a shotgun."[64] Allstate filed a declaratory judgment action, asserting its right to deny coverage under the policy contract. After Allstate's motion for summary judgment in the declaratory action was denied, the case ultimately ended up in the Court of Appeals.

In a decision frustratingly similar to the findings of the expected or intended litigation, the Court of Appeals ruled that a material issue of fact existed as to whether the death could, as stated in the exclusion, reasonably be expected to result from the insured's mishandling of the shotgun.

The court stated: "under the terms of Allstate's exclusionary clause, the inquiry [as to coverage] does not stop with the determination that the loss resulted from a criminal act."[65]

One must ask the question, "why not?" The court further stated that the phrase "reasonably expected to result" is subject to a "variety of different meanings in a civil versus criminal elision."[66]

One would think that as a matter of law the court could have determined that cleaning a loaded shotgun in a confined area could reasonably be expected to result in some form of bodily injury or property damage. Several other courts have had little problem making similar determinations in situations where the criminal act may not have been "intentional."[67]

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61. *See* Allstate Ins. Co. v. Zuk, 574 N.E.2d 1035 (N.Y. 1991) at 1037; *and* Green v. Allstate Ins. Co., 576 N.Y.S.2d 639, 640 (1991).

62. *See id.* at 1036.

63. *See id.*

64. *Id.*

65. *Id.* at 1037.

66. *Id.*

67. *See* 20th Century Ins. Co. v. Stewart, 74 Cal. Rptr. 2d 492 (Cal. App. 1998) (Insured's son played Russian roulette with his parents' revolver. The gun fired killing a young man. The insured's son was convicted of voluntary manslaughter); Allstate Ins. Co. v. Peasley, 932 P. 2d 1244 (Wash. 1997) (Insured pled guilty to reckless endangerment in discharging a firearm in a manner which caused substantial risk of serious harm to another person. Exclusion

Decided five months after the *Zuk* decision, the Appellate Division of the state's Supreme Court added to the New York exception in *Green v. Allstate Ins. Co.*[68] In a very brief opinion, the court stated that the "reasonably expected to result" policy language creates a fact question for the jury, even though the insured was convicted of second degree assault in relation to firing a slingshot into a crowded parade site. Again, one must ask the question, what other result could have been expected from such an act?

D. The Insanity of An Insured

At least three courts have reviewed a criminal acts exclusion in conjunction with claims arising out of the acts of insane persons.[69] In all three cases Allstate's criminal acts language was at issue. In all three cases the courts deferred to other policy reasons to deny the claims rather than deal with the criminal acts issue.[70]

One of the more troubling cases on this issue is *Allstate Ins. Co. v. Mata*.[71] Allstate's insured, William Hardimon, murdered Sylvian Saultman, and then killed himself. Although Hardimon had been seeing a psychiatrist prior to the incident, he had never been declared insane.

The estates of both Hardimon and the victim alleged that Hardimon was insane at the time of the shooting. The estates were able to convince the trial

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precluded coverage.); Hooper v. Allstate Ins. Co., 571 S. 2d 1001 (Ala. 1990)(Insured pled guilty to second degree assault in conjunction with a shooting incident in which the insured was drinking and handling his loaded shotgun; insured's friend was shot in the face.); Allstate Ins. Co. v. Burrough, 914 F. Supp. 308 (W.D. Ark. 1996) (Insured's 14-year-old son stole his grandfather's pistol. The boy then gave the gun to another boy, who in turn gave it to another. The gun was used in a drive-by shooting. The insured's son was guilty of the crime of furnishing a firearm to a minor but he was never charged.); Allstate Ins. Co. v. Schmitt, 570 A.2d 488 (N.J. Super. 1990) (Excluded coverage for insured convicted of assault.); Steinke v. Allstate Ins. Co., 621 N.E. 2d 1275 (Ohio Ct. App. 1993) (No coverage for damages arising out of the insured's conviction for disorderly conduct.); Allstate Ins. Co. v. Sowers, 776 P.2d 1322 (Or. Ct. App. 1989) (Exclusion barred coverage to insured convicted of unlawfully resisting arrest when he struck a police officer.).

68. Green v. Allstate Ins. Co., 576 N.Y.S. 2d 639 (1991).

69. *See* Prasad v. Allstate Ins. Co., 644 So. 2d 992 (Fla. 1994) (Court found psychotic insured who forgot to take his anti-psychotic medication acted with the intent necessary to exclude coverage in stabbing of claimant); Cary v. Allstate Ins. Co., 897 P. 2d 409 (Wash. App. 1995)(Insured found not guilty in criminal proceeding due to insanity. Court enforced insanity exclusions to preclude payment of the claim).

70. In *Cary v. Allstate Ins. Co.*, the insanity exclusions (*see supra* note 34) were enforced; in *Prasad v. Allstate*, and *Mata v. Allstate*, the intentional acts exclusions applied thus alleviating the need for a review of the criminal acts exclusion.

71. Mealy's Litigation Reports, Nov. 14, 1996, document number 170112.

court that Allstate's motion for summary judgment filed in the declaratory action should not be granted. The estates argued that a question of fact existed as to the insured's mental state prior to the murder and to whether he expected or intended the injury.

Allstate appealed the trial court's decision and won. The Michigan Court of Appeals stated:

> This is not to say that the insured is necessarily criminally liable for his acts. We find that an insane or mentally ill individual can still form the requisite intent to injure another and yet may not be considered criminally culpable . . . [H]is actions can only be considered intentional under the terms of the policy exclusion, and Saultman's death was a reasonable and expected result of his acts.[72]

V. DRAFTING CONSIDERATIONS

After reviewing the growing number of exceptions, courts have at times struggled to find the criminal acts exclusion inapplicable. It seems appropriate to consider ways in which an insurer might draft such an exclusion to fulfill its goals (preserving an ability to deny coverage for egregious, heinous crimes without having to litigate whether the insured had "expected" or "intended" the results of his or her actions) and yet not offend the judiciary's sense of fairness and equity. In short, without some attempt at clarifying or narrowing the criminal acts exclusion, insurers twenty years from now may see hundreds of decisions "interpreting" their exclusion, just as today we see hundreds of cases interpreting the expected or intended exclusion.[73]

As we have seen with the "sudden and accidental" language of the pre-1986 Commercial General Liability policies' pollution exclusion, ambiguity from the perspective of the courts is a curse for any policy provision. Although the criminal acts exclusion in its early years has taken many forms, the courts to date have not found the language ambiguous in a homeowners

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72. *See id.*

73. One writer described the litigation over the expected or intended provision as a "hodgepodge of judicial interpretation." *See* John Dwight Ingram, *The "Expected or Intended" Exclusion Clause in Liability Insurance Policies: What Should it Exclude?*, 13 WHITTIER L. REV. 713, 721 (1992).

policy.[74] Admittedly, however, the path cut by some of the exclusions is wide, perhaps too wide at times.[75]

As with any worthy endeavor, one must learn by trial and error. The same may be said in regard to policy drafting, although for obvious financial reasons carriers strive to "get it right" the first time. Based upon litigation results alone, Allstate's language appears to be effective (in a very broad manner) except in the state of New York. Whether there is an acceptable alternative to Allstate's exclusionary language of no coverage for losses which could "reasonably be expected to result from a criminal act," remains to be seen.

VI. AUTOMOBILE POLICIES

From trial and error we know, based upon litigation results to date, what policy language the courts will not accept. The courts generally will not accept a criminal acts exclusion in an auto policy. In *Sledge v. Continental Casualty Company*[76], a Louisiana court ruled that the criminal acts exclusion in an *auto* policy would violate public policy. Continental asserted the

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74. In fact a number of courts have stated explicitly that the language is *not* ambiguous. *See* Allstate Ins. Co. v. Brown, 16 F.3d 222 (7th Cir. 1994) pg. 226; Castro v. Allstate Ins. Co., 855 F. Supp. 1152 (S.D. Cal. 1994); Allstate Ins. Co. v. Lewis, 918 F. Supp. 168, 170 (S.D. Miss. 1995); 20th Century Ins. Co. v. Stewart, 74 Cal. Rptr. 2d 492, 494 (Cal. App. 1998); Horace Mann Ins. v. Drury, 445 S.E. 2d 272 (Ga. App. 1994); Allstate Ins. Co.. v. Freeman, 443 N.W.2d 734 (Mich. C.A. 1989).

75. *See* Steven E. Green, MICH. LAW. WKLY., Dec. 8, 1997, at 4. This editorial is critical of the scope of Allstate's criminal acts exclusion. (Green writes: "Many acts which traditionally gave rise to insurance coverage fit within the broadest definition of a 'crime.' [Michigan law] makes it a crime to attend, frequent [or host?] any place where gambling is permitted. If someone slips on the steps while entering a friend's house for penny-ante poker, is coverage excluded? [Michigan law] makes it a misdemeanor to have possession or control of a firearm while intoxicated. If a deer hunter has a few beers and accidentally injures someone, is coverage excluded?"). *See also Divided Washington Supreme Court Rules Homeowners Coverage Excluded After Insured Shot Victim*, Insurance Coverage Litigation Report, May 2, 1997, at 409 (The dissenting judge in *Allstate v. Peasley* is critical of the scope of the term "criminal" as contained in Allstate's homeowners policy. Supreme Court Judge Charles W. Johnson wrote: "Here, a guest in the home of [the insured] was shot in the stomach. Both the victim and [the insured] contend the shooting was accidental. Based on those scant facts and [the insured's] admission, I cannot agree that the average purchaser of insurance would label his acts as "criminal . . . ." Allstate Ins. Co. v. Peasley 932 P.2d 1244, 1283 (Wash. 1997) (Johnson, J., dissenting). The Court ruled 7-2 in favor of enforcing Allstate's criminal acts exclusion in a situation where the insured pled guilty to second degree reckless endangerment for the shooting of a friend).

76. Sledge v. Continental Cas. Co., 639 So. 2d 805 (La. Ct. App. 1994).

exclusion after the insured's 15-year-old son was asked to take over driving the insured vehicle while the father attempted to sleep late at night.[77] Following an accident, Continental asserted its exclusion and denied wrongful death claims because the boy's operation of the car violated Louisiana law forbidding minors under 17 from operating a motor vehicle late at night.[78]

The *Continental* decision makes sense. The violation of any rule of the road, while not intentional, can arguably be considered a criminal act. An insured who commits an non-egregious auto violation that unintentionally causes bodily injury or property damage is typically not considered to have committed a morally reprehensible act. Denials based upon a criminal acts exclusion for claims of this sort are, and will be, considered contrary to public policy by the courts and by society at large.[79]

Fortunately, "public policy considerations" are typically not as great when the court scrutinizes homeowners liability coverages.[80] In fact a number of courts have specifically held that homeowners criminal acts exclusions do not violate public policy.[81]

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77. *See id.* at 809-810.

78. Continental's auto policy stated: "We do not provide [liability] coverage for: 1. Personal Injury, bodily injury or property damage arising out of: a. An act committed in violation of a law or ordinance by, or with the knowledge or the expressed or implied consent of a covered person." *See id.* at 812.

79. As of this writing, at least two other *auto* cases have been decided against an insurer who attempted to assert a criminal acts exclusion following an auto accident. Unfortunately, a copy of one of the opinions is not presently available. According to the *NAII's Weekly Law Digest*, June 29, 1998, the Michigan Court of Appeals recently found Farm Bureau's criminal acts exclusion ambiguous. In *Farm Bureau Mutual Ins. Co. v. Blood*, No. 197772, (Mich. App 1998), the Court of Appeals found the criminal acts exclusion ambiguous because the policy: "fails to specify exactly what type of loss the policy purports to exclude if it arises out of a criminal act of the insured. By contrast, in most of the other subsections of the 'Exclusions' section, the policy delineates what types of damages will not be covered." *Id.* at 479; *see also,* Mendoza v. Rivera-Chavez, 945 P.2d 232 (Wash. App. 1992) ("Felony" exclusion under an auto policy was not enforced in situation where the insured was guilty of vehicular assault and vehicular homicide. Exclusion was found to violate public policy in the context of an auto policy. The insured had been drinking prior to the accident).

80. *See* Allstate Ins. Co. v. Schmitt, 570 A. 2d 488, 494 (N.J. Super. Ct. App. Div. 1990). In reviewing a criminal acts exclusion for the first time in a homeowners policy, the Superior Court of New Jersey reached the same conclusion: "We emphasize the limited contours of our opinion [enforcing the exclusion]. This case involves an exclusion contained in a homeowners policy. We are thus not concerned with legislation involving automobiles...that must be construed 'with liberality in effecting the broadest protection . . . of accident victims consistent with the language of the pertinent statute.'"

81. *See, e.g.*, Allstate Ins. Co. v. Juniel, 931 P.2d 511 (Col. Ct. App. 1996) (Exclusion enforced in case where the insured pled guilty to menacing and assault); Allstate Ins. Co. v.

The public policy considerations facing insurers contemplating the implementation of a criminal acts exclusion was best described by Michael F. Aylward in his article *Does Crime Pay? Insurance for Criminal Acts.*[82] Aylward writes:

> Disputes over coverage for criminal acts are no more likely to disappear than crime itself. Insurers will continue their efforts to insulate themselves from such claims through ever more restrictive policy provisions. In the final analysis, however, the resolution of these coverage disputes often seems to turn on the conflict of two antithetical public policy goals: the first, making funds available to compensate victims of crime, and the second, the proposition that indemnifying criminals may encourage them and undercut the sanctions that society has imposed to deter that conduct.[83]

VII. PROPOSED CRIMINAL ACTS EXCLUSION

In light of the failures of the criminal acts exclusion in auto policies and with an eye toward the somewhat lessened public policy considerations involved with the interpretation of the homeowners policy, perhaps one way to address the growing number of exceptions is to narrow the exclusion. Is it possible to narrow the scope of the exclusion while at the same time creating a clear "bright line" test for the judiciary to follow in determining whether the criminal acts exclusion applies?

The following draft of a criminal acts exclusion for a homeowners policy attempts to address some of the more problematic exceptions the courts have developed in order to find coverage:

Norris, 795 F. Supp. 272 (S.D. Ind. 1992) (Exclusion applied in case where the insured was convicted of felony criminal recklessness); Allstate Ins. Co. v. Lewis, 918 F. Supp. 168 (S.D. Miss. 1995) (Exclusion applied in a case where the insured pled guilty to manslaughter).

82. *See supra* note 18.

83. *Id.* at 198; *see also,* Rivera v. Nevada Med. Liab. Ins. Co., 814 P.2d 71 (Nev. 1991) (In response to the public policy arguments made by the claimant against enforcement of the criminal acts exclusion in a medical practice policy the Supreme Court of Nevada wrote: "[I]nsurance companies base their premiums on the items covered in the policies. The average law-abiding professional would not desire to pay more so that the policy would cover their own criminal or intentionally tortious conduct.") *Id.* at 75.

Losses Not Covered:

This policy does not provide coverage for bodily injury or property damage caused by or resulting from any intentional or criminal acts of any insured person. A "criminal act" is any act or omission for which a penal statute or ordinance permits or requires any term of imprisonment or sentence of public service duties.

Clearly this limited version of a criminal acts exclusion would not permit insurers to deny coverage in a number of situations in which current exclusions have been upheld. But on the other hand, it stands a strong chance of providing enough public policy reasons for the courts to support application of the exclusion in the vast majority of cases in which the exclusion would be asserted by the carrier.

Simply stated, if a crime is serious enough for the criminal courts to permit or require the offender to be incarcerated, then there is no reason for insurers (and each of their law-abiding policyholders) to have to pay the cost of such crime.

This is an era when an insurer can end up paying a single family $2.5 million for the life of one person killed by a deranged insured.[84] Decisions like this demonstrate that insurers must seriously consider the need to limit their liability by means of a criminal acts exclusion. Insurers owe it to the vast majority of their policyholders to keep claims costs as low as possible. Most policyholders would be shocked and appalled to find their premium dollars going to pay for the acts of mass murderers, rapists, and other such criminals. On the other hand, few of us would be shocked to find our dollars paying for injuries caused by kids playing with slingshots or fireworks.

84. This is also an era where plaintiff attorneys can, and do find insurance coverage for the most heinous crimes. In addition to the criminal acts exclusion, many homeowners carriers have created specific exclusions in an effort to prevent coverage for child molestation cases. Some have called these exclusions the "Michael Jackson clause." Farmers Insurance spokesman Jon Millen recently commented in response to a question concerning the need for the exclusion. He said, "it's outrageous that we even have to issue a statement (and a policy endorsement) that individuals will not be covered for committing heinous crimes against others, but that's where we are in society today." Jon Hilkevitch, *Abuse Not Covered, Insurers Are Saying*, CHI. TRIB., Dec. 24, 1993, at 1.

CONCLUSION

The criminal acts exclusion as it presently stands in some home liability policies is not a "perfect" coverage defense to all the issues created by the criminal acts of insureds. But litigation nationwide has shown that it is a step in the right direction. Implementation of a well-drafted criminal acts exclusion serves as a clearer means of expressing the intent of insurers that morally reprehensible acts by insureds should not be covered, thus potentially reducing the need for costly, time consuming, and sometimes dangerous coverage litigation.

As for the *Berdella* decision in January of 1992: the verdict does not merely continue to stand as the single largest award in United States legal history. The case's effect has been much more far reaching. The verdict more than likely prompted many personal lines carriers to reexamine their liability policy language. Not surprisingly, Economy Fire and Casualty adopted a criminal acts exclusion in its Home policy, issued in October of 1992, nine months after the *Berdella* decision.[85]

85. Economy preferred home policy, Oct. 1992 at 12. The exclusion states: "Section II – Exclusions 1. Coverage E – Personal Liability and Coverage F – Medical Payments to Others do not apply to bodily injury or property damage: a. Which may reasonably be expected to result from the intentional or criminal acts of an insured person, or which are in fact expected, anticipated or intended by an insured person." *Id.*

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
ALABAMA	Yes	Hooper v. Allstate Ins. Co., 571 So.2d 1001 (Ala. 1990)	Insured pled guilty to charge of second degree assault.
	No	Allstate Indem. Co. v. Lewis, 985 F. Supp. 1341 (M.D. Ala. 1997)	Insured found not guilty of assault, negligence, wantonness, and conspiracy to kill.
ALASKA	Yes	Allstate Ins. Co. v. Roelfs, 698 F. Supp. 815 (D. Alaska 1987)	Minor insured pled guilty to sexual assault and molestation.
ARKANSAS	Yes	Allstate Ins. Co. v. Burrough, 914 F. Supp. 308 (W.D. Ark. 1996), *aff'd,* 120 F.3d 834 (8th Cir. 1997)	Minor insured provided a stolen gun to another minor. Gun was used in the shooting of a bystander. Coverage did not apply to resulting shooting even though the criminal courts never pushed for a conviction.
ARIZONA	Yes (in dicta)	Ohio Cas. Ins. Co. v. Henderson, 927 P.2d 815 (Ariz. Ct. App. 1996), *vacated*, 939 P.2d 1337 (Ariz. 1997)	Insured guilty of armed robbery and murder. Although not a criminal acts exclusion case, the Arizona Court of Appeals indicated that if a criminal acts

**. Excl. Appl.= Exclusion Applicable?

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
			exclusion would have been in the policy then the court would have potentially reached a different result. The Arizona Supreme Court sided with the carrier in the appeal.
CALIFORNIA	Yes	CAL. CIV. CODE § 1668 (Deering 1994)	*"Certain contracts unlawful"* Insurance contracts are void and against public policy if they are written to "exempt anyone from responsibility for his own fraud or willful injury to the person or property of another, or violation of law, whether willful or negligent."
	Yes	Castro v. Allstate Ins. Co., 855 F. Supp. 1152 (S.D. Cal. 1994)	First degree murder.
	Yes	Allstate Ins. Co. v. Talbot, 690 F. Supp. 886 (N.D. Cal. 1988)	Insured pled guilty to felony child molestation.
	No	Horace Mann Ins. Co. v. Barbara B., 846 P.2d 792 (Cal. 1993)	Insured pled guilty to child molestation. Coverage triggered by allegation of "negligent touching"

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
			(this was a school insurance policy).
	Yes	20th Century Ins. Co. v. Stewart, 74 Cal. Rptr. 2d 492 (Cal. Ct. App. 1998)	Insured's son played Russian roulette with his parents' revolver. The gun fired killing one person. The insured's son was convicted of voluntary manslaughter.
	Court did not reach the issue	Allstate Ins. Co. v. Gilbert, 852 F.2d 449 (9th Cir. 1988)	Insured pled nolo contendere to one count of lewd or lascivious acts with child under age 14. Court found that the insured's acts were intentional and did not reach the criminal acts exclusion.
	Yes	Allstate Ins. Co. v. Tankovich, 776 F. Supp. 1394 (N.D. Cal. 1991)	Insured pled guilty to racially motivated hate crimes.
COLORADO	Yes	Allstate Ins. Co. v. Juniel, 931 P.2d 511 (Colo. Ct. App. 1996)	Insured pled guilty to misdemeanor of menacing and second degree felony assault.
	No	Allstate Ins. Co. v. Lewis, 732 F. Supp. 1112 (D.	Juvenile insured found "delinquent" by criminal court.

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
		Colo. 1990)	Delinquent acts are not "criminal" as defined by state law.
CONNECTICUT		No published decisions.	
DELAWARE		No published decisions.	
FLORIDA	Yes	Jett v. Monticello Ins. Co., 1993 U.S. Dist. LEXIS 12897 (M.D. Fla. 1993)	A general liability policy; the insured, an investigation service, was guilty of illegally taping telephone conversations.
	Yes	Reliance Ins. Co. v. Lazzara Oil Co., 601 So. 2d 1241 (Fla. Dist. Ct. App. 1992)	A general liability policy; the insured intercepted wire or oral communications, a third degree felony.
	Court did not reach the issue	Prasad v. Allstate Ins. Co., 644 So. 2d 992 (Fla. 1994)	Insane insured acted "intentionally" during assault so the court did not reach the criminal acts issue.
	Yes	Allstate Ins. Co. v. S.L., 704 F. Supp. 1059 (S.D. Fla. 1989), *aff'd*, 896 F.2d 558 (11th Cir. 1990)	Insured sexually molested a young girl. The exact nature of the criminal charge is impossible to tell from this decision.

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
	Yes	Allstate Ins. Co. v. Travers, 703 F. Supp. 911 (N.D. Fla. 1988)	Insured convicted of two counts of sexual battery on child under 12 and two counts of lewd and lascivious assault in the presence of a child under 14.
	Yes	Allstate Ins. Co. v. Myers, 951 F. Supp. 1014 (M.D. Fla. 1996)	Insured violated a state criminal statute which made it a crime for HIV-positive people to have sex with others without first informing the potential partners of their disease. The insured died before charges were filed.
GEORGIA	Yes	Allstate Ins. Co. v. Dillard, 859 F. Supp. 1501 (M.D. Ga. 1994), *aff'd*, 70 F.3d 1285 (11th Cir. 1995)	Minor insured under a mobile home policy shot a friend but was not charged with a crime due to his age.
	Yes	Horace Mann Ins. Co. v. Drury, 445 S.E.2d 272 (Ga. Ct. App. 1994)	Insured guilty of misdemeanor possession of fireworks. Court found the exclusion applies to misdemeanors as well as felonies.

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
	Yes	Allstate Ins. Co. v. Grayes, 454 S.E.2d 616 (Ga. Ct. App. 1995)	Assault with a deadly weapon. Charges were eventually dropped.
	Yes	Continental Cas. Co. v. H.S.I. Fin. Servs., Inc., 466 S.E.2d 4 (Ga. 1996)	Attorney guilty of theft of client's funds from a law firm account. A professional liability policy insuring the firm was at issue.
HAWAII		No published decisions.	
IDAHO		No published decisions.	
ILLINOIS	Yes	Illinois State Med. Ins. Servs., Inc. v. Cichon, 629 N.E.2d 822 (Ill. App. Ct. 1994)	A medical malpractice policy; the insured doctor pled guilty to the sexual assault of at least two patients.
	Pending	Allstate Ins. Co. v. Neely, No. 96 CH 6786. (Cook County Chancery Court argued Aug. 6, 1997)	Insured pled guilty to involuntary manslaughter.
	Yes	Fruit of the Loom, Inc. v. Travelers Indem. Co., 672 N.E.2d 278 (Ill. App. Ct. 1996)	"Violation of law" exclusion in a general liability policy applied to a corporate insured guilty of violating state pollution control statutes.

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
INDIANA	Yes	Allstate Ins. Co. v. Norris, 795 F. Supp. 272 (S.D. Ind. 1992)	Insured pled guilty to charge of felony criminal recklessness.
	Yes	Allstate Ins. Co. v. Barnett, 816 F. Supp. 492 (S.D. Ind. 1993)	Insured pled guilty to charge of criminal recklessness while armed with a deadly weapon.
	Yes	Allstate Ins. Co. v. Carmer, 794 F. Supp. 871 (S.D. Ind. 1991)	Minor insured found "delinquent" in criminal court.
	Yes	Allstate Ins. Co. v. Brown, 16 F.3d 222 (7th Cir. 1994)	Insured pled guilty to recklessly inflicting serious bodily harm while armed with a handgun.
IOWA	Yes	Ideal Mut. Ins. Co. v. Winker, 319 N.W.2d 289 (Iowa 1982)	Insured pled guilty to second degree murder (a law enforcement liability policy).
KANSAS	Yes	MGM, Inc. v. Liberty Mut. Ins. Co., 855 P.2d 77 (Kan. 1993)	Insured under a general liability policy was guilty of illegally taping the telephone conversations of employees.
KENTUCKY		No published decisions.	

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
LOUISIANA	Yes	Young v. Brown, 658 So. 2d 750 (La. Ct. App. 1995)	Insured pled guilty to negligent injuring.
	Yes	Nash v. Durapau, 592 So. 2d 504 (La. Ct. App. 1991)	Minor insured found guilty of theft.
	No	Sledge v. Continental Cas. Co., 639 So. 2d 805 (La. Ct. App. 1994)	Named insured allowed underage son to drive car at night. Auto accident resulted in death and injuries. Carrier attempted to deny coverage under auto policy. Court found that the exclusion violated public policy in the context of an auto policy.
	No	Ellis v. Transcontinental Ins. Co., 619 So. 2d 1130 (La. Ct. App. 1993)	Insured under a general liability policy was never criminally charged with a violation of the Fair Labor Standards Act.
MAINE		No published decisions.	
MARYLAND	Yes	St. Paul Fire and Marine Ins. Co. v. Aragona, 365 A.2d 309 (Md. Ct. Spec. App. 1976),	Attorney insured under a malpractice policy was guilty of embezzlement.

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
		aff'd, 378 A.2d 1346 (Md. 1977)	
	Yes	Medical Mut. Liab. Ins. Soc'y of Maryland v. Azzato, 618 A.2d 274 (Md. Ct. Spec. App. 1993)	Doctor insured under a medical malpractice policy pled guilty to two counts of violation of a controlled substance statute. Doctor provided cocaine to the claimant/patient who overdosed as a result of the use of the narcotic.
MASSACHUSETTS		No published decisions.	
	Yes	MASS. GEN. LAWS ANN., ch. 175, § 47(6)(b)(1997)	Insurers cannot insure "any person against legal liability for causing injury, other than bodily injury, by his deliberate or intentional crime or wrongdoing."
MICHIGAN	Yes	Allstate Ins. Co. v. Freeman, 443 N.W. 2d 734 (Mich. 1989)	Insured found guilty of intentionally discharging a firearm, but without malice.
	Court did not reach the issue.	Allstate Ins. Co. v. Mata, No. 170112 (Mich. Ct. App. 1997)	Allegedly insane insured murdered ex-fiancee and then killed himself.

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
	No	Farm Bureau Mut. Ins. v. Blood, 583 N.W.2d 476 (Mich. Ct. App. 1998)	Insured guilty of serving alcohol to a minor (auto policy).
	Yes	Allstate Ins. Co. v. Miller, 575 N.W. 2d 11 (Mich. Ct. App. 1997)	Insured was killed by police officers after opening fire in a restaurant, killing one patron.
	Yes	Allstate Ins. Co. v. Kabalka, 572 N.W.2d 265 (Mich. Ct. App. 1997)	Insured pled nolo contendere to prescribing medicine without a license, a misdemeanor.
	Yes	Allstate Ins. Co. v. Green, 831 F.2d 145 (6th Cir. 1987)	Alleged sexual assault by the insured's minor son. Exclusion not applicable because the assault was not committed by an insured person, but rather it was committed by two of his friends. The exclusion clause only bars coverage where injuries are caused by an insured.
	Yes	Allstate Ins. Co. v. Keillor, 511 N.W.2d 702	Insured's son guilty of furnishing alcohol to a minor. The

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
		(Mich. Ct. App. 1993)	minor was then involved in an auto accident.
	Yes	Allstate v. Hampton, 433 N.W.2d 334 (Mich. Ct. App. 1988)	Insured guilty of sexual assault on 12-year-old daughter.
MINNESOTA	No	Tower Ins. Co. v. Judge, 840 F. Supp. 679 (D. Minn. 1993)	Reckless homicide as a result of electrocution. Exclusion did not apply because the carrier failed to explain that the endorsement reduced coverage.
	Yes	Liebenstein v. Allstate Ins. Co., 517 N.W.2d 73 (Minn. Ct. App. 1994)	Insured convicted of assaulting a police officer and obstructing legal process.
MISSOURI	Yes	Western Cas. & Sur. Co. v. City of Palmyra, 650 F. Supp. 981 (E.D. Mo. 1987)	A commercial insured covered under a general liability policy was guilty of wiretapping.
	Court did not reach the issue	St. Paul Fire and Marine Ins. Co. v. Starr, 651 S.W. 2d 517 (Mo. App. 1983)	Attorney insured under a professional liability policy was guilty of "dishonesty, fraud,

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
			deceit, or misrepresentation."
	Court did not reach the issue	Metropolitan Prop. & Cas. v. Ham, 930 S.W.2d 5 (Mo. App. 1996)	Insured's 14-year-old daughter guilty of arson.
MISSISSIPPI	Yes	Allstate Ins. Co. v. Lewis, 918 F. Supp. 168 (S.D. Miss. 1995)	Insured pled guilty to manslaughter.
MONTANA		No published decisions.	
	Yes	MONT. CODE ANN. § 28-2-702 (1997)	*"Contracts which violate policy of the law"* – exemption from responsibility. "All contracts which have for their object, directly or indirectly, to exempt anyone from responsibility for his fraud, for willful injury to the person or property of another, or for violation of law, whether willful or negligent, are against the policy of the law."
NEBRASKA		No published decisions.	
NEVADA	Yes	Allstate Ins. Co. v. Foster, 693 F.	Insured pled guilty to lewdness to a minor.

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
		Supp. 886 (D. Nev. 1988)	
	Yes	Rivera v. Nev. Med. Liab. Ins. Co., 814 P.2d 71 (Nev. 1991)	Insured gynecologist under medical malpractice policy was convicted of sexually assaulting a female patient.
NEW HAMPSHIRE	Yes	Allstate Ins. Co. v. Stamp, 588 A.2d 363 (N.H. 1991)	Minor insured shot a police officer.
NEW JERSEY	Yes	Allstate Ins. Co. v. Schmitt, 570 A.2d 488 (N.J. Super. Ct. App. Div. 1990)	Insured pled guilty to aggravated assault by "recklessly caus[ing] bodily injury to another with a deadly weapon."
	No	Princeton Ins. Co. v. Chunmuang, 678 A.2d 1143 (N.J. Supp. App. Div. 1996), *rev'd*, 698 A.2d 9 (N.J. 1997)	Court did not apply exclusion to gynecologist under a medical malpractice policy even though the doctor pled guilty to "several counts" of sexual assault. The court found that the sexual assault in the case at issue resulted from a "medical incident" arising out of the supplying of "professional services".

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
NEW MEXICO	Yes	New Mexico Physicians Mut. Liab. Co. v. LaMure, 860 P.2d 734 (N.M. 1993)	Insured doctor convicted of felony assault after sexually assaulting a minor patients.
NEW YORK	No	Ins. Co. of N. Am. v. Chinoise Rest. & Trading Corp., 445 N.Y.S.2d 835 (1981)	Insured covered under a general liability policy.
	No	Green v. Allstate Ins. Co., 576 N.Y.S.2d 639 (1991)	Guilty plea to assault does not establish as a matter of law that the act was "criminal" in a civil action.
	No	Allstate Ins. Co. v. Zuk, 571 N.Y.S.2d 429 (1991)	Insured convicted of second degree manslaughter
NORTH CAROLINA	No	Durham Board of Educ. v. Nat'l Union Fire Ins. Co., 426 S.E.2d 451 (N.C. App. 1993)	Criminal acts exclusion did not apply to a board of education sued as a result of sexual assault by one of its teachers. The exclusion did not apply to the board because the civil lawsuit did not allege that the board was guilty of a criminal act.
NORTH DAKOTA		No pub. dec.	

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
	Yes	N.D. CENT. CODE, § 9-08-02 (1987)	*"Contracts Against the Policy of the Law"* "All contracts which have for their object, directly or indirectly, the exempting of anyone from responsibility for his own fraud or willful injury to the person or property of another, or violation of law, whether willful or negligent, are against the policy of the law."
OHIO	Yes	Steinke v. Allstate Ins. Co., 621 N.E.2d 1275 (Ohio Ct. App. 1993)	Insured convicted of disorderly conduct.
	No	Michigan Millers Ins. Co. v. Anspach, 672 N.E.2d 1042 (Ohio App. 1996)	Insured juveniles served as lookouts during burglary and arson. Juveniles did not know the house was occupied at the time. Death of occupants was covered because criminal act was intended toward property, not people.
	Yes	Allstate Ins. Co. v. Cutcher, 920 F. Supp. 796 (N.D. Ohio 1996)	Insured's minor son found "delinquent" as a result of the death of claimant.

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
			Age of "criminal" insured had no bearing on enforcement of exclusion.
OKLAHOMA	Yes	OKLA. STAT. ANN. tit. 15 § 212 (West 1993)	*"Certain contracts against policy of law"* "All contracts which have for their object, directly or indirectly, to exempt any one from responsibility for his own fraud, or willful injury to the person or property of another or violation of law, whether willful or negligent, are against the policy of the law."
	No	Lutheran Benev. Ins. Co. v. Nat'l Catholic Risk Retent., 939 F. Supp. 1506 (N.D. Okla. 1995)	Priest pled guilty to five counts of forcible sodomy, one count of indecent exposure, and five counts of lewd molestation. The court did not apply the exclusion under a church policy because the exclusion was contained only in the personal injury portion of the policy, not the bodily injury portion.

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
	Yes	All American Ins. Co. v. Burns, 971 F.2d 438 (10th Cir. 1992)	Bus driver insured under a church liability policy pled guilty to two counts of lewd molestation.
OREGON	Yes	Allstate Ins. Co. v. Sowers, 776 P.2d 1322 (Or. Ct. App. 1989)	Insured convicted of resisting arrest during a scuffle with a police officer.
PENNSYLVANIA	No	Bensalem Township v. Western World Ins. Co., 609 F. Supp. 1343 (E.D. Pa. 1985)	Exclusion did not apply to an insured under a general liability policy even though the insured violated the Age Discrimination in Employment Act.
	No	Allstate Ins. Co. v. Brown, 834 F. Supp. 854 (E.D. Pa. 1993)	Insured found guilty of assault against a police officer. Court reasoned that negligence allegation was enough to trigger coverage and defense obligation.
RHODE ISLAND		No published decisions.	
SOUTH CAROLINA		No published decisions.	
SOUTH DAKOTA		No published decisions.	
TENNESSEE	No	Allstate Ins. Co. Ins. Co. v. Garth,	Insured pled guilty to carrying a concealed

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
		No. 02A01-9409-CV-00201 1995 WL 593075 (Tenn. App. 1995)	weapon that discharged after it fell in her purse at a play and discharged killing one person.
	Yes	Allstate Ins. Co. v. Brooks, 814 S.W.2d 737 (Tenn. App. 1990)	Insured convicted of assault with a deadly weapon.
	Court did not reach the issue	Knox-Tenn Rental Co. v. The Home Ins. Co., 2 F.3d 678 (6th Cir. 1993)	Insured covered under a professional liability policy, pled guilty to fraud. The applicability of the exclusion was not reached by the court because the insurer failed to properly reserve its rights during the defense of the insured.
TEXAS		No published decisions.	
UTAH	No	Allstate Ins. Co. v. Worthington, 46 F.3d 1005 (10th Cir. 1995)	Exclusion not applicable in situation where the co-insured wife failed to warn authorities that her husband planned to kill the claimant.
VERMONT		No published decisions.	
VIRGINIA		No pub. dec.	

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
WASHINGTON	Yes	Allstate Ins. Co. v. Peasley, 932 P.2d 1244 (Wash. 1997)	Insured pled guilty to second degree reckless endangerment. Exclusion applies to intentional as well as unintentional criminal acts.
	Yes	Podiatry Ins. Co. v. Isham, 828 P.2d 59 (Wash. Ct. App. 1992)	Insured doctor violated the Consumer Protection Act by performing unnecessary surgery without the informed consent of the claimant.
	Court did not reach the issue	Cary v. Allstate Ins. Co., 897 P.2d 409 (Wash. Ct. App. 1995)	Insured stabbed and killed claimant's husband but was found insane in criminal proceeding. Exclusion was not needed in this coverage action (two insanity exclusions applied).
	No	Mendoza v. Rivera-Chavez, 945 P.2d 232 (Wash. Ct. App. 1997)	"Felony" exclusion under an auto policy was not enforced in situation where the insured was guilty of vehicular assault and vehicular homicide. Exclusion was found to violate public policy.

STATE	EXCL. APPL.**	CASE CITE OR STATUTORY CITE	CRIME/ COMMENTS
WEST VIRGINIA		No published decisions.	
WISCONSIN		No published decisions.	
WYOMING		No published decisions.	

IT'S BETTER TO HAVE TWELVE MONKEYS CHASING YOU THAN ONE GORILLA: *HUMANA INC. V. FORSYTH*, THE MCCARRAN–FERGUSON ACT, RICO, AND DETERRENCE

*Eric Beal**

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INTRODUCTION

The United States is the largest market for insurance in the world[1] and the insurance industry in the U.S. controls more than $2 trillion dollars in assets worldwide,[2] creating an environment rife with the potential for fraud and criminal activity.[3] Indeed, "[a]s early as 1866, the insurance trade, though still in its infancy was subject to widespread abuse."[4] In particular, healthcare fraud, committed by healthcare providers, consumers, and insurers alike continues to be pervasive,[5] intractable,[6] and costly.[7]

Insurance companies can bilk policyholders in many ways. For example, healthcare insurance contracts often stipulate that the insurer will pay a certain percentage of costs, e.g., 80%, leaving the policyholder with a co-payment of the remaining 20%. Some insurance companies negotiate secret

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1. *See* Brief of Amicus Curiae Trial Lawyers for Public Justice at *10, Humana v. Forsyth, 119 S. Ct. 710 (1999) (No. 97-303) (citing *Wishful Thinking, A World View of Insurance Solvency Regulation, Staff of Subcomm. on Oversight and Investigations of the House Comm. on Energy and Commerce,* 103d Cong. 1, 51 (1994) (hereinafter "Wishful Thinking")).

2. *See* S. REP. NO. 102-310, at 1 (1992). There are over 5,000 insurance companies and operations in the U.S. *See id.*

3. *See* STAFF OF HOUSE COMM. ON ENERGY AND COMMERCE, 101ST CONG., 2D SESS., FAILED PROMISES: INSURANCE COMPANY INSOLVENCIES (Comm. Print 101-P 1990) ("FAILED PROMISES"). The House Committee on Energy and Commerce concluded that:

> The business of insurance is uniquely suited to abuse by mismanagement and fraud. Making believable promises is a stock item in every con man's bag of tricks. The prepayment of large, often vast, sums of money with few restrictions lends itself naturally to monumental wasting of assets through greed, incompetence, and dereliction of duty. This combination of easy money based on easy promises makes the insurance industry an irresistible target for financial knaves and buccaneers.

Brief of Amicus Curiae Betty Cordial at *21, Humana v. Forsyth, 119 S. Ct. 710 (1999) (No. 97-303) (citing FAILED PROMISES).

4. United States v. Southeastern Underwriters Ass'n, 322 U.S. 533, 544 (1943). *See generally* 21 BRITANNICA, INSURANCE, 741-54 (15th ed. 1995).

5. The United States Attorney General ranks health care fraud, including Medicare/Medicaid billing fraud, behind only terrorism as the nation's most pressing criminal problem. *See* Thomas O'Donnel, *Clinton Enters Fray Over Health-Care Fraud*, DENV. BUS. J., July 18, 1997, at 15.

6. "Healthcare fraud, it appears, is evolving just as rapidly as the medical marketplace." Julie Johnson, *Managed Care Fraud: To Track Down Crime, Federal Officials Follow the Money Trail,* AM. MED. NEWS., May 20 1996, at 3.

7. Insurance fraud, including fraud perpetrated by providers and consumers, costs an estimated $30 billion dollars in 1997. *See* Jane See White, *How Provider Fraud Flattens Corporate Profits*, 16 BUS. & HEALTH 28 (March 1, 1998), *available in* 1998 WL 13573062.

discounts with health-care providers such as hospitals or clinics, with the result that the insurance company pays substantially less than 80% of costs and the policyholders unwittingly pay more than 20%.[8] Other frauds committed by insurance companies include "churning",[9] "low-balling",[10] and "twisting".[11]

Recently, consumers have brought class action law suits against insurance companies to halt these fraudulent practices[12] under a variety of legal theories, including the Racketeer Influenced Corrupt Organizations Act

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8. *See, e.g.*, Forsyth v. Humana, 114 F.3d 1467 (9th Cir. 1997) (insurance company negotiated secret discounts and allegedly created an elaborate cover-up to prevent being caught); Ambrose v. Blue Cross & Blue Shield, 95 F.3d 41 (4th Cir. 1996) (unpublished decision) (insurer negotiated secret volume discounts with care providers, which they applied only to their portion of costs); Hoover v. Blue Cross & Blue Shield, 855 F.2d 1538 (11th Cir. 1988); Everson v. Blue Cross & Blue Shield, 898 F. Supp. 532 (N.D. Ohio 1994); Misch v. Community Mut. Ins. Co., 896 F. Supp. 734 (S.D. Ohio 1994).

9. "Churning" occurs when insurance agents pressure policy-holders to cash-in existing policies for new, more expensive policies which result in higher premiums for the same or worse coverage for the consumer, and higher profits for the agent and the insurance company. *See* Sherman v. Kaiser, 664 A.2d 221, 223 (Pa. Commw. Ct. 1995); Diane A. Nygaard, *Class Actions Against Insurance Companies*, 34 TRIAL 75 (Oct. 1998). *See also* Eileen B. Eglin & Richard J. Rogers, *Agents' and Brokers' Liability: Understanding Their Integral Role*, 563 PRACT. L. INST. 109, 126-28 (1997); *Churning Suit Filed,* TAMPA TRIB., Jan. 17, 1998, at 1; William C. Rempel, *Lawyers Seek to Remove Judge in Prudential Class Action*, L.A. TIMES, Dec. 4, 1996, at D3; Scot J. Paltrow, *A Matter of Policy: How a State Becomes Popular with Insurers - But Not Consumers*, WALL ST. J., Jan. 14, 1998, at A1 (describing how a forklift operator was urged by American General Life & Accident Ins. Co. to cash out his $7,500 life-insurance policy and buy a new one, which cost more than twice as much for the same coverage).

10. "Low-balling" is the practice of insurers to under-compensate for an insured's loss. *See* 63 J. BUSINESS 145 (1990). *See also* Paltrow, *supra* note 9 at A1.

11. Twisting involves misrepresentations made about policies by insurers to induce consumers to switch insurance companies. *See* 4 COUCH ON INSURANCE § 55:20 (3d ed.1998). For example, the nation's second largest life-insurer, Metropolitan Life Ins., may be indicted for fraudulent sales practices by federal prosecutors. Met Life allegedly deceived consumers by marketing whole-life insurance policies as "savings and retirement" plans. *See* Rick Morales, *Metropolitan Life is Told it is Facing Indictment for Fraudulent Practices,* ST. LOUIS POST- DIS., October 9, 1998, at C11; *Reductio Ad Absurdum or 'Judicial Economy' ; Sup. Ct. Asked to Decide*, HEALTH & LIFE INS. LIT. R., July 23, 1997, at 9.

12. *See, e.g.*, Ambrose, 95 F.3d 41; Forsyth, 114 F.3d 1467. *See also* Eglin & Rogers, *supra* note 9; Robert Tomsho, *Slick Operation: Some Health Insurers Leave Patients to Foot Excessive Co-payments*, WALL ST. J., Aug. 21, 1995 at A1 (discussing the recent trend of class actions that challenge insurance companies' clandestine health care provider discounts); Katie Cook Morgan, Note, *Leaving the Management of "Managed Care" up to the States: The Health Insurance Industry and the Need for Regulation of the Regulators*, 65 U. CIN. L. REV. 225 (1996).

("RICO").[13] Because RICO is a federal law that provides for treble damages and fee shifting,[14] it is an effective anti-fraud action which is used by insurance consumers, insurance companies, and state insurance commissioners.[15]

Insurance companies have attempted to avoid liability under RICO, arguing that the McCarran-Ferguson Act[16] preempts general federal laws[17] such as RICO. Insurers argue that the McCarran-Ferguson Act ("MFA") bars a cause of action under RICO because to do so would "invalidate, impair, or supercede" state laws that regulate the business of insurance.[18] Under this theory, RICO's private right of action and treble damage remedies "impair" state laws which punish less severely the same conduct as that which RICO also prohibits.

Courts of Appeals have disagreed over the issue of whether state laws that regulate the business of insurance are "impair[ed], invalidate[d], or supercede[d]" by federal laws such as RICO which proscribe the same conduct, but which provide different remedies.[19] In *Forsyth v. Humana*

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13. 18 U.S.C. §§ 1961-1968 (1982).

14. *See* Part IIB *infra* at 9-10.

15. "Civil RICO is probably the single most effective deterrent that presently exists against national and international conspiracies to evade oversight by insurance regulators and to defraud consumers of insurance products." *See* James E. Long & Donald M. Wright, *RICO: Law, Practice, and Issues in the Context of Insurer Insolvency*, 9 J. INS. REG. 344, 345 (1991). Insurers, too, benefit from RICO. *See* Part IVA *infra* at 24-25. Insurance company receivers, who are court-appointed to manage the estates of insolvent insurance companies, also use RICO against the looting of insurance company assets through embezzlement and fraud; in other words, when insurance companies are victimized by fraud from within. *See* Brief of Betty Cordial, Humana v. Forsyth, 119 S. Ct. 710 (1999) (No. 97-303) at *1-*4.

16. 15 U.S.C. §§ 1011-1013. The Act states in relevant part: "No Act of Congress shall be construed to invalidate, impair, or supercede any law enacted by any state for the purpose of regulating the business of insurance . . . ." *Id.* at § 1012(b).

17. General federal laws are those which do not specifically relate to the business of insurance. *See* Barnett Bank v. Nelson, 517 U.S. 25 (1996).

18. *See, e.g.*, Brief for the Petitioners, Humana v. Forsyth, 119 S. Ct. 710 (1999) (No. 97-303); Brief of Amicus Curiae Alliance of American Insurers, Humana v. Forsyth, 119 S. Ct. 710 (1999) (No. 97-303); Brief of Amicus Curiae Consumer Credit Insurance Association, Humana v. Forsyth, 119 S. Ct. 710 (1999) (No. 97-303); Farrokh Jhabvala, *The "Direct Conflict" Test for First Clause McCarran-Ferguson Cases*, 33 TORT & INS. L. J. 1147 (1998).

19. *Compare* Ambrose v. Blue Cross & Blue Shield, 891 F. Supp. 1153 (E.D. Vir. 1995), *aff'd*, 95 F. 3d 41 (4th Cir. 1998) (unpublished opinion) (concluding that RICO's treble damages remedy would greatly impair Virginia's careful balancing of insurance regulations and remedies); Doe v. Norwest Bank Minnesota, 107 F.3d 1297, 1307 (8th Cir. 1997) ("[T]he intrusion of RICO's substantial damage provisions into a state's insurance regulatory program may so impair the state law as to bar application of RICO."); and Kenty v. Bank One, 92 F.3d

Inc.,[20] the U.S. Court of Appeals for the Ninth Circuit concluded that the McCarran-Ferguson Act does not bar the application of RICO to the business of insurance.[21] The court held that RICO does not "impair, invalidate, or supercede" Nevada state laws that regulate the business of insurance because RICO does not directly conflict with any Nevada laws that regulate insurance.[22] The U.S. Supreme Court agreed to review the Ninth Circuit's interpretation of the McCarran-Ferguson Act.[23] In *Humana Inc. v. Forsyth*, the Court unanimously affirmed the Ninth Circuit's decision, adopting the "direct conflict" approach first articulated by Judge Easterbrook in *NAACP v. American Family Mutual Insurance Co.*[24]

In Section II, this case note discusses the histories of RICO and the McCarran-Ferguson Act. Section III provides the facts, procedural history of, and conclusions of law in *Humana Inc. v. Forsyth*. Section IV explores the origins of the "direct conflict" test and argues that the U.S. Supreme Court correctly concluded that RICO should remain a viable cause of action against

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384, 392 (6th Cir. 1996) ("The different liability under Ohio law for violations, as well as different standards of proof necessary to demonstrate misrepresentations, means that RICO does impair the ability of Ohio to regulate [unfair and deceptive acts].") *with* Sabo v. Metropolitan Life Ins. Co., 137 F.3d 185 (3d Cir. 1998) (providing a survey of decisions on this issue, rejecting the 'careful balance' argument of Ambrose, and holding that RICO does not 'invalidate, impair, or supercede' Pennsylvania's scheme of insurance regulation); NAACP v. American Family Mut. Ins. Co., 978 F.2d 287, 297 (7th Cir. 1992) ("[S]tate and federal rules that are substantively identical but differ in penalty do not conflict with or displace each other.") and Merchants Home Delivery Serv., 50 F.3d 1486, 1492 (9th Cir. 1995).

20. 114 F.3d 1467 (9th Cir. 1997).

21. *See id.* at 1480.

22. *Id.* The term "conflict" refers to the concept of "conflict preemption" as discussed *infra* note 42 and part IVA.

23. The question presented was as follows:

> Whether the application of a federal statute—here the Racketeer Influenced and Corrupt Organizations Act ("RICO")–to the business of insurance would "invalidate, impair, or supercede" state law regulating the same conduct in contravention of the McCarran-Ferguson Act where the state and federal statutory prohibitions are parallel, but the remedies provided are materially different.

Brief on the Merits of Petitioners at *i, Humana Inc. v. Forsyth, 119 S. Ct. 710 (1999) (No. 97-303).

24. 978 F.2d 287, 297 (7th Cir. 1992). The Court held that: "RICO can be applied in this case in harmony with [Nevada's] regulation. When federal law is applied in aid or enhancement of state regulation, and does not frustrate any declared state policy or disturb the State's administrative regime, the McCarran-Ferguson Act does not bar the federal action." 119 S. Ct. 710, 714 (1999).

insurance fraud. The meaning of the McCarran-Ferguson Act in its historical context supports the conclusion that the Act creates a form of "inverse preemption" under which only general federal laws that directly conflict with state laws enacted to regulate insurance are preempted. Part IVB argues that if RICO actions against insurance fraud are barred by the McCarran-Ferguson Act, insurers will not be sufficiently deterred from defrauding policyholders.

I. HISTORY

A. The McCarran-Ferguson Act

The McCarran-Ferguson Act was enacted in 1945 in reaction to *United States v. South-Eastern Underwriters Association*.[25] The Court in *South-Eastern Underwriters* held that insurance transactions were inter-state commerce,[26] and thus could be regulated by federal laws[27] under the Commerce Clause[28] of the United States Constitution. Before *South-Eastern Underwriters*, it was assumed that the insurance business did not implicate the commerce clause and, therefore, that Congress could not regulate the business of insurance.[29] *South-Eastern Underwriters* raised concerns that

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25. 322 U.S. 533 (1944). *See generally* Alan M. Anderson, *Insurance and Antitrust Law: The McCarran-Ferguson Act and Beyond*, 25 WM. & MARY L. REV. 81, 82-95 (1983) (discussing primary aspects of the MFA and the forces behind adoption of the act); Jonathan R. Macey & Geoffrey P. Miller, *The McCarran-Ferguson Act of 1945: Reconceiving the Federal Role of Insurance Regulation*, 68 N.Y.U. L. REV. 13, 20-24 (1993) (discussing primary provisions of the MFA); Nancy R. Page, Comment, *Risky Business: Consumer Protection of the Insurance Industry*, 23 HARV. J. ON LEGIS. 287, 294-96 (1986) (summarizing the regulatory effects of the MFA); Willy E. Rice, *Federal courts and the Regulation of the Insurance Industry: An Empirical and Historical Analysis of Courts' Ineffectual Attempts to Harmonize Federal Antitrust, Arbitration, and Insolvency Statutes with the McCarran-Ferguson Act 1941-1993*, 43 CATH. U. L. REV. 399, 400-1, 410-13 (1994) (providing overview of pre-MFA court decisions and of major provisions of the Act).

26. 322 U.S. at 539-61.

27. In particular, the Sherman Antitrust Act, 15 U.S.C. §§ 1-7, which prohibits monopolies, was feared by insurers. *See* R.K. Powers, Note, *The Year of S.E.V.A.*, CHI. KENT L. REV. 317, 320 (1945) (insurance industry reaction to South-Eastern Underwriters and legislative history of the MFA).

28. "Congress shall have Power . . . To regulate Commerce . . . among the several States . . . ." U.S. CONST. Art 1, § 8, cl. 3.

29. *See* Paul v. Virginia, 75 U.S. 168, 183 (1869). *See also* United States Dept. of Treasury v. Fabe, 508 U.S. 491, 499 (1993); St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531, 538-539 (1978).

federal law would preempt state laws that regulate insurance.[30] In response to these concerns, Congress passed the McCarran-Ferguson Act, which declared: "[T]he continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States."[31] Specifically, the McCarran-Ferguson Act provides that: "No Act of Congress shall be construed to invalidate, impair, or supercede any law enacted by any state for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless the Act specifically relates to the business of insurance . . . ."[32] One year later in 1946, the U.S. Supreme Court noted that: "(o)bviously Congress' purpose was broadly to give support to the existing and future state systems for regulating and taxing the business of insurance."[33]

Courts have adopted a three-part test to determine whether, under the McCarran-Ferguson Act, state law bars the availability of federal remedies: 1) does the federal statute at issue "specifically relate to the business of insurance"?; 2) was the state statute that might be impaired by a federal law enacted "for the purpose of regulating the business of insurance?"; and 3) would application of the federal statute "impair, invalidate, or supercede" the state statute?[34] If the federal statute does specifically relate to the business

30. *See Barry*, 438 U.S. at 539. Under the Supremacy Clause of the U.S. Constitution, federal law trumps state law. *See* Perez v. Campbell, 402 U.S. 637, 649 (1971) (state laws which "stand as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress" are invalid under the Supremacy Clause) (citing Hines v. Davidowitz, 312 U.S. 52, 67 (1941)).

31. 15 U.S.C. § 1101 (1982).

32. 15 U.S.C. § 1012(b). The Act provided further that the Clayton Act, 15 U.S.C. §§ 12-27, the Sherman Act, 15 U.S.C. §§ 1-7, and Federal Trade Commission Act, 15 U.S.C. § 41, et. seq., still apply to the extent that state laws do not regulate activities prohibited under these federal laws. *See* § 1012(b).

33. SEC v. National Securities, Inc., 393 U.S. 453, 458 (1969) (quoting Prudential Ins. Co. v. Benjamin, 328 U.S. 408, 429 (1946)) (internal quotations omitted).

34. *See* United States Dept. of Treasury v. Fabe, 508 U.S. 491 (1993); Ambrose v. Blue Cross & Blue Shield, 891 F. Supp. 1153, 1158 (E.D. Va. 1995), *aff'd*, 95 F.3d 41 (4th Cir. 1996); Doe v. Norwest Bank Minn., 107 F.3d 1297, 1305 (8th Cir. 1997); Davister Corp. v. United Rep. Life Ins. Co., 152 F.3d 1277 (10th Cir. 1998); Forsyth v. Humana, 114 F.3d at 1479; Kenty v. Bank One, 92 F.3d 384, 391 (6th Cir. 1996); Merchants Home Delivery Serv. v. Hall, 50 F.3d 1486, 1489 (9th Cir. 1995); NAACP v. American Family Mut. Ins. Co., 978 F.2d 287 (7th Cir. 1992); Sabo v. Metropolitan Life Ins. Co., 137 F.3d 185, 188 (3d Cir. 1998); United States v. Rhode Island Insurers' Insolvency Fund, 80 F.3d 616, 619 (1st Cir. 1996).

of insurance, then it is not barred under the McCarran-Ferguson Act.[35] If the state statute which is in peril of being impaired, invalidated, or superceded was not enacted for the purpose of regulating the business of insurance, then it is afforded no protection under the Act.[36] Finally, if the federal law does not "invalidate, impair, or supercede" the state law in question, then it is not barred under the McCarran-Ferguson Act.[37]

It is undisputed that RICO does not specifically relate to the business of insurance.[38] There is likewise little controversy over whether the state laws in question were enacted to regulate the business of insurance.[39] It is the meaning of the phrase "invalidate, impair, or supercede" that has been contested.[40] It is this third part of the test that the *Humana* decision addresses.

Because the phrase "invalidate, impair, of supercede" is not defined within the McCarran-Ferguson Act, courts have supplied their own interpretations. In addition to relying on the traditional tools of statutory construction,[41] many courts have borrowed from federal preemption

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Some courts use a four part test, but they are substantively equivalent. *See, e.g.,* Forsyth v. Humana, 114 F.3d at 1479.

35. *See Humana*, 119 S. Ct. at 716; *Fabe*, 508 U.S. at 501.

36. *See id.*

37. *See id.*

38. *See, e.g., Humana*, 119 S. Ct. at 716 ("RICO is not a law that 'specifically relates to insurance'."); *Kenty*, 92 F.3d at 391; *Merchants Home*, 50 F.3d at 1489; *Sabo*, 137 F.3d at 188; *Norwest Bank*, 107 F.3d at 1305; *Ambrose*, 891 F. Supp. at 1159. Although RICO does not expressly mention insurance in its text, insurance was included as an example of legitimate businesses that are infiltrated by criminals. *See* S. Rep. No. 91, 60, 91st Cong., 1st Sess. 76 (1969).

39. *See id.* In *Forsyth v. Humana*, the policyholders argued that fraud is not "the business of insurance," and therefore the state laws that stand to be preempted by RICO would not apply to the conduct. The court rejected this argument, stating that: "It is useless 'to point to a practice forbidden by federal law . . . and observe that this practice is not itself insurance' . . . [because] such an interpretation would 'read the McCarran-Ferguson Act out of existence.'" 114 F.3d at 1479-80. *See also* D. Howard, *Uncle Sam versus the Insurance Commissioners: A Multi-Level Approach to Defining the "Business of Insurance" Under the McCarran-Ferguson Act*, 25 WILLIAMETTE L. REV. 1 (1989).

40. *See* Jhabvala, *supra* note 18 at 1153 ("It is the third factor-whether application of a general federal law will "invalidate, impair, or supercede" a state statute enacted for the purpose of regulating the business of insurance-that has become the crucial battleground. . .")

41. These tools are: the "plain meaning" of the statute, *see* United States v. Fabe, 508 U.S. at 500 (quoting Group Life Ins. & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 210 (1979)) ("[T]he starting point in a case involving construction of the McCarran-Ferguson Act, like the starting point in any case involving the meaning of a statute, is the language of the statute itself."); *SEC*, 393 U.S. at 458-60, and the intent of the legislature, *see SEC*, 393 U.S.

jurisprudence,[42] reasoning that the McCarran-Ferguson Act creates an "inverse-preemption" under which general federal laws may be preempted by state laws that are enacted to regulate the business of insurance.

The notion that the McCarran-Ferguson Act creates an "inverse-preemption" originated in *NAACP v. American Family Insurance Co.*[43] The plaintiffs in *American Family* alleged that they were denied homeowner's insurance policies on account of their race in violation of the Fair Housing Act ("FHA").[44] The defendants argued that because the FHA does not specifically mention insurance, and because enforcing it would "invalidate, impair, or supercede" Illinois state laws that regulate insurance, the McCarran-Ferguson Act bars the application of the Fair Housing Act to the business of insurance.[45] Judge Easterbrook, writing for the court, rejected this argument and instead concluded that the McCarran-Ferguson Act establishes an "inverse preemption" under which only federal laws that "directly conflict" with state laws are preempted.[46] Even though the court in *American Family* cites no precedent for this conclusion,[47] a majority of other

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at 458 ("The legislative history of the McCarran-Ferguson Act offers no real assistance."); *Fabe*, 508 U.S. at 507-8 (examining the McCarran-Ferguson Act's legislative history).

42. "Preemption analysis is invoked whenever the Court is called upon to examine the interplay between the enactments of two different sovereigns-one federal and the other state." Community Communications Co. v. Boulder, 455 U.S. 40, 61 (1982). There are three types of preemption: (1) "express preemption," in which Congress defines the extent to which a federal law preempts state law; (2) "field preemption," in which Congress so pervasively regulates a given issue, e.g., nuclear power or labor relations, that state laws which infringe on the 'field' are preempted, even though Congress did not explicitly so provide; and (3) "conflict preemption," in which federal law preempts state laws that 'conflict' with state laws, i.e., it is impossible to comply with both laws, or the state law "stands as a obstacle to the accomplishment and execution of the full purposes and objectives of Congress." Boggs v. Boggs, 117 S. Ct. 1754, 1762 (1997); *See also* Gade v. National Solid Waste Management Ass'n, 505 U.S. 88, 98 (1992).

43. 978 F.2d at 293 ("The McCarran-Ferguson Act establishes a form of inverse preemption, letting state law prevail over general federal rules–those that do not 'specifically relate to the business of insurance.'").

44. *See id.* at 291. The Fair Housing Act, 42 U.S.C. §§ 3601-3631 (1968).

45. *See id.* at 295.

46. *See id.* at 296 ("The McCarran-Ferguson Act is a form of inverse preemption, so principles defining when state remedies conflict with (and so are preempted by) federal law are pertinent in deciding when federal rules invalidate, impair, or supercede state rules.").

47. *Cf.* Villafane-Neriz v. FDIC, 75 F.3d 727, 735 (1st Cir. 1996) (the MFA "transformed the legal landscape by overturning the normal rules of preemption." Indeed, the [MFA] "imposes what is, in effect, a clear statement rule, a rule that state laws enacted for the purpose of regulating the business of insurance do not yield to *conflicting* federal statutes unless a

Courts of Appeals have followed the Seventh Circuit's lead by adopting a "direct conflict" test.[48]

B. The Racketeer Influenced Corruption Organizations Act

RICO[49] was enacted to combat organized crime in the United States, a "highly sophisticated, diversified and widespread activity that annually drains billions of dollars from America's economy by unlawful conduct and the illegal use of force, fraud, and corruption."[50]

Although "the primary purpose of RICO [is to address] the infiltration of legitimate businesses [by organized crime],"[51] legitimate businesses such as insurance "enjoy neither an inherent incapacity for criminal activity nor immunity from its consequences."[52]

RICO makes it unlawful for "any person employed by or associated with any enterprise engaged in [or affecting] interstate or foreign commerce, to . . . participate . . . in the conduct of the enterprise's affairs through a pattern of

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federal statute specifically requires otherwise.") (citing United States v. Fabe, 508 U.S. at 500, 507) (internal quotes omitted) (emphasis added).

48. *See, e.g.*, Merchants Home Delivery Serv. Inc. v. Hall, 50 F.3d 1486, 1492 (9th Cir. 1995); Murff v. Professional Medical Ins. Co., 97 F.3d 289, 292 (8th Cir. 1996) (holding that the MFA does not preempt application of the Age Discrimination in Employment Act); Nationwide Mut. Ins. Co. v. Cisneros, 52 F.3d 1351, 1363 (6th Cir. 1995) (citing American Family and holding that the additional remedies provided by the FHA do not conflict with Ohio law); Sabo v. Metropolitan Life Ins. Co., 137 F.3d 185, 194-95 (3d Cir. 1998); *Villafane-Neriz*, 75 F.3d at 735 (1st Cir. 1996). *But see* Ambrose, 95 F.3d at 41 (concluding that RICO's treble damages remedy would greatly impair Virginia's careful balancing of insurance regulations and remedies).

49. Racketeer Influenced and Corrupt Organizations Act, Pub. L. No. 91-452, 84 Stat. 922 (1970) (codified at 18 U.S.C.§§ 1961-1968 (1982)). Congress enacted RICO as Title IX of the Organized Crime Control Act of 1970. RICO's "legislative history clearly demonstrates that . . . [Congress] intended [RICO] to provide new weapons of unprecedented scope for an assault upon organized crime and its economic roots." Russello v. United States, 464 U.S. 16, 26 (1983).

50. Organized Crime and Control Act of 1970, Pub. L. 91-452, 84 Stat. 922 (Statement of Findings and Purpose). For a detailed discussion of RICO's legislative history, see G. Robert Blakey, *The RICO Civil Fraud Action in Context: Reflections on Bennett v. Berg*, 58 NOTRE DAME L. REV. 237 (1982).

51. U.S. v. Turkette, 452 U.S. 577, 591 (1981). *See also* Sedima, S.P.R.L. v. Imrex Corp., 473 U.S. 479 (1985). The Court admonished that: "The fact that [RICO] is used against respected businesses allegedly engaged in a pattern of specifically identified criminal conduct is hardly a reason for assuming [it] is being misconstrued." *Id.* at 499.

52. *Sedima*, 473 U.S. at 499.

racketeering activity."[53] RICO provides a private right of action under which "any person injured in his business or property by reason of a violation" of RICO may bring suit to recover threefold the damages sustained plus "the cost of suit, including a reasonable attorney's fee."[54] Congress directed that RICO's "provisions . . . shall be liberally construed to effectuate its remedial purposes."[55] Although the lower courts have attempted to restrict RICO's reach,[56] and despite calls to reform the RICO "monster,"[57] the U.S. Supreme Court continues to interpret RICO broadly.[58]

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53. 18 U.S.C. § 1962(c). Racketeering activity includes: "any act . . . 'indictable' under numerous specific federal criminal provisions, including mail and wire fraud." *Sedima*, 473 U.S. at 481 (1985). *See* 18 U.S.C. § 1961(1)(A). Background material on the elements and burdens of proof of RICO would be gratuitous because the merits of the respondent's RICO claim against Humana are not an issue in this appeal. For information on the mechanics of RICO litigation, see JED S. RAKOFF & HOWARD W. GOLDSTEIN, CIVIL RICO AND CRIMINAL LAW AND STRATEGY (1998).

54. 18 U.S.C. § 1964(c). In addition, the United States may bring criminal charges or initiate civil proceedings against those who violate RICO. *See* 18 U.S.C. § 1963 (criminal penalties); § 1964(a) and (b) (civil proceedings initiated by the Attorney General).

55. Organized Crime Control Act of 1970, Pub. L. No. 91-452, tit. IX, § 904(a), 84 Stat. 922, 947. The U.S. Supreme Court has endorsed an expansive reading of RICO. *See Sedima*, 473 U.S. 479 at 498.

56. *See generally* Jost, *The Fraudulent Case Against RICO*, CAL. LAW., at 49 (When the private bar began to bring RICO suits, the district courts reacted with hostility and undertook judicially to redraft the statute in an effort to dismiss civil suits in all possible ways); Susan Getzendanner, *Judicial "Pruning" of "Garden Variety Fraud" Civil Rico Cases Does Not Work: It's Time for Congress to Act*, 43 VAND. L. REV. 673 (urging elimination of mail and wire fraud as predicate acts to narrow civil RICO); Paul H. Rubin and Robert Zwirb, *The Economics of Civil RICO*, 20 U.C. DAVIS L. REV. 883, 887-95 (1987).

57. The controversy over the scope of RICO has created "the widest and most persistent circuit split on an issue of federal law in recent memory." H.J., Inc. v. Northwestern Bell Tel. Co., 492 U.S. 229, 251 (1989) (Scalia, J. concurring). For a thorough discussion of the forces that seek RICO reform and a rebuttal of their arguments, see G. Robert Blakey & Thomas A. Perry, *An Analysis of the Myths that Bolster Efforts to Rewrite RICO and the Various Proposals for Reform: "Mother of God ' Is this the End of RICO ?"*, 43 VAND. L. REV. 851 (1990).

58. *See, e.g.*, Anne B. Poulin, *RICO: Something for Everyone*, 35 VILL. L. REV. 853, 860 (1990) ("A number of lower courts sought avenues to narrow [civil RICO], but the Supreme Court has refused to narrow it to any significant degree."). For example, the U.S. Court of Appeals for the Second Circuit attempted to limit civil RICO by requiring plaintiffs to allege that: 1) the defendants had been convicted of a RICO violation or a predicate act, e.g., mail fraud, upon which their RICO claim was based; and 2) that the injury to the plaintiff was caused by an activity which RICO was designed to deter. *See Sedima*, 741 F.2d at 495-502. While the U.S. Supreme Court noted that "private civil actions under the statute are being brought almost solely against [respected and legitimate enterprises], rather than against the archetypal, intimidating monster," it nevertheless reversed the Second Circuit, reasoning that:

II. *HUMANA INC. V. FORSYTH*

A. Facts and Procedural History

During the period of 1985 through 1988 Forsyth and the other respondents contracted for health insurance through employee benefit plans with Humana Health Insurance Inc.[59] There were two classes of plaintiffs: the employer purchasers of group health insurance (Premium Payors), and the employee beneficiaries of those policies who made coinsurance payments for health care (Co-Payors).[60] The contracts provided that Humana Insurance would pay 80% of the employee's hospital charges (over and above the deductible) while Co-Payors were responsible for the remaining 20%.[61] Humana Insurance negotiated a discount with Humana Hospital Sunrise,[62] however, that resulted in Humana Insurance paying substantially less than its 80% obligation (and the Co-Payors paying much more than 20%).[63]

"RICO is to be read broadly" as "an aggressive initiative to supplement old remedies and develop new methods for fighting crime." *Sedima*, 473 U.S. at 497, 498.

The lower courts have generally been reluctant to allow RICO's treble damages, provision for reasonable attorneys fees, and the stigma of being a "racketeer" to be leveled against 'garden variety' offenders. 'Garden variety' offenses arise out of business deals gone bad. For instance, a bank might be sued under RICO for charging a higher rate of interest than that stipulated in the loan agreements. *See* Haroco, Inc. v. American Nat'l Bank and Trust Co., 747 F.2d 384, 385 (7th Cir. 1984). Or a policyholder may sue an insurance agent after the agent's insurance company became insolvent and failed to pay its claims. *See* Ocean Energy II, Inc., v. Alexander & Alexander, Inc., 868 F.2d 740, 741-42 (5th Cir. 1989).

59. *See Forsyth*, 114 F.3d at 1471. Humana Inc. allegedly created Humana Insurance in the early 1980's as a way to direct business to hospitals owned by Humana during a period of diminishing hospital usage. *See* Brief for Respondents at *1, Humana v. Forsyth, 119 S. Ct. 710 (No. 97-303) (quoting 1988 Humana Annual Report).

60. *See Forsyth*, 114 F.3d at 1472. Since the district court granted Humana's motion for summary judgment against the Premium Payor's RICO claim because the Premium Payor Class failed to "adequately demonstrate a direct relationship between the injury asserted and the injurious conduct alleged or a concrete financial injury for the purposes of RICO," *Forsyth*, 827 F. Supp. 1498,1520 (D. Nev. 1995), only the Co-Payor's RICO claim was on appeal to the U.S. Supreme Court and only it will be dealt with here.

61. *See Forsyth*, 114 F.3d at 1472.

62. *See id.* The discount allegedly started at 40% in 1985, increased to 55.7% in 1986, and then retroactively increased to 89.1% at the end of 1986. *See* Respondent's Brief at *2, n.3.

63. *See Forsyth*, 114 F.3d at 1472. For example, the average charge for four days of hospitalization was $5,000, which results in a co-payment of $1,000. Of the $5,000, Humana insurance should have paid $4,000 (80% X 5,000). Instead, after the 89% discount from Humana Hospital Sunrise, they paid only $550 (5,000-(89% X 5,000)). The co-payment of $1,000 to Humana Insurance represents an overcharge of $890. This fraud allegedly resulted in over 20 million dollars in illicit profit for Humana Insurance. *See* Respondent's Brief at *2,

Notwithstanding this arrangement, Humana Insurance allegedly falsely represented to the Co-Payors that it was paying 80% of the cost of care.[64]

The plaintiffs brought a class action asserting, *inter alia*, that Humana violated RICO by engaging in a scheme to defraud the Co-Payors.[65] Humana filed a motion for summary judgment, arguing that the plaintiff's RICO action was barred by the McCarran-Ferguson Act. The district court granted the motion, reasoning that to allow plaintiffs to sue under RICO would "invalidate, impair, or supercede" Nevada's "comprehensive regulatory scheme."[66] Specifically, the court wrote: "For this court to allow Plaintiffs to pursue the harsher RICO penalties for behavior which the Nevada Legislature apparently did not deem worthy of such penalties, would be tantamount to allowing Congress to intercede in an area expressly left to the states under the McCarran-Ferguson Act."[67] The court concluded by noting that because the Employee Retirement Income Security Act preempts causes of action under Nevada state law [68] and the McCarran-Ferguson Act bars a

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n.2. Columbia/HCA Healthcare Corp. is allegedly involved in a similar scheme in Florida. Its hospitals are accused of giving "hefty discounts" to insurance companies, and in return, the insurance companies funnel patients to the hospitals which then raise the prices to offset the discounts. *See* Greg Martin, *Florida man's lawsuit claims medical fraud*, LAS VEGAS REV. J., Oct. 9, 1998 at 1A.

64. For example, Humana sent forms called "Explanation of Benefits" ("EOBs") to co-payors which falsely represented that Humana had paid their 80% share of the cost of care. *See* Brief for Respondents at *3.

65. *See Forsyth*, 827 F. Supp. at 1498-99. In addition to the RICO cause of action, the plaintiffs alleged that Humana violated the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 et seq. ERISA is a "comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans" by regulating such plans. Shaw v. Delta Air Lines, 463 U.S. 85, 90 (1983). The plaintiffs alleged that Humana breached a fiduciary duty owed to the Co-Payor class, engaged in transactions prohibited by ERISA, and retained excessive compensation. *Forsyth*, 827 F. Supp at 1498-99. Finally, the plaintiffs alleged that Humana committed antitrust violations prohibited by the Sherman Act. The district court granted summary judgment on the Sherman Act action and held that the although the Co-Payor class could assert an ERISA action for benefits due under the benefits plan, damages under ERISA are limited to the amount that they were overcharged for co-payments. *Id.* at 1508.

66. Nevada's regulatory scheme consists of the following laws: NEV. REV. STAT. § 686A.310 (2) (Michie 1997) (after a 1987 amendment, provides a private cause of action to insureds for deceptive claims processing practices by insurers); NEV. REV. STAT. § 689B.061 (Michie 1997) (requiring that benefits from discounts be applied to a policyholder's co-payment); NEV. REV. STAT. §§ 207.350-207.520 (Michie 1997) (Nevada's "little RICO" statute).

67. *Forsyth*, 827 F. Supp. at 1521.

68. See *infra* note 164 for a discussion of ERISA preemption.

RICO action, its ruling may be perceived as leaving the plaintiffs without an adequate remedy.[69]

On appeal, the Ninth Circuit affirmed the district court's ruling on ERISA (including damages),[70] but it reversed the grant of summary judgment against the Co-Payor's RICO claim.[71] The court concluded that although there is "symmetry" between RICO's private right of action and the administrative scheme under Nevada law,[72] "[t]his symmetry . . . does not create a conflict between federal and state law," and thus the Co-Payor's RICO action is not barred by the McCarran-Ferguson Act.[73] In reaching this conclusion, the court relied on *Merchants Home Delivery Service Co. v. Hall*,[74] in which the court adopted the "direct conflict" test as enunciated in *NAACP v. American Family*.[75]

B. The U.S. Supreme Court Decision

Writing for a unanimous court, Justice Ginsburg affirmed the Ninth Circuit's ruling.[76] The Court phrased the question on appeal as follows: "Does a federal law, which proscribes the same conduct as state law, but provides materially different remedies, 'impair' state law under the McCarran-Ferguson Act?"[77] The Court concluded that under the McCarran-Ferguson Act federal regulation is not precluded "merely because the

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69. "[T]he court recognizes that Plaintiffs may view the interplay between the McCarran-Ferguson Act and ERISA as posing a preemptive 'Catch-22,' with McCarran-Ferguson precluding Plaintiff's federal RICO claim and ERISA barring Plaintiff's state RICO claim." *Forsyth*, 827 F. Supp. at 1522.

70. "[T]he co-payors have already won a judgment for damages under [ERISA] for the injuries they suffered as a result of defendant's actions. The district court determined, and we agree, that the Co-Payors are entitled to recover . . . all amounts they were forced to pay over and above their contractual co-payment obligation." *Forsyth*, 114 F.3d at 1475.

71. *See id.* at 1481-82.

72. *See supra* note 66 for a description of Nevada's regulatory scheme.

73. "We held that the application of the federal statute although it "prohibited" acts which were also prohibited under a state's insurance laws does not 'invalidate, impair, or supercede' the state's laws under § 2(b) of the McCarran-Ferguson Act." *Forsyth*, 114 F.3d 1180.

74. 50 F.3d 1486 (9th Cir. 1995)

75. *See Merchants Home*, 50 F.3d at 1492 ("We adopt the Seventh Circuit's well reasoned approach.").

76. *See* 119 S. Ct. at 714. The 9-0 vote is somewhat surprising, especially given that Chief Justice Renquist has characterized RICO as "very possibly the single worst piece of legislation on the book," and has exhorted: "Get RICO Cases Out of My Courtroom." Rehnquist, *Get RICO Cases Out of My Courtroom*, WALL. ST. J., May 19, 1989, at A14.

77. *Id.* at 715.

regulation imposes liability additional to, or greater than, state law."[78] The Court reasoned that: "Were this not so federal law would "impair" state insurance laws imposing fees or taxes whenever federal law imposed additional fees or greater tax liability."[79]

The Court's interpretation of the McCarran-Ferguson Act adopts the "direct conflict" test of *American Family*. The Court construed the text of section 2(b) of the McCarran-Ferguson Act as follows:

> When federal law does not *directly conflict* with state regulation, and when application of the federal law would not frustrate any declared state policy or interfere with a State's administrative regime, the McCarran-Ferguson Act does not preclude its application.[80]

Applying these criteria to the facts at hand, the Court stated: "We see no frustration of state policy here. RICO's private right of action and treble damages provision appear to complement Nevada's statutory and common-law claims for relief."[81] In reaching this conclusion, the Court noted that no official from Nevada "filed [a] brief at any stage of this lawsuit urging that application of RICO to the alleged conduct would frustrate any state policy, or interfere with the State's administrative regime."[82]

III. ANALYSIS

The "direct conflict" inverse-preemption test was introduced by Judge Easterbrook in *NAACP v. American Family*.[83] Although some of Judge

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78. *Id.* at 717. Or as Easterbrook put it: "Duplication is not conflict." *American Family*, 978 F.2d at 295.

79. *Forsyth*, 119 S.Ct. at 717.

80. *Id.* at 717 (emphasis added).

81. *Id.* at 719.

82. *Id.* at 719. *Cf. American Family*, 978 F.2d at 297 ("No official of Wisconsin has appeared in this litigation to say that a federal remedy under the Fair Housing Act would frustrate any state policy.")

83. The notion that the McCarran-Ferguson Act creates a form of "inverse-preemption" under which state law is not "invalidated, impaired, or superceded" by federal law unless there is a 'direct conflict' between the laws as per traditional federal preemption analysis first appears in *American Family*. The idea that McCarran-Ferguson creates a form of inverse-preemption has been widely influential in cases that require interpretation of the MFA. *See supra* note 48. Even detractors of the 'direct conflict' inverse-preemption interpretation of the McCarran-Ferguson Act acknowledge that it has allowed courts to reach the "right" result in some cases.

Easterbrook's opinions have been criticized for simply finding a way to reach Easterbrook's pre-chosen result,[84] this analysis argues that based on the meaning of the McCarran-Ferguson Act in a historical context and on economic theories of deterrence, Easterbrook got it right in *American Family* with the "direct conflict" test.

A. The Meaning of "invalidate, impair, or supercede"

Easterbrook eschews the use of traditional tools of statutory construction such as "plain meaning" and legislative intent.[85] Instead, he embraces statutory text and structure as guiding interpretive principles.[86] In his search for statutory meaning, Easterbrook advocates considering the meaning of the language in its historical context. Easterbrook writes:

See Jhabvala, *supra* note 18, at 1161 ("Despite its many deficiencies, the 'direct conflict' test has permitted courts to arrive at the 'right' result in certain cases [e.g., NAACP v. American Family] . . . . The achievement of a desirable end, however, can never justify the utilization of any means whatsoever . . ."). Farrokh Jhabvala represents the Consumer Credit Insurance Association, an insurance industry organization, as amicus curiae. *See* Brief of Amicus Curiae of the Consumer Credit Insurance Association, *supra* note 16, at *1.

84. An evaluation written by the Chicago Council of Lawyers stated: "Judge Easterbrook has been perceived as selecting a result consistent with his views of economic efficiency and then working backwards, and often outside the record, to reach the result he deems appropriate." Chicago Council of Lawyers, *Evaluation of the United States Court of Appeals for the Seventh Circuit*, 43 DEPAUL L. REV. 673, 750 (1994). Easterbrook may be "willing to assume facts that are not part of the record in order to support the conclusion he apparently wishes to reach." *Id.* at 759.

85.

> 'Plain meaning' as a way to understand [statutory] language is silly. In interesting cases, meaning is not 'plain'; it must be imputed; and the choice among meanings must have a footing more solid that [sic] a dictionary-which is a museum of words, a historical catalogue rather than a means to decode the work of legislatures.

See Frank H. Easterbrook, *Text, History, and Structure in Statutory Interpretation*, 17 HARV. J.L. & PUB. POL'Y 61, 67 (1994) [hereinafter *Text & Structure*]. Easterbrook likewise holds a low opinion of the use of legislative history to determine legislative intent: "We must determine what Congress meant by what it enacted, not what Senators and Representatives said, thought, wished, or hoped." *American Family*, 978 F.2d at 294 (discussing the McCarran-Ferguson Act). *See also* Frank H. Easterbrook, *The Role of Original Intent in Statutory Construction*, 11 HARV. J.L. & PUB. POL'Y 59 (1988) [hereinafter, *Original Intent]*; Frank H. Easterbrook, *Statute's Domains*, 50 U. CHI. L. REV. 533 (1983).

86. *See* Easterbrook, *Text & Structure*, *supra* note 85 at 67 ("statutory text and structure, as opposed to legislative history and intent (actual or imputed), supply the proper foundation for meaning.").

> Original meaning is derived from words and structure, and perhaps from identifying the sort of problem the legislature was trying to address. What any member of Congress thought his words would do is irrelevant. We do not care about his mental processes. **Meaning comes from the ring the words would have had to a skilled user of words at the time, thinking about the same problem.**[87]

The meaning of the phrase "invalidate, impair, or supercede" at the time the McCarran-Ferguson Act was conceived supports the notion that the Act "establishes a form of inverse preemption."[88] Or in Easterbrook's words, the "ring" that the words "invalidate, impair, or supercede" would have had "to a skilled user of words at the time, thinking about the same problem" is that the words all refer to what is know known as preemption doctrine.

If Congress meant, when it passed the McCarran-Ferguson Act, that "no federal law shall be construed to *preempt* any state law enacted to regulate the business of insurance," then why for heaven's sake did not they simply say so? Because, in short, "preempt" did not mean in 1945 what it does in modern lexicon. At the time the McCarran-Ferguson Act was passed, the term "preempt" narrowly referred to what is now called "field preemption".[89] "Preempt" was not used to refer to conflict preemption or express preemption

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87. *See* Easterbrook, *Original Intent*, *supra* note 85, at 61 (emphasis added). The Supreme Court, too, states that: "[S]tatutory language must always be read in its proper context." McCarthy v. Bronson, 500 U.S. 136, 139 (1991).

88. Humana, and much of the insurance industry as amicus curiae, argued that based on dictionary meanings of the words 'invalidate, impair, or supercede', RICO's treble damages remedy reduce the effectiveness of state regulations by undermining the exclusive control of insurance commissioners over the remedies available to defrauded policyholders. See A. Raymond Randolph, *Dictionaries, Plain Meaning, and Context in Statutory Interpretation*, 17 HARV. J.L. & PUB. POL'Y 71 for a discussion of the pitfalls of relying on dictionary definitions of words rather than the *meanings* of the words in historical context.

89. *See, e.g.,* Puerto Rico v. Shell Co., 302 U.S. 253, 260 (1937) (Federal law had not "preempted the ground occupied by the local act and superceded it"); Faitoute Co. v. Asbury Park, 316 U.S. 502, 507 (1942) (rejecting the argument that a "field of lawmaking has been preempted"); Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 237 (1947) (Congress had not moved "into these fields" and "pre-empted them"). Preempt, meaning displacement of state law, first appeared in New York Central Rail Road v. Winfield, 244 U.S. 147, 169 (1917), in which Justice Brandeis dissented that: "The contention that Congress has, by legislating on one branch of a subject relative to interstate commerce, preempted the whole field - has been made often in this court . . . ." However, the majority in Winfield used the word supercede. *See id.* at 148 ("State laws covering the same field are necessarily superceded").

until the mid -1950's.[90] Instead, the concept that is now called preemption was referred to by the words "invalidate",[91] "impair",[92] and "supercede".[93]

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90. *See, e.g.,* Weber v. Anheuser-Busch, Inc., 348 U.S. 468, 480 (1955) (although the "areas that have been preempted . . . are not susceptible to delimitation, 'obvious conflict, actual or potential, leads to easy judicial exclusion of state action'); San Diego Unions v. Garmon, 359 U.S. 236, 240 (1959). Contemporary "conflict preemption" and "express preemption" are even more recent uses of "preempt". *See, e.g.,* City of Burbank v. Lockheed Air Terminal, 411 U.S. 624, 636 (1973) ("express pre-emption section"); Northwest Cent. Pipeline v. State Corp. Comm'n, 489 U.S. 493, 515 (1989) ("conflict pre-emption analysis").

91. The Court regularly used the phrase "invalidates . . . law" to describe preemption. *See* Brief for the United States as Amicus Curiae Supporting Respondents at *12, Humana v. Forsyth 119 S. Ct. 710 (1999) (No. 97-303). *See, e.g.,* Hines v. Davidowitz, 312 U.S. 52, 69 n.23 (1941) ("In the only case of this type in which there was an outstanding treaty provision in conflict with the state law, this Court held the state law invalid"); Todok v. Union State Bank, 281 U.S. 449, 456 (1930) ("The treaty did not invalidate the provisions of the Nebraska statute"); Carpenters & Joiners Union v. Ritter"s Café, 315 U.S. 722, 734 (1942) (Reed, J. dissenting) ("legislation forbidding picketing . . . was invalidated" as "unconstitutional"); Carter v. Virginia, 321 U.S. 131, 139 (1944) (Black, J. concurring) ("This Court could invalidate the Virginia regulations, but only the Congress could devise . . . regulations to take their place."). *See also* Parker v. Brown, 317 U.S. 341, 361 (1943); Gwin, White, & Prince, Inc. v. Henneford, 305 U.S. 434, 446 (1939) (Black, J., dissenting).

92. At the time that the McCarran-Ferguson Act was passed, the Court used the phrase "impair . . . law" to describe partial-preemption. *See* Brief for the United States at *14, Humana v. Forsyth 119 S. Ct. 710 (1999) (No. 97-303). *See, e.g.,* United States v. Waddill, Holland & Flinn, Inc., 323 U.S. 353, 357 (1945) (state construction of local law "cannot operate by itself to impair or supercede a long-standing Congressional declaration of priority" for certain kinds of claims); Henry Ford & Son, Inc. v. Little Falls Fibre Co., 280 U.S 369, 378 (1930) ("[T]he powers conferred by [the statute] on the Commission do not extend to the impairment of the operation of those laws or to the extinguishment of the rights acquired under them"); Guaranty Trust Co. v. United States, 304 U.S. 126, 143 (1938) ("Even the language of a treaty wherever reasonably possible will be construed so as not to override state laws or to impair rights arising under them."). *See also,* New York, New Haven & Hartford R.R. v. State of New York, 165 U.S. 628, 631 (1897) ("[T]he mere grant to Congress of the power to regulate commerce . . . among the States did not . . . impair the authority of the States to establish . . . regulations."); Peck v. Jenness, 48 U.S. 612, 614 (1849) (state law liens "not to be annulled, destroyed, or impaired under proceedings in bankruptcy"); Corfield v. Coryell, 6 F. Cas. 546 (E.D. Pa. 1823) (No. 3230) (Congress' power over interstate commerce does not "impair the right of the state governments to legislate").

93. "Supercede" was also used by the Court to refer to preemption where the federal law displaces state law. *See* Brief for the United States at *16, Humana v. Forsyth 119 S. Ct. 710 (1999) (No. 97-303). *See, e.g.,* Illinois Commerce Comm'n v. Thomson, 318 U.S. 675, 682 (1943) ("[T]he Interstate Commerce Commission . . . has power to supercede an intrastate rate by prescribing in its stead a new rate"); Midstate Horticultural Co. v. Pennsylvania R.R., 320 U.S. 356, 359 (1943) ("Respondent however insists the Act has not superceded, but has merely modified its common law contractual right"); Allen-Bradley Local No. 1111 v. Wisconsin

The words "invalidate, impair, and supercede" were used by the dissenting Justices in *South-Eastern Underwriters* to describe the undesirable consequences of the decision; namely, that in the wake of *South-Eastern Underwriters*, federal laws would have preempted existing state laws that regulated insurance. "Invalidate" was used by then Chief Justice Stone in his dissent in *South-Eastern Underwriters*: "The government admits that statutes of at least five states will be *invalidated* by [this] decision as in conflict with the Sherman Act . . . ."[94] Justice Stone noted that: "The extent to which still other state statutes will now be *invalidated* as in conflict with the commerce clause has not been explored in any detail in the briefs and argument or in the Court's opinion."[95] Justice Black, writing for the Court, responded that: "The argument that the Sherman Act necessarily *invalidates* many state laws regulating insurance we regard as exaggerated."[96] "Impair" was used in Justice Jackson's dissent to mean "preempt". Justice Jackson argued that: "When Congress [exercises its power to regulate interstate commerce], it *impairs* state regulation only insofar as it actually conflicts with the federal regulation."[97] "Supercede" was likewise used by Justice Jackson in *South-Eastern Underwriters*: "I have little doubt that if the present trend continues federal regulation eventually will *supercede* that of the states."[98]

Justices Jackson, Black, and Chief Justice Stone were unquestionably "skilled user[s] of words at the time" that the McCarran-Ferguson Act was written. They were "thinking about the same problem" with which drafters of the McCarran-Ferguson Act were concerned – that federal legislation would rob the states of the power to regulate the business of insurance. Because the dissents in *South-Eastern Underwriters* identified the legal consequences to which Congress responded when it enacted the McCarran-Ferguson Act, the dissenters' use of these terms supplies the "ring" of the

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Employment Relations Bd., 315 U.S. 740, 749 (1942) (as the "federal system of alien registration," the Court is "more ready to conclude that a federal Act in a field that touched international relations superceded state regulation than . . . where a State [regulates] local matters"); J.I. Case Co. v. NLRB, 321 U.S. 332, 338 (1944) ("The very purpose of providing by statute for the collective agreement is to supercede the terms of separate agreements of employees"); Davies Warehouse Co. v. Bowles, 321 U.S. 144, 152 (1944) ("[W]e think Congress did not intend . . . to supercede the power of a state regulatory commission . . ."); District of Columbia v. Pace, 320 U.S. 698, 703 (1944) ("This general rule . . . would hardly supercede a special statutory measure . . .").

94. 322 U.S. at 581 (emphasis added).

95. *Id.* (emphasis added).

96. *Id.* at 562 (emphasis added).

97. *Id.* at 587 (emphasis added).

98. 322 U.S. at 586 (dissenting) (emphasis added).

McCarran-Ferguson Act's language.[99] Since "invalidate, impair, and supercede" meant in 1945 what we now mean by "preempt," the McCarran-Ferguson Act means that "no state law enacted to regulate the business of insurance shall be *preempted* by federal laws that do not specifically relate to insurance."

There are three types of preemption: 1) express preemption; 2) field preemption; and 3) conflict preemption.[100] Humana essentially argued for a field preemption analysis under which the McCarran-Ferguson Act left the whole field of insurance regulation to the states.[101] The Court concluded that this is too broad a view, under which many other federal laws would be preempted.[102] The Court "reject[ed] any suggestion that Congress intended to cede the field of insurance regulation to the States, saving only instances in which Congress expressly orders otherwise."[103] It makes little sense to argue for an express preemption analysis, which would mean that state law could preempt federal law when the state expressly says it does.[104] Under a

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99. *See* United States v. Turley, 352 U.S. 407, 411 (1957) (common-law terms construed consistently with common-law meaning); Moskal v. United States, 498 U.S. 103, 121 (1990) (Scalia, J., dissenting) ("When a statute employs a term with a specialized legal meaning relevant to the matter at hand, that meaning governs . . . . As Justice Frankfurter more poetically put it: "If a word is obviously transplanted from another legal source . . . it brings its soil with it.'").

100. *See supra* note 42.

101. *See* Petitioner's Brief, *supra* note 18, at *14 ("[I]f a federal preemption analysis were to be adopted for application of the McCarran-Ferguson Act, the "field preemption" of Rice v. Santa Fe Elevator Corp., 331 U.S. 218 (1947) would appear to be the better analogy[,] . . . leav[ing] the entire field of insurance regulation to the states.").

102. For example, 18 U.S.C. §§ 1341, 1342, which criminalizes mail and wire fraud would be preempted under Humana's expansive reading of the McCarran-Ferguson Act. In addition, the Fair Housing Act, the Truth in Lending Act, 15 U.S.C. § 1601, and the Truth in Advertising Act would be inapplicable to the business of insurance.

103. *Humana*, 119 S. Ct. at 718 ("If Congress had meant generally to preempt the field for the states" it would have said "No federal statute [that does not say so explicitly] shall be construed to apply to the business of insurance.") (citing *Merchants Home*, 50 F.3d at 1492).

104. Interestingly, Easterbrook implies that states do, under McCarran-Ferguson, have the power to 'expressly preempt' federal law: "Nothing in this conclusion permits federal law to displace states' choices about the proper conduct of the business of insurance. If Wisconsin wants to authorize redlining, it need only say so; if it does, then any challenge to that practice under the auspices of the Fair Housing Act becomes untenable." *American Family*, 978 F.2d at 297. However, Easterbrook here is pointing out that there was no conflict between Wisconsin law and the FHA that would make it impossible to comply with both laws. But his analysis leaves the door open to argue that if Nevada simply enacted a law that required insurance companies to negotiate secret discounts with hospitals and to not share the discounts with policyholders, then a RICO action challenging the practice would be barred under the MFA because RICO would 'directly conflict' with a Nevada law that regulates the business of

conflict preemption analysis, federal laws that directly conflict with state laws that regulate the business of insurance are preempted.

Humana echoes Easterbrook's reasoning in *NAACP v. American Family* in which he rejected the argument "[t]hat a federal rule increasing the probability that a state norm will be vindicated (or augmenting the damages assessed in the event of violation) conflicts with a decision by the state that remedies should be limited or rare."[105] Since states are usually free to more severely deter conduct that is prohibited by federal law without creating a conflict under which the state law is preempted, neither should broader federal remedies be preempted under the McCarran-Ferguson Act because they "increase the probability that a state norm will be vindicated."[106]

Although *Humana v. Forsyth* represents the first time that the Court has expressly adopted the "direct conflict" test for section 2(b) McCarran-Ferguson Act cases, it's own precedents have done so implicitly. In *SEC v. National Securities, Inc.*,[107] the Court was asked "whether the McCarran-Ferguson Act bars a federal remedy which affects a matter subject to [Arizona] state insurance regulation,"[108] to which the Court replied:

> Arizona has not commanded something which the Federal Government seeks to prohibit. [Arizona] has permitted respondents to consummate the merger, it did not order them to do so . . . . The paramount federal interest in protecting shareholders is in this situation perfectly compatible with the

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insurance. This scenario was addressed directly by the Justices during oral arguments. *See* United States Supreme Court Transcript (No. 97-303) at *42 (1998) (the Court's questions attempted to divine the limits of a direct conflict test; what would a state have to do to bar RICO actions versus insurers within its borders?).

105. *American Family*, 978 F.2d at 295.

106. "In the main, federal regulation of a subject-even thoroughgoing federal regulation-does not prevent states from adding remedies to the arsenal established by federal law." *American Family*, 978 F.2d at 296. In support of this statement, Easterbrook cites to two cases: Silkwood v. Kerr-McGee Corp., 464 U.S. 238 (1984) (holding that states may require firms engaged in the nuclear power industry to pay punitive damages for violating state law that duplicates federal regulation, even though federal law assumes a lower cap on monetary liability) and California v. ARC America Corp., 490 U.S. 93 (1989) (concluding that states may require antitrust violators to pay damages to indirect purchasers in addition to the federal treble damages to direct purchasers).

107. 393 U.S. 453 (1969). Although the Court applied a conflict preemption-type analysis, they did not frame the issue in terms of "inverse preemption". That observation was left to Easterbrook.

108. *Id.* at 462.

> paramount state interest in protecting [share]holders .... In these circumstances, we simply cannot see the conflict.[109]

Additionally, in *Department of Treasury v. Fabe*, the Court observed that: "Ordinarily, a federal law supercedes any inconsistent state law. The [McCarran-Ferguson Act] reverses this by imposing what is, in effect, a clear statement rule that state laws enacted 'for the purpose of regulating the business of insurance' do not yield to *conflicting* federal statutes unless a federal statute specifically requires otherwise."[110] More recently, in *Barnett Bank v. Nelson*, the Court stated that: "By its terms . . . the Act does not apply when the *conflicting* federal statute specifically relates to the business of insurance."[111]

RICO supplements, rather than conflicts, with state laws. RICO states that: "Nothing in this title shall supercede any provision of Federal, State, or other law imposing criminal penalties or affording civil remedies in addition to those provided for in this title."[112] Humana claimed that RICO upsets the careful balancing of damages that states have created in their regulatory schemes. The Court rejected this argument, reasoning that Nevada, like many states, provides a private right of action under state law for fraud[113] in addition to common law causes of action which may result in punitive damages being levied against insurers.[114] In addition, state insurance

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109. *Id.* at 463.

110. 508 U.S. 491, 507 (1993) (emphasis added).

111. 517 U.S. 25, 38 (1996) (emphasis added). Barnett Bank concerned a federal statute that *did* specifically relate to insurance.

112. 84 Stat. 947 (1970).

113. In Nevada, for instance, under NEV. REV. STAT. § 42.010, a jury may award punitive damages if the defendant is guilty of fraud, malice, or oppression. *See* Ainsworth v. Combined Ins. Co. of America, 763 P.2d 673 (Nev. 1988). Additionally, NEV. REV. STAT. § 686A.310 (2) (Michie 1997) provides policyholders with a private right of action for violations of the Nevada Unfair Trade Practices Act (§ 686A.310 addresses unfair insurance trade practices in particular). *See also* CAL. CIV. CODE §§ 1750-1784 (West 1998) ("Consumer's Legal Remedies Act"); 815 ILL. COMP. STAT. ANN. 505 (1993) ("Consumer Fraud and Deceptive Business Act"; authorizes punitive damages); N.Y. GEN. BUS. LAW § 349 (McKinney 1988) ("Consumer Protection From Deceptive Acts and Practice"; provides up to three times damages sustained plus attorney's fees); PA. STAT. ANN. tit. 73 §§ 201-201-9.2 (West 1993) (3x damages available). Finally, most states have "little RICO" statutes which prohibit the same, and in some cases more, conduct as federal RICO prohibits. *See* JOHN E. FLOYD, RICO STATE BY STATE (1998).

114. Nevada common law provides a cause of action for an insurance company's tortious breach of the implied covenant of good faith and fair dealing. *See* Ainsworth v. Combined Ins. Co. of America, 763 P.2d 673 (Nev. 1988). Nevada common law already allows punitive

commissioners have the power to revoke an insurance company's license to operate in the state.[115] Finally, many states' regulations provide that the state laws are not exclusive of other remedies.[116] The availability of a RICO

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damages awards against insurance companies. *See id.* (jury award of $5,939,500 in punitive damages in addition to $200,000 in compensatory damages for only $9,600 in benefits that were denied). Unlike compensatory damages, punitive damages take into account the wrongdoer's wealth. Since Humana had $173 million in earnings in 1997 (up from 12 million in 1996), *see* Kristen Haukebo, *The Sale of Humana: The People the Humana CEO: Gregory Wolf Gets Undefined Promise of Major Role*, COURIER-J. LOUSVILLE at 10A, punitive damages would likely be contemplated under common law, especially given Humana's efforts to conceal the fraud.

The seminal case recognizing the action in tort of a breach of the implied covenant of good faith and fair dealing against an insurer, Gruenburg v. Aetna Ins. Co., 510 P.2d 1032 (Cal. 1973), characterized the duty as: "neither party will do anything which will injure the right of the other to receive the benefits of the agreement." *Id.* at 1036. Other states followed California's lead. *See, e.g.*, Rawlings v. Apodaca, 726 P.2d 565, 578 (Ariz. 1986) (punitive damages are appropriate when insurer's conduct is aggravated, outrageous, malicious, or fraudulent); Best Place, Inc. v. Penn America Ins. Co., 920 P.2d 334, 345 (Hawaii 1996) (punitive damages available for willful insurer breach of duty of good faith); Andrew Jackson Life Ins. Co. v. Williams, 566 So. 2d 1172, 1191 (Miss. 1990) (punitive damages of 7x compensatory damages considered not excessive); Smith v. American Family Mut. Ins. Co., 294 N.W.2d 751, 766 (N.D. 1980) (punitive damages 16x compensatory damages not excessive); Christian v. American Home Assurance Co., 577 P.2d 899 (Okla. 1978) (punitive damages available against insurer); Nichols v. State Farm Mut. Auto. Ins., 306 S.E.2d 616 (S.C. 1983) (recognizing action against insurer for bad faith); Savage v. Educator's Ins. Co., 908 P.2d 862, 864-65 (Utah 1995) (discussing action for insurer's breach of covenant of good faith and fair dealing).

115. Nevada's Insurance Commissioner may suspend or revoke an insurance company's license to do business. *See* NEV. REV. STAT. § 686A.183(1)(b) (Michie 1997). *See also* ALASKA STAT. § 21.36.320(f) (Michie 1998); ARK. CODE ANN. § 23-66-210 (a)(2) (Michie 1994); COLO. REV. STAT. § 10-3-1109(1)(b) (1998); DEL. CODE ANN. tit. 18, § 2311(a)(2) (1989); GA. CODE ANN. § 33-6-9(1)(2) (1994); HAW. REV. STAT. § 431:13-202(2) (1993); IDAHO CODE § 41-1329A (1998); IND. CODE ANN. § 27-4-1-6(a)(2) (Michie 1997); IOWA CODE ANN. § 507B.11(2) (West 1998); KAN. STAT. ANN. § 40-2407(a)(2) (1993); LA. REV. STAT. ANN. § 22-1217.1(2) (West 1994); MISS. CODE ANN. § 83-5-49 (1991); MO. REV. STAT. § 375.946(2) (West 1991); NEB. REV. STAT. § 44.1542(2) (1994); N.H. REV. STAT. ANN. § 417.13 (1998); N.J. STAT. ANN. § 17B:30-20 (West 1996); N.M. STAT. ANN. § 59A-16-29 (Michie 1995); N.D. CENT. CODE § 26.1-04-13(1)(b) (1995); OHIO REV. CODE ANN. § 3901.22(D)(1) (Anderson 1996); OR. REV. STAT. § 746.015(5)(b) (1989); PA. CONS. STAT. § 1171.9 (1998); R.I. GEN. LAWS § 27-29-9(b) (1994); S.C. CODE ANN. § 38-57-320 (Law. Co-op 1985); TENN. CODE ANN. § 56-8-112(2) (1994); VT. STAT. ANN. tit. 8, § 4726(b) (1993); VA. CODE ANN. § 33-11-6(b) (Michie 1997); W. VA. CODE § 33-11-8(b) (1996).

116. *See, e.g.*, VA. CODE ANN. § 33-11-6(c) (Michie 1997) ("No order of the commissioner pursuant to this article or order of court to enforce it . . . shall in any manner relieve or absolve any person affected by such an order or hearing from any other liability, penalty, or forfeiture under law."). *See also* ALASKA STAT. § 21.36.340 (Michie 1996); ARIZ.

remedy little more upsets such a balance than do administrative remedies, state anti-fraud statutes, and common law actions.[117]

Nevertheless, the Court's decision in *Humana* may be narrowly read to mean that if federal and state remedies are radically different, a state's weak enforcement provisions may evince a policy or goal that would be frustrated by more severe federal remedies.[118] The Court observed that: 1) "RICO[] does not proscribe conduct that [Nevada's] laws governing insurance permit"; 2) "Both [RICO] and [Nevada law] provide a private right of action"; and 3) "RICO authorizes treble damages; Nevada law permits recovery of compensatory and punitive damages."[119] Under these circumstances "RICO can be applied . . . in harmony with the State's regulation." But the situation might well be different if the state either: 1) *does* permit conduct which a federal law prohibits;[120] 2) provides that the administrative remedies are

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REV. STAT. ANN. § 20-456(C) (West 1998); COLO. REV. STAT. § 10-3-1111 (1998); DEL. CODE. ANN. tit. 18, § 2314 (1989); GA. CODE ANN. § 33-6-14 (1996); HAW. REV. STAT. § 431:13-204 (1993); IND. CODE ANN. § 27-4-1-17 (Michie 1996); IOWA CODE ANN. § 507B.12 (West 1986): KY. REV. STAT. ANN. § 304.12-120(4) (Banks-Baldwin 1996); MINN. STAT. ANN. § 72A.29 (West 1996); MO. ANN. STAT. § 375.948 (West 1991); MONT. CODE ANN. § 33-18-1004(4),(5) (1997); NEB. REV. STAT. ANN. § 44-1534 (Michie 1993); N.J. STAT. ANN. § 17B: 30-21 (West 1996); N.Y. INS. LAW § 2409 (McKinney 1996); N.C. GEN. STAT. § 58-63-55 (1996); N.D. CENT. CODE § 26.1-04-19 (1995); PA. STAT. ANN. tit. 40, § 1171.13 (West 1992); R.I. GEN. LAWS § 27-29-10 (1994); S.D. CODIFIED LAWS § 58-33-44 (Michie 1996); TENN. CODE ANN. § 56-8-114 (1994); VT. STAT. ANN. tit. 8, § 4726 (1993); W. VA. CODE § 33-11-9 (1996).

117. It is worth noting that, during a period when the National Alliance of Insurance Commissioners ("NAIC") was considering amendments to the NAIC Model Unfair Trade Practices Act, *see* NAIC Model Laws, Regulations and Guidelines, Vol. IV, p. 880 (1995) (Nevada's laws are based on the NAIC Model Act. *See* NAIC Brief at *3, Humana v. Forsyth, 119 S. Ct. 710 (1999) (No. 97-303)), the Insurance Advisory Committee successfully opposed granting state insurance commissioners the power to bring class actions on behalf of injured consumers. NAIC Brief at *12. The Insurance Advisory Committee argued that "persons injured have an adequate remedy at law," and that state insurance commissioners should not assume "a role that is usually the province of the jury—that is, ascertain who may have been harmed and by what extent." *Id.* (citing NAIC Proceedings, Vol. 1, 490, 509 (1972)). Thus, having derailed insurance commissioners' ability to sue on behalf of consumers because consumers had sufficient means of redress under other laws, the industry argues that the most potent remedy available to wronged consumers, RICO, should also be barred.

118. "While we reject any sort of field preemption, we also reject the polar opposite of that view, i.e., that Congress intended a green light for federal regulation whenever the federal law does not collide head on with state regulation." 119 S. Ct. at 717.

119. *Id.* at 714 (emphasis added).

120. For example, in American Deposit Corp. v. Schacht, 84 F.3d 834 (7th Cir. 1996), the court concluded that under the MFA an Illinois law which required insurers to obtain a certificate of authority before selling retirement certificates of deposit ("CD's") would be impaired by the National Bank Act, 12 U.S.C. § 21 et seq., which authorizes CD sales. Thus,

exclusive of all other statutory and common law rights of action; or 3) expressly rejects the recovery of punitive damages.

For example, the Court stated that section 2(b) of the McCarran-Ferguson Act "belies any congressional intent to preclude federal regulation merely because the regulation imposes liability additional to, or greater than, state law."[121] But if a state's insurance regulations were to explicitly provide that they supplied the sole means of redress, to the exclusion of all other actions under state statutory or common law for an insurer's fraudulent, unfair, or deceptive act, then perhaps RICO would "frustrate [a] declared state policy."[122] Although insurer's will likely make this argument in future cases, they will be undermined by state insurance commissioners, who are largely in accord with the Courts's conclusion that, absent a direct conflict, RICO actions should not be barred under the McCarran-Ferguson Act.[123] However, as discussed *supra* Part IIB, many federal district courts have been wary of unleashing RICO against insurers, reasoning that RICO's "draconian" damages provision will disrupt state's administrative regulatory schemes.[124]

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the court held that: "Illinois may regulate the sale of the Retirement CD despite the fact that selling the Retirement CD may be a practice that the National Banking Act expressly authorizes." *American Deposit*, 84 F.3d at 844. In other words, since state law prohibits something that federal law allows, the MFA "inverse preemption" bars the federal law because the federal law directly conflicts with the state law.

121. *Humana*, 119 S. Ct. at 717.

122. *Id.* As an example of how a policy goal may be frustrated, the Court cites Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1983). The issue in Shaw was whether, or to what extent did ERISA preempt a New York state law which forbade discrimination in employee benefit plans on the basis of pregnancy. *Id.* at 92-93. The Court held that ERISA preempted state law to the extent that the state law prohibited that which was allowed under Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e et seq. If ERISA preempted the New York anti-discrimination law altogether, then the goal of encouraging state and federal enforcement of Title VII would be frustrated. Under this analysis, if RICO was preempted by the McCarran-Ferguson Act, RICO remedies would be preempted only to the extent that they frustrate a state goal, e.g., in states that do not allow punitive damages, RICO plaintiffs could only recover compensatory damages, but a RICO action would not itself be barred.

123. National Association of Insurance Commissioners ("NAIC") argued in favor of affirming *Humana*. The NAIC consists of the principle state insurance regulatory officials. *See* NAIC Brief at *1.

124. *See, e.g.*, Ambrose v. Blue Cross & Blue Shield, 891 F. Supp 1153, 1165 (E.D. Va. 1995) ("The prospect of treble damages and attorney's fees would weaken, diminish and do serious injury, if not nullify, [the state regulatory scheme] . . . . It would convert a system of public redress into a system of private redress."); Wexco Inc. v. IMC, Inc., 820 F. Supp. 194, 204 (M.D. Pa. 1993) ("The availability of a federal private action under RICO would not merely nullify the state's chosen regulatory remedies for insurance entity misconduct . . . but [would] upset the balance of relationships between insurance entities and insureds which are

Ultimately, courts that seek to trim the use of RICO in "garden variety" cases may myopically read *Humana* to bar RICO actions against insurers.

Paradoxically, if Humana Inc. had prevailed they might have hampered the insurance industry's ability via RICO to "fight back" against fraud committed by policyholders.[125] RICO has been described as being "the single most valuable tool available to insurers through the American jurisprudence system."[126] Insurers have brought RICO actions for fraud against policyholders, attorneys, and other insurance companies.[127] So perhaps Humana and its amicus' arguments "prove too much," for insurers would stand to lose RICO actions against policyholder fraud under an expansive reading of the McCarran-Ferguson Act's cession of regulatory power to the states.

Finally, *Humana* will have consequences for McCarran-Ferguson Act cases that concern the applicability of other general federal laws such as the Fair Housing Act, the Age Discrimination in Employment Act, the Americans

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established and regulated by [existing state laws]"); LeDuc v. Kentucky Central Life Ins. Co., 814 F. Supp. 820, 829 (N.D. Cal. 1992) ("[A]pplying RICO here would nullify the state's determination of the appropriate remedies for certain conduct and would supercede remedies and regulatory supervision provided by California law."); Lindsey v. Allstate Ins. Co., 1999 WL 27464 (Jan. 13, 1999) (W.D. Tenn. 1999) (RICO claim preempted because Tennessee law does not provide for a private cause of action nor treble damages for unfair or deceptive trade practices).

125. *See* Andrew D. Fieklow & Stephen P. Eisenburg, *Civil RICO: Insurers Fight Back*, 21, 29 TORT & INS. L.J. 1 (1986) ("RICO . . . has the potential to serve as an effective weapon to the insurance industry in the battle against insurance fraud."); Hope Viner Samborn, *Relying on RICO: Using Civil Racketeering Laws, Insurers Collect Big Damages from Attorneys and Others Who Aid Fraud*, 84 ABA J. 30 (May 1998).

126. Larry E. Parish, *RICO Civil Remedies: An Untapped Resource for Insurers*, 49 INS. COUNSEL. J. 337 (1982).

127. *See, e.g.*, Aetna Cas. & Sur. Co. v. P & B Auto Body, 43 F.3d 1546 (1st Cir. 1994) (insurance company brings RICO action against auto body shops for filing fraudulent insurance claims); State Farm Mut. Auto. Ins. Co. v. Amann, 828 F.2d 4 (9th Cir. 1987) (insurer sought RICO treble damages for submission of false claims); Vandliner Ins. Co. v. All Risk Serv., Ltd., 990 F. Supp. 1145 (E.D. Mo. 1997) (insurance company sought damages for violation of RICO); Soans v. Empire Blue Cross & Blue Shield, 970 F. Supp. 230 (S.D.N.Y. 1997) (insurance company wins a RICO action for misrepresentations on insurance applications); Blue Cross of California v. SmithKline Beecham, No. 397CV01795 AVC (D. Conn. filed Aug. 19th, 1997) (thirty-five insurance companies brought a RICO action against pharmaceutical company for alleged improper billing and kick-backs). State insurance commissioners also have used RICO on behalf of insolvent insurance companies that were defrauded by company executives. *See* NAIC Brief *supra* note 115 at *16.

with Disabilities Act, and the Truth in Lending Act.[128] Before *Humana*, some courts drew a distinction between RICO and other federal laws which provided for compensatory damages.[129] These distinctions, to the extent that states do not have a declared policy against what the federal law provides, no longer have force. By adopting the reasoning of *American Family*, the *Humana* court tacitly approved the result that the business of insurance should not be exempted from federal civil rights legislation.[130]

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128. *See, e.g.*, Davister Corp. v. United Republic Life Ins. Co., 152 F.3d 1277 (10th Cir. 1998) (holding that because the Federal Arbitration Act conflicts with Utah law the FAA is preempted under the MFA); Edwards v. Your Credit, 148 F.3d 427 (5th Cir. 1998) (concluding that TILA is not barred by the MFA because "no direct impairment exists."); Murff v. Professional Medical Ins. Co., 97 F.3d 289 (8th Cir. 1996) (MFA does not preclude ADEA action); Nationwide Mutual Ins. Co. v. Cisneros, 52 F.3d 1351 (6th Cir. 1995) (FHA not preempted); United Farm Bureau Mut. Ins. Co. v. Metropolitan Human Relations Comm., 24 F.3d 1008 (7th Cir. 1994) (MFA does not bar a white homeowner's action under the FHA for failure to renew his policy); Villafane-Neriz v. FDIC, 75 F.3d 727 (1st Cir. 1996) (action under the Federal Deposit Insurance Act not preempted by the MFA); Winslow v. IDS Life Ins., 1998 WL 852876 (Sept. 30, 1998) (D. Minn.) (MFA does not preempt ADA as applied to issuance of insurance policies). *See also* Comment, Steven Koch, *McCarran-Ferguson Act Immunity from the Truth in Lending Act and Title VII*, 48 U. Chi. L. Rev. 730 (1981).

129. *See, e.g.*, Winslow, 1998 WL 852876 at *8 ("Unlike RICO . . . the ADA does not provide for extraordinarily punitive damages - treble damages, costs, and attorney's fees - and therefore does not allow damages so substantial that they impair the regulatory scheme established by Minnesota state law.").

130. Some courts have concluded that Congress simply could not possibly have intended to bar application of civil rights laws to the business of insurance. *See, e.g.*, Spirt v. Teachers Ins. & Annuity Ass'n, 691 F.2d 1054 (2d Cir. 1982).The Spirt court wrote:

> We find, based on the historical context, the legislative history and judicial interpretations of that history, that Congress, in enacting [the McCarran-Ferguson Act] primarily intended to deal with the conflict between state regulation of insurers and the federal antitrust laws, had no intention of declaring that subsequently enacted civil rights legislation would be inapplicable to any and all of the activities of an insurance company that can be classified as "the business of insurance."

Id. at 1065. *See also* EEOC v. Wooster Brush Co., 523 F. Supp. 1256 (N.D. Ohio 1981) (MFA inapplicable to Title VII); Women in City Gov't United v. New York, 515 F. Supp 295 (S.D.N.Y. 1981) (same); Ben v. General Motors Acceptance Corp., 374 F.Supp. 1199 (D. Colo. 1974) (MFA does not bar claims under 42 U.S.C. §§ 1982 and 1985).

B. Deterrence of Insurance Industry Fraud[131]

Although the Court did not discuss the economics of RICO and insurance fraud in *Humana v. Forsyth*, an analysis of the incentives that RICO creates supports the Court's conclusion that RICO "advances the State's interest in combating insurance fraud."[132]

The way to deter any activity, in this case fraud, is to make its costs larger than its benefits.[133] Although compensatory damages are thought of primarily as remuneration for a harm,[134] they also deter commission of future like harms.[135] As a matter of law punitive damages are awarded to punish egregious conduct.[136] Under an economics analysis punitive damages ensure

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131. Some readers may object to relying on notions of economic efficiency or deterrence to gauge the policy implications of a particular ruling or statute. As Justice Holmes dissented in Lochner v. New York, 198 U.S. 45 (1905), "[t]he 14th Amendment does not enact Mr. Herbert Spencer's Social Statics." Yet, the economic analysis of law has been described as "the most important development in legal scholarship of the twentieth century." ROBERT COOTER & THOMAS ULEN, LAW AND ECONOMICS 2 (2d ed. 1997) (quoting Yale law professor Bruce Ackerman). Even if the result one obtains from a law and economics approach is not taken as gospel, it is nevertheless a useful way to begin assessing the effects on behavior of competing legal norms.

132. 119 S. Ct. at 719. However, Easterbrook discusses the economics of civil RICO and fraud in Mosler v. S/P Enterprises, Inc., 888 F.2d 1138, 1143-44 (7th Cir. 1989) (analyzing treble damages for victims of securities fraud).

133. *See* RICHARD POSNER, ECONOMIC ANALYSIS OF LAW 164 (2d. ed. 1977) [hereinafter POSNER, ECONOMIC ANALYSIS].

134. *See* RESTATEMENT (SECOND) OF TORTS § 903 cmt. A, (1979) (compensatory damages are awarded primarily to compensate victims for their injuries).

135. POSNER, ECONOMIC ANALYSIS *supra* note 133, at 154. Compensatory damages may efficiently inhibit some wrongful conduct. *Id.* at 143. This concept is illustrated by the famous "Hand Formula": Burden of precaution = (probability that the harm will occur) x (the amount of harm) or B = PL. *See* United States v. Carroll Towing Co., 159 F.2d 169 (2d Cir. 1947). The formula was orginally used to determine whether negligence had occured. But it is also a means to determine the optimal investment in safety, or put another way, how much liability will beget desired behavior. For example, assume that all harms could be avoided, but at a cost to society. If a $200 dollar harm that would occur with 100% probability could be avoided for $100 dollars worth of prevention, then a $200 amount of compensatory damages is desirable because it provides an incentive to spend $100 to prevent a $200 loss, resulting in a "savings" to society of $100. But if the damages were multiplied by a factor of three, then a $600 dollar penalty would encourage the would-be violator to spend *more* ($600) than the amount of harm ($200) to avoid the large penalty, resulting in a social loss of $400. This is an example of inefficient over-deterrence.

136. *See* RESTATEMENT (SECOND) OF TORTS § 908 (Punitive damages are within the discretion of the jury to award based upon: 1) the degree of wrongfulness of the conduct; and 2) the defendant's wealth); City of Newport v. Fact Concerts, Inc., 453 U.S. 247, 266-67 (1981) ("Punitive damages . . . are . . . intended to . . . punish the tortfeasor whose wrongful

that the wrongdoer internalizes, or "pays for" the full cost of his wrongful conduct when the probability of being caught is less than 1.0;[137] when not all of the victims seek compensation;[138] and when the traditional measure of compensatory damages does not account for the totality of the victims' injury.[139] RICO's treble damages are a blend of compensatory and punitive damages.[140] Treble damages effect: 1) deterrence of future violations;[141] 2) compensation for accumulative harm;[142] and 3) private enforcement.[143] All three of these rationales for treble damages are present in *Humana v. Forsyth.*

1. Optimal Deterrence

Optimal deterrence theory posits that wrongdoers should internalize the cost of their wrongdoing.[144] A rational would-be racketeer will violate the law if the expected benefits from the violation exceed the expected costs.[145] Thus, illegal activity is deterred by making the expected costs outweigh the expected benefits.[146] In addition, the probability that the crime will be detected and punished must be included in the expected costs, so that a crime

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action was intentional or malicious, and to deter him and others from similar extreme conduct."); Gertz v. Robert Welch, Inc., 418 U.S. 323, 350 (1974) ("[Punitive damages] are . . . private fines levied by civil juries to punish reprehensible conduct and to deter its future occurrence.").

137. *See, e.g.*, A. Mitchell Polinsky & Steven Shavell, *Punitive Damages: An Economics Analysis*, 111 Harv. L. Rev. 869, 873-74 (1998).

138. *See* ROBERT COOTER & THOMAS ULEN, LAW AND ECONOMICS 391 (1988). For a discussion of the effect of a punitive damages multiplier on the expected punishment, see *infra* note 160.

139. *See* Judith A. Morse, *Treble Damages Under RICO: Characterization and Computation*, 61 NOTRE DAME L. REV. 526-28 (1986).

140. *See id.* To the extent that RICO damages exceed compensation for harm (including accumulative harm), the remainder is punitive in nature.

141. *See* RICHARD POSNER, ANTITRUST LAW, AN ECONOMIC PERSPECTIVE, 221-22 (1976).

142. Accumulative harm is harm that is to "elusive and indeterminate" to be adequately measured and compensated for under traditional damage principles. *See* Morse, *supra* note 139, at 528 n.13. *See also* Blakey & Perry, *supra* note 57, at 943.

143. *See* Morse, *supra* note 139, at 533.

144. *See* POSNER, ECONOMIC ANALYSIS, *supra* note 133, at 167. In order for wrongdoers to be required to internalize the cost of their wrongdoing they must pay the social costs of the violation plus "the costs to the legal system of substituting coercive transactions for market transactions." *Id.* at 167. Social costs include the cost of information to detect the crime, costs of concealment, and other opportunity costs. The costs of coercive transactions includes the cost of enforcement (including the trial).

145. *See id.* at 164.

146. *See id.* at 164.

with a low probability of being detected carries a higher penalty.[147] Finally, because the ultimate goal of a criminal penalty is to motivate the "criminal" to negotiate with the "victim" for the desired good instead of committing fraud, the damages must exceed the cost to the victim (or compensatory damages) so the would-be racketeer will not be indifferent as between stealing or negotiating.[148] Thus, in order for damages ("D") to deter undesired conduct, they must be greater than the probability ("P") that the crime will be detected and punished multiplied by the loss ("L") of the crime. This may be simply represented as: $D > P \times L$.[149] In Humana's case, the choice was between either keeping *all* of the discounts or sharing the discounts with the policyholders. Humana still would have been better off to negotiate and share the discounts, i.e., because Humana paid for 80% of the cost, they would have likewise received 80% of the discount-windfall. Evidently Humana believed that the payoff from committing fraud outweighed the possibility of detection and punishment.

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147. *See id.* at 165. For example, suppose that an offense has an expected cost of $100. If the probability of detection is 100%, then a $100 fine will optimally deter. But if the probability of detection is 50%, then the expected cost would be 100 x .5, or $50. In this scenario, the crook will have an incentive to commit the crime, because the expected benefit ($100) is double that of the expected cost ($50). Therefore, a $200 penalty is necessary to optimally deter (200 x .5 = 100). *See also* RICHARD A. POSNER, ANTITRUST LAW, AN ECONOMIC PERSPECTIVE, 223-24 (1976).

148. *See id.* at 166. This is so because market transactions cost less than litigation. Transaction costs are the costs of bargaining in the market for the desired good. *See id.* Some crimes are value maximizing because the transaction costs are prohibitive. Posner gives the following example of high transaction costs: he breaks into a cabin during a blizzard and steals some food – the owner was miles away and could not be contacted. *See id.* Where transaction costs are prohibitive, such as in this example, the expected penalty should not be set too high or else some value maximizing criminal behavior, e.g., stealing food to prevent illness or death, will be deterred. But where transaction costs are low, a market transaction should not be substituted with legal actions, which impose substantial costs on both parties. In Humana's case, the transaction costs were not prohibitive. For instance, Humana could have tried to renegotiate its contract with the Co-Payors so that everyone would share in the discounts, but Humana would still get a larger share of the windfall. This way, Humana would not be substituting fraud for a market transaction, yet everyone would be better off. If punitive damages are used, "exchange will be much more likely to occur through voluntary transactions, which may be much less costly than litigation." Polinsky & Shavell, *supra* note 137, at 947. *See also* Guido Calabresi & A. Douglas Melamed, *Property Rules, Liability Rules, and Inalienability: One View of the Cathedral*, 85 HARV. L. REV. 1089, 1115-24 (1972).

149. Polinsky & Shavell discuss an alternate formula that expresses the same idea: Damages = P x (H/P) where P = the probability of being found liable and H = the amount of harm. *See supra* note 137, *Polinsky & Shavell*, at 889, n.48. Polinsky & Shavell also discuss the perpetrator's attitude towards risk. *See id.* This analysis assumes that insurers are risk neutral, i.e., that they are neither risk-seeking nor risk-adverse.

The probability that a crime will be detected[150] depends upon three factors: 1) the cost of information; 2) the 'concealability' of the crime; and 3) incentives for investigation. The cost of information about whether a crime has occurred and if so, who did it, simply reflects the amount of resources needed to answer these questions. The costs may be very low, as when the offender turns himself in and confesses to the crime, or they may be extremely high as in some cases of environmental pollution, or as evidenced by the independent counsel's investigation of President Clinton which cost over $40 million dollars. In addition, some crimes are more easily concealed than are other crimes. For example, it is very difficult to conceal arson, while it is easier to conceal embezzlement. Finally, there must be incentives for investigating criminal activity, particularly when the cost of information is high and the crime is easily concealed.[151] If, as in this case, the amount of injury to a class of victims is individually very low, the expected recovery per victim will not be enough for any one person to bear the costs of initiating expensive litigation.[152]

Some economists have suggested that because most of the cost of detection is discovering a criminal's identity and because in most RICO cases the racketeer's identity is known, "multiplication of damages may not be justified."[153] While it may be true that in many criminal investigations, e.g., of homicide, learning the perpetrator's identity is more costly than deciding if a crime has occurred, it is misleading to say that therefore, the costs of detection in fraud cases are comparatively low. Indeed, in cases of murder one suspects that a crime may have occurred because there is a dead body; the discovery of the criminal act triggers the search for the criminal. In fraud cases, the victim may simply not know, nor have any reason to expect, that

150. This analysis assumes that, of the crimes detected, 100% of detections will result in a penalty. In reality, there is enforcement error. See ROBERT COOTER & THOMAS ULEN, *supra* note 138, at 393-96 for an excellent discussion of enforcement error.

151. These factors are interdependent. For instance, if fraud is easily well concealed, it will cost more to uncover it; potential plaintiffs may be even more unlikely to either know that they are being snookered or know to initiate a lawsuit if they feel that they have been cheated.

152. *See* POSNER, ECONOMIC ANALYSIS *supra* note 133, at 448, 469; Polinsky & Shavell, *supra* note 137 at 888 ("A person will tend not to bring a suit if the legal cost and the value of time and effort he would have to devote to the suit exceed the expected gain."). For a discussion of how RICO affects the victim's expected payoff from litigation, see *infra* note 183.

153. Paul H. Rubin & Robert Zwirb, *The Economics of Civil RICO*, 20 U.C. DAVIS L. REV. 883, 901 (1987).

they have been treated unfairly.[154] The president of the National Insurance Crime Bureau, which assists insurers in suing those who defraud any of its 1,000 member insurance companies (including attorneys and health care providers), states that because civil RICO fraud cases involve extensive investigation, "[They] are not inexpensive cases to develop . . . It is very labor intensive."[155] Fraud cases, such as in *Forsyth v. Humana*, have a low probability of detection because investigation is expensive, the crime is easily concealed, and individual plaintiffs have little incentive to initiate litigation to recover relatively small amounts of damages. Therefore, RICO's treble damages motivate victims to enforce RICO's prohibitions, thus deterring would-be insurance company racketeers.[156]

In *Forsyth v. Humana,* for example, Humana Inc. apparently went to great lengths to conceal its fraudulent scheme.[157] Humana falsely represented

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154. This is perhaps particularly true in an insurer - insured relationship because many insureds may not understand a complex policy, much less understand how the policy premiums work (assuming that they scrutinize co-payment bills). *See generally* Todd D. Rackoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 Harv. L. Rev. 1173, 1268-69 (1983) (discussing the "doctrine of reasonable expectations" being used to protect consumers' expectations of coverage that are based on agents' oral representaions).

155. Hope Viner Samborn, *Relying on RICO: Using Civil Racketeering Laws, Insurers Collect Big Damages From Attorneys and Others Who Aid Fraud*, 84 ABA J. 30 (May 1998).

156. "Because frauds are easily concealed, trebling is important to produce proper incentives." *Mosler,* 888 F.2d at 1143 (Easterbrook, J.) (quoting Carter v. Berger, 777 F.2d 1173, 1176 (7th Cir. 1985)). *See also* Kemezy v. Peters, 79 F.3d 33, 35 (7th Cir. 1996) (When a tortious act is concealable, a judgment equal to the harm done by the act will underdeter."); Zazu Designs v. L'Oreal, S.A., 979 F.2d 499, 508 (7th Cir. 1992) ("Punitive damages are appropriate when some wrongful conduct evades detection; a multiplier then both compensates and deters.") (quoting FDIC v. W.R. Grace & Co., 877 F.2d 614, 623 (7th Cir. 1989)); FDIC v. W.R. Grace & Co., 877 F.2d 614, 623 (7th Cir. 1989) ("Suppose the average defrauder is brought to book only half the time. To confront him with a sanction that will make fraud worthless to him and thus deter him, it is necessary that when he is caught he be made to pay twice as much as his profits.").

157. Humana's efforts to conceal the kickbacks are investments in a transfer payment. A transfer payment is "a purely pecuniary transaction." POSNER, ECONOMIC ANALYSIS, *supra* note 133, at 7. Theft is a good example of an investment in a transfer payment. The thief invests time and other resources to gain a sum of money possessed by another. Unlike speeding, for instance, where the benefits to the scofflaw (reaching one's destination quickly) might be weighed against the social cost of speeding (increased risk of accident, pollution, etc.,.), the thief's possession of another's cash neither produces nor conserves resources. In order to optimally deter, the thief must internalize the social costs of a societal investment of resources to detect the theft and also the costs of substituting expensive litigation for the market. Because the wrongdoer should internalize the costs of their wrongdoing, Humana, if found liable for fraud, should pay for the costs of obtaining information about their crimes and the costs of

to policyholders that the company was paying 80% of healthcare costs in "Explanations Of Benefits" ("EOBs").[158] Also, Humana Insurance allegedly wrote checks to Humana Hospital Sunrise for the correct amount, or 80% of the healthcare costs to make it appear that Humana Insurance had paid the correct amount.[159] Then, Humana Hospital Sunrise allegedly remitted 89% of the payment back to Humana Insurance via monthly inter-company ledger

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substituting cheap negotiation with costly litigation. RICO accomplishes this with the treble damages provision and the fee shifting provision.

Concealment of insurance company fraud may also be facilitated by HMO 'gag clauses' and audit confidentiality laws. For example, a lawsuit against Humana in Florida alleges that the company maintains 'gag' clauses that prevent doctors from telling patients about financial agreements with Humana that limit access to care. *See* Marty Rosen, *Judge expands suit against Humana*, ST. PETERSBURG TIMES at 1A (Apr. 25, 1998). "Doctors cannot talk about a referral to a specialist without Humana's approval; doctors can't tell a patient they need to go to the hospital without Humana's approval; and doctors must support Humana in an appeal [for care]." *Id. See also* Morgan, *supra* note 12, at 226 (the negotiated rate of discounted payments is typically shrouded by a confidentiality agreement between the insurance company and the hospital).

In Illinois, an audit confidentiality law was recently passed. *See* L.H. Otis, *Allstate Pushes Ill. Audit confidentiality Law*, NAT'L UNDERWRITER at 4 (Aug. 11, 1997). As the title implies, the legislation was due to intense lobbying by Allstate Ins. Co. *See id.* The law ensures the confidentiality of internal company audits to prevent the audits from being used by outside attorneys in lawsuits against insurers. The law has the potential to "discourage public attempts to root out insurance company fraud or illegal claims practices." *Id.* The law denies access to some internal business records, and it makes discovery of other documents more difficult, in some cases requiring *in camera* review before the documents can be obtained. *See id. See also* Scot J. Paltrow & Leslie Scism, *Insurer Has Fought Hard to Keep Its Audits, Other Internal Documents Under Wraps*, WALL ST. J., Aug. 7, 1997, at A4. By making information about possible fraudulent conduct harder to get, audit confidentiality laws make information more costly, concealment more effective, thus further deterring victims from pursuing claims. And "anything that makes victims less aggressive in investigating and litigating makes fraud more profitable to its perpetrators." *Mosler*, 888 F.2d at 1144 (Easterbrook, J.).

158. *See* Respondent's Brief at *2-3. An EOB looks like this:

MAJOR MEDICAL EXPENSES COVERED:	
PAYMENT DETERMINATION SUMMARY:	
17.00 [at] 80.00% =	$13.60
TOTAL PAID:	$13.60
BENEFITS PAYABLE TO:	
Humana Hospital Sunrise	$13.60
TOTAL PAID:	$13.60

159. *See id.* at *4-5.

transfers.[160] Furthermore, Humana allegedly concealed the fraud from the Co-Payors, its billing agent, Humana insurance sales staff, and regional hospital administrators.[161] After over two years of operation, Humana's questionable billing practices were finally exposed by the media in 1987.[162] In response, Humana issued a press release falsely claiming that the Co-Payors had been billed at the discounted rate.[163]

2. ERISA Damages Are a Sub-Optimal Deterrent

As the district court noted in *Forsyth v. Humana*, plaintiffs who allege fraud by their employer-provided health care insurer face a "preemptive 'Catch-22'": their RICO action may be barred by the McCarran-Ferguson Act and their actions under state law are preempted by ERISA.[164] The

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160. *See id.* at *4.

161. *See id.* at *3-4.

162. *See id.* at *4.

163. *See id.*

164. ERISA's preemption clause provides that ERISA supercedes any and all state laws that relate to, refer to, or have a connection with any employee benefit plan. *See* 29 U.S.C. § 1144(a). The only exception is ERISA's Savings Clause which preserves from federal preemption state laws regulating the business of insurance. *See id.* at § 1144(b)(2)(A). Courts generally use a three part test to determine whether a state law regulates the business of insurance: 1) does the practice affect the transferring or spreading a policyholder's risk; 2) is the practice an integral part of the policy relationship between the insurer and the insured; 3) is the practice limited to entities within the insurance industry. *See* Metropolitan Life. Ins. Co. v. Massachusetts, 471 U.S. 724, 740-43 (1985). In addition, the state law must be specifically directed towards the insurance industry. *See* Pilot Life Ins. v. Dedeaux, 481 U.S. 41, 48-50 (1987). Using these criteria, courts regularly conclude that state laws that might be used against insurance company fraud are preempted by ERISA because the laws are not considered to be a "regulation of the business of insurance". *See, e.g.,* Custer v. Pan American Life Ins. Co., 12 F.3d 410 (4th Cir. 1993) (claims against insurer under West Virginia Unfair Trade Practice statute are preempted by ERISA); Lister v. Stark, 890 F.2d 941 (7th Cir. 1989) (ERISA preempts action for state common law fraud); Kanne v. Connecticut Gen. Life Ins. Co., 867 F.2d 489 (9th Cir. 1988) (ERISA preempts private right of action created by California Insurance Code for unfair insurance practices); Ryan v. Fallon Community Health Plan, 921 F. Supp. 34 (D. Mass. 1996) (ERISA preempts claims under Massachusetts statute prohibiting unfair and deceptive insurance practices). Nevada has a 'little RICO' law, NEV. REV. STAT. § 207.470 (Michie 1997), but it too would be preempted by ERISA. See Morgan, *supra* note 12 for a discussion of how this "preemptive Catch-22" leaves policyholders without an adequate, if any, remedy against insurance company fraud like that in *Humana*.

It is worth noting that recent U.S. Supreme Court cases have reined in ERISA preemption somewhat, letting more state law stand. In Blue Cross & Blue Shield v. Travelers Ins. Co., 514 U.S. 645 (1995) the Court held that a New York state statute which imposed surcharges on HMO's was not preempted by § 514 of ERISA. Travelers was followed by California Div. of Labor Standards Enforcement v. Dillingham Constr., 519 U.S. 316 (1997) (California labor

district court concluded that under ERISA: "[T]he proper measure of damages would be to restore the [plaintiffs] to the position they would have occupied but for the breach of trust."[165] While this may represent a correct calculation of damages for a breach of fiduciary duty under ERISA, it is an inadequate deterrent of insurance company fraud.[166]

The district courts' computation of expectation damages is a sub-optimal deterrent for several reasons. First, according to the district court in *Forsyth v. Humana*, expectation damages would equal the amount that the co-payors were over charged. For example, under the agreement that Humana had with Co-Payors, for a $1,000 procedure Humana should pay $800, leaving a $200 co-payment. Applying the 89% discount, the actual cost of the procedure is only $110, so Humana should pay $88 (80% x 110) and the co-pay should be $22 (20% x 110). But instead of $22, the Co-Payors were billed the un-discounted rate of $200 – or an over charge of $178. According to the district court, the Co-Payors should receive the difference between what they paid without the discount, and what they would have paid including the discount, or in the example above, the $178. This damages calculation is a sub-optimal deterrent because, as is demonstrated *supra*, damages must take into account the probability of detection to optimally deter. Thus, if the probability of detection in cases of insurance company fraud of this kind are relatively low, e.g., 50%, then damages must be set at more than twice the cost of the harm. So in the example above, to optimally deter a $178 dollar harm that has a 50% probability of detection, damages must be $356 (2 x 178). Under the district court's calculation, insurance companies have no incentive to not defraud policyholders because the company's expected benefit ($178) will always exceed the expected cost ($89) given a 50% probability of detection.[167] Because RICO's treble damages compensate for the low

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law which proscribed a minimum wage for public works contractors not preempted by ERISA) and DeBuono v. New York Comm'r of Health, 520 U.S. 806 (1997) (NY tax on medical center's gross receipts not preempted). *See also* Maria O'Brien Hylton, *Recent Development in ERISA Law*, 49 LABOR L. J. 1065 (1998) (discussing the above cases).

165. *Forsyth*, 827 F. Supp. at 1508 (quoting Donovan v. Biewirth, 745 F.2d 1049, 1056 (2nd Cir. 1985)).

166. "If perpetrators [of fraud] pay what they took when they get caught, and keep the proceeds the rest of the time, then fraud is profitable." Mosler, 888 F.2d at 1144 (Easterbrook, J.).

167. In real numbers, the 30,597 Co-Payors seek RICO damages of $5 million dollars, which is the amount of difference between the un-discounted and discounted co-payments. *See* Respondent's Brief at *7. Assuming that the difference in co-payments is $5,000,000, then if the probability of detection is 33% or lower, trebled damages would be required to deter an

probability of detection, they provide a deterrent to insurance companies to engage in this type of fraud. In the above example, treble damages boosts the expected cost to $267 (3 x 89), which is sufficiently greater than the expected benefit of $178 to deter a rational would-be racketeer.

Second, even assuming a 100% probability of detection, merely making Humana give back to the Co-Payors the amount that they were overcharged does not put the Co-Payors in as good a position as they would have been but for Humana's breach. Had the Co-Payors not been overcharged, they would have: 1) not been deterred from using healthcare benefits,[168] and 2) would have had more healthcare dollars with which to purchase more or better care.[169] RICO damages were designed to compensate for accumulative harm, which include injuries such as lost health care opportunities.[170]

Third, a multiplier is required to compensate for those who were harmed by Humana's scheme, but who are not a part of the class action.[171] For example, if Humana fraudulently received an average of $5,000 from 2,500 policyholders, or $12.5 million dollars, but only 1,000 of the policyholders sue, then Humana would pay ERISA damages in the amount of $5 million

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insurer from engaging in this type of scheme. Otherwise, the insurer expects to get a $5 million benefit for an expected cost of less than $2 million.

168. This is simply a matter of supply and demand. An increase in the cost of a good results in lower demand for the good. *See* POSNER, ECONOMIC ANALYSIS, *supra* note 133, at 4; Kennedy v. Connecticut Gen. Life. Ins. Co., 924 F.2d 698, 699 (7th Cir. 1991) (noting that "Co-payments sensitize employees to the costs of health care, leading them . . . to use less . . . "); Kansas Hosp. Ass'n v. Whiteman, 835 F. Supp. 1556, 1566 (D. Kan. 1993) (noting that imposing Medicare co-payments decreases utilization of benefits). For instance, if a procedure costs $1000, the un-discounted co-payment is $200, while the after-discount co-payment is only $22. This over-charge of $178 dollars reduces the utilization of health care benefits.

169. For example, if a cesarean section birth costs $10,000, given a $1,000 cap on the co-payment, instead of a $2,000 co-payment (20% x 10,000), the co-payment would be capped at $1,000. The after discount C-section cost is $1,100 (10,000 - (89% x 10,000)), 20% of which is $220. One can imagine a weary, new mother might like to stay a couple of extra days in the hospital before returning to the responsibilities of home and work. But she could not because she did not receive the discount which would have left her with an extra $780 (1,000 - 220) with which to pay for further medical care.

170. *See* Morse, *supra* note 139, at 528 n.13 ("Accumulative harm is that harm falling outside the range of legal damages, too elusive and indeterminate for adequate measurement by traditional damage principles."). In this case, the Co-Payors should receive damages in the amount of the value of the services they *would have purchased* had the price been lower, i.e., at the discounted cost.

171. Class actions do not consist of everyone who was harmed. Some victims may relocate out of the state, some may have died in the several years since the harm occurred, and some may have otherwise not become part of the class action.

dollars. Even with a 100% probability of detection and liability Humana would be better off by $7.5 million dollars for having committed fraud in this example. Treble damages ensure that fraud will not be profitable in cases in which not all victims participate in the class action.[172]

Humana seems to argue that RICO's treble damages will over-deter marginal conduct. That is to say, multiplied damages may deter socially beneficial conduct that either borders on being criminal or may be confused with criminal behavior. As a generality this argument has merit.[173] But specifically looking at the case against Humana, it is hard to see any beneficial borderline activity that will be deterred by RICO. This is so in part because the contract the Co-Payors had with Humana stipulated that Humana pay 80% and the Co-Payors cover the remaining 20% (but not to exceed $1,000 total). This agreement presumably distributed the risks of inflation and the rewards of decreasing medical costs. Except for the co-payments that would have been capped at $1,000, Humana could not improve their position without worsening the Co-Payors's position, i.e., any socially beneficial negotiations that Humana made, unless shared, would result in a co-payment of more than 20%.

Others argue that allowing RICO damages in contract enforcement cases is equivalent to allowing one party to unilaterally impose a liquidated or punitive damages penalty for which neither party had bargained.[174] This argument is unpersuasive in this context for two reasons. First, insurance companies control the terms of the contract; policyholders could not bargain for punitive damages even if they wanted to do so,[175] and considering the nature of the insurer - insured relationship, insureds may not even be aware that a breach has occurred.[176] Because insurers dictate the terms of policies

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172. *See generally* COOTER & ULEN, *supra* note 138, at 391.

173. For example, if Humana could be better off by breaching and make no one else worse off, then this would be an efficient breach.

174. *See* Rubin & Zwirb, *supra* note 153, at 907. Humana and its Amicus hint at this argument, claiming that increased litigation and damages will result in increased costs of business which the insurer had not contemplated.

175. *See* Morgan, *supra* note 12, at 241. Many have suggested that insurance contracts are essentially contracts of adhesion. *See, e.g.*, Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 HARV. L. REV. 1173, 1269 (1983).

176. "Parties may want punitive damages to be paid for breach in two contexts[:] . . . when the breached-against party does not automatically observe whether performance has occurred . . . or may not be able to prove this in court or lacks a financial incentive to sue." Polinsky & Shavell, *supra* note 137, at 938.

and have control over whether they will commit fraud,[177] implied punitive damages for breach of contract in the form of RICO damages for policyholders do not raise the same concerns as they might raise in other kinds of contracts.[178]

Second, and more fundamentally, implied punitive damages *are* warranted in cases of insurance fraud that are a breach of contract. Generally, implied liquidated or punitive damages may be inefficient because they discourage efficient breaches by raising the costs of a breach.[179] If one party can breach and be better off while at the same time not making the non-breaching party any worse off, the breach is efficient. By locking parties into a contract, liquidated damages for breach of contract prevent entrants into the market.[180] But here, liquidated damages in the form RICO damages prevent "entrants" into the "market" of insurance fraud. This is exactly the kind of "breach of contract" that RICO was designed to deter.

Finally, it has been suggested that because punitive damages which are levied against corporations will be borne by non-culpable parties, i.e., shareholders and consumers, "the importance of punitive damages may be considerably attenuated for corporate defendants."[181] This may be true of the retributive aspect of punitive damages, e.g., the culpable party cannot be made to pay damages, but the deterrent effects are not necessarily "attenuated" because shareholders and consumers may themselves ensure that the wrongs are not repeated. Shareholders may remove the culpable party and enact other measures to avoid future liability,[182] and consumers may

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177. "If . . . a reprehensible act is purely intentional, over-deterrence cannot occur." *Id.* at 907 n.120.

178. Perhaps there are some fraud prevention costs that Humana would incur. *See* Polinsky & Shavell, *supra* note 137, at 895 n.65 ("[A] firm may want . . . to impose punitive internal sanctions on its employees in order to deter them from acting in ways that cause harm[;] . . . the greater the likelihood that employees would escape such sanctions, the more the firm may want to spend on its monitoring and screening efforts."). Yet other health insurance companies in Nevada, such as Blue Cross & Blue Shield, seem to have not had any trouble sharing negotiated hospital discounts with their policyholders. *See* Respondent's Brief at *3. Polinsky & Shavell, *supra* note 137, at 938 suggest that "because insureds would in principle be willing to pay higher premiums in an insurance company can be deterred from [falsely denying a small claim], the insurer may benefit from an agreement to pay punitive damages when it is found liable . . . ."

179. *See* Lake River Corp. v. Carborundum Co., 769 F.2d 1284, 1289 (7th Cir. 1985).

180. *See* P. Aghion & P. Bolton, *Contracts as a Barrier to Entry*, 77 AMER. ECON. REV. 388-401 (1987).

181. Polinsky & Shavell, *supra* note 137, at 948.

182. For instance, after the national restaurant chain "Shoney's" settled a class action race discrimination lawsuit in 1992 for $132.5 million, the shareholders bought out the culpable

boycott a business that has been found liable for egregious behavior until it is reformed. Thus, although the effect of punitive damages on a corporation may miss the culpable individual(s), it can nevertheless achieve a deterrence of future violations.

3. Multiplied Damages and Fee Shifting Encourage Private Enforcement

RICO's treble damages provision not only provides a deterrent against concealed fraud and compensates victims for accumulative harm, it also encourages private parties to enforce RICO's prohibitions against fraud and other racketeering activity.[183] By raising plaintiff's expected benefit from litigation, treble damages provide a greater incentive to victims to risk the costs associated with litigation.[184] RICO also provides for reasonable attorney's fees for prevailing plaintiffs, which of course provides an incentive for lawyers to take RICO cases.[185] In conjunction, these provisions provide

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party and instituted reforms to avoid future lawsuits. *See* Steve Watkins, *Racism du jour at Shoney's*, 257 THE NATION 424 (1993). The shareholders were admittedly motivated by self-interest - they sought to preserve the value of their stock investments in Shoney's. Yet their reforms led to Shoney's becoming an award winning model of affirmative action. *See* Rhonda Kerr, *Shoney's: 'A Changed Company,'* NASHVILLE BUSINESS JOURNAL, vol. 9, p. 1 (Sept. 1993). One can easily imagine that an insurance company's liability insurer would also be interested in avoiding further claims, and would intervene after a policyholder sustains a large penalty.

183. *See* Shearson/American Express, Inc. v. McMahon, 482 U.S. 220, 241 (1987) (treble damages provision creates "vigorous incentives for plaintiffs to pursue claims"). *See also* Reiter v. Sonotone, Corp., 442 U.S. 330, 344 (1979) (discussing the Clayton Act: "Congress created the treble damages remedy . . . precisely for the purpose of encouraging private challenges to . . . violations.").

184. *See* POSNER, ECONOMIC ANALYSIS, *supra* note 133, at 242. Easterbrook writes that: "If victims recoup only what they lost [e.g. ERISA damages], and face the burdens and uncertainties of the legal process plus the costs of their own counsel, then victory will not make them whole, and the shortfall may mean that victims will not vigorously investigate and litigate." Mosler, 888 F.2d at 1144. Usually in civil cases the plaintiff's net expected payoff [Pe] of litigating is equal to the probability of winning [Pw] multiplied by the amount of damages [D] awarded minus the expected costs of litigation [C], or Pe = (Pw x D) - C. RICO's trebling of damages increases the plaintiff's expected payoff. For example, if Pw = .5, C = 50,000, and D = $250,000, then Pe = $75,000. Trebling D obtains a Pe of $325,000, or $250,000 greater expected net payoff than without multiplied damages. *See also* Polinsky & Shavell, *supra* note 137, at 938 ("[I]f an insurance company fabricates a reason for not paying a small claim, the insured may not sue because of the uncertainty of success and the cost of a lawsuit.").

185. Fee shifting also boosts the plaintiff's expected payoff. In the above example for instance, shifting the plaintiff's attorney's fees onto the defendant results in a net expected

powerful incentives for private enforcement of RICO.[186] The risk inherent in a system of private enforcement is that treble damages causes a wasteful investment in pursuing RICO claims which ultimately result in over-deterrence.[187] For example, imagine that a $100,000 harm has a 1/3 probability of being detected and punished. Treble damages would provide optimal deterrence: (100,000/ ⅓) = $300,000.[188] But if the lure of treble damages increases the probability that the crime will be detected and the perpetrator will pay damages, e.g., from 1/3 to 2/3, then treble damages will be double optimal damages (300,000 > 100,000/ ⅔ or 150,000).[189] With respect to RICO, if over-deterrence exists one would expect that it would be evidenced by greater numbers of RICO complaints being filed. But this is not the case. The number of RICO cases filed has decreased from 903 in 1980 to around 840 during the period from 1993 to 1997.[190] Moreover, no one has

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payoff of $375,000. Fee shifting is consistent with the idea that wrongdoers should internalize the costs of their wrongdoing, including enforcement.

186. Private civil suits are essential to the enforcement of many laws. *See, e.g.,* Basic Inc. v. Levinson, 485 U.S. 224, 231 (1988) ("a private cause of action . . . constitutes an essential tool for enforcement of the1934 [Securities Exchange] act's requirements"); Newman v. Piggie Park Enterprises, Inc., 390 U.S. 400, 402 (1968) (Congress allowed fee-shifting . . . because a plaintiff who obtains relief in a civil rights lawsuit "does so not for himself alone but also as a "'private attorney general.'").

187. "The probable over-enforcement in RICO cases means that society will inefficiently spend too much on enforcing this statute. [But] the major cost is over-deterrence of useful activity . . ." Rubin & Zwirb, *supra* note 153, at 903. For example, over-deterrence may result in useful products being withdrawn form the market, or may increase the cost of goods - a cost that is ultimately passed on to consumers. *See* Polinsky & Shavell *supra* note 137, at 893.

188. This example assumes that transaction costs are minimal, i.e., that the defendant should not be liable for *more* than $300,000 so as to discourage use of the legal system to effect a transaction that would have been cheaply performed in the market.

189. *See* Polinsky & Shavell *supra* note 137, at 894, n.66 for a more formal statement of the effect of a damages multiplier on the probability of litigation. One way to reduce over-deterrence that may result from the incentives created by trebling is "decoupling." Decoupling involves awarding only some of the damages to the injured party, with the rest of the award going to the state. Thus, "[d]ecoupling mitigates the propensity of punitive damages awards to encourage unnecessary litigation, but does not dilute deterrence because defendants' damage payments are unaffected." *Id.* at 923. Some states already have decoupling statutes. *See* BMW of North America v. Gore, 517 U.S. 559, 616 (1996) (Justice Ginsburg, dissenting) (listing decoupling statutes recently enacted or proposed in Arizona, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Missouri, Montana, New Jersey New Mexico, Oregon, and Utah).

190. *See* Respondent's Brief at *44, n.35 (citing Judicial Business of the United States Courts 1997, Table C-2A). This trend may be due to a phenomenon represented in the "Laffer Curve of Litigation." *See* Steven C. Salop & Lawrence J. White, *Economic Analysis of Private Antitrust Litigation*, 74 GEO. L.J. 1001,1020 (1986). Namely, that aggressive enforcement prompted by fee shifting and multiplied damages initially results in an increased number of

suggested that the insurance companies' defrauding of policyholders out of healthcare benefits is the kind of 'useful' activity deserving of shelter from aggressive enforcement under RICO. Of course, we do not want to discourage insurance companies from negotiating for discounted rates. If they did so and shared the benefits, everyone would be better off. But that is precisely what Humana did not do.

Ultimately, it is hard to know exactly how much potentially beneficial behavior might be deterred by a treble damages remedy. But it is clear that the district court's award of ERISA damages in *Forsyth v. Humana* provides little deterrent if the probability of being caught is less than 1.0 or if not all victims sue. Reimbursement of overcharges as the sole penalty actually provides an incentive to commit fraud. While treble damages may be "too much" and result in inefficient deterrence of socially beneficial behavior, mere reimbursement for the overcharges is "too little." This inflexibility has led critics to argue for judicial discretion to tailor RICO damages to the circumstances of the case.[191]

Finally, a system of private enforcement is needed because states' administrative enforcement schemes are inadequate.[192] States' insurance regulatory agencies are generally underfunded,[193] overburdened,[194] or may

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claims because plaintiffs have high incentives to pursue claims. *See id.* As perpetrators are punished and other would-be violators are deterred, the number of claims drops off because there is less fraud occurring. *See id.*

191. *See* Jonathan Turley, *The RICO Lottery and the Gains Multiplication Approach: An Alternative Measurement of Damages Under Civil RICO*, 33 VILL. L. REV. 239, 279 (1988) (arguing for RICO damages to be measured according to the racketeer's gains rather than the victim's losses); Rubin & Zwirb, *supra* note 153, at 911-12 (suggesting that RICO damages should be available only if the defendant is convicted of a criminal RICO violation or treble damages should be eliminated altogether). *But see* Blakey & Perry, *supra* note 57, at 943 ("Treble damages . . . contain an appropriate balance of swift, sure, and severe deterrence."); Polinsky & Shavell, *supra* note 137, at 920 (rejecting a gains-based approach to damages unless "removing the defendants gain is potentially appropriate and necessary only when the defendant is an individual [as opposed to a corporation] who acted maliciously and obtained a socially illicit gain.").

192. Recent Congressional investigations have found that states are simply unable to combat interstate and international insurance fraud. *See* "Wishful thinking", *supra* note 1.

193. Insurance regulators lack the resources to prevent and prosecute systemic fraud and corruption in the insurance industry. *Id. See also* Paltrow, *supra* note 9, at A1 (detailing the meager budget of the Indiana Insurance Dept. and the deleterious effects on its effectiveness).

194. *See id.* Colorado also provides a good example. The Colorado Insurance Dept. received over 7,000 consumer complaints against insurance companies. The Dept. imposed fines in only seven of these cases, the highest of which was $ 20,000. *See* Scott J. Paltrow, *Top Insurance-Industry Advocate is Hired to Audit State Agency,* WALL ST. J., June 11, 1998, at B2.

simply fail to adequately enforce the state's laws.[195] RICO allows insureds to act as "private attorneys general", thus assisting state insurance commissioners to regulate insurer misconduct.

CONCLUSION

Although the McCarran-Ferguson Act sought to minimize federal interference with state laws that regulate the business of insurance, it did not do so unconditionally. The original meaning of the McCarran-Ferguson Act's language supports the Court's conclusion that only federal laws that directly conflict with state laws are barred by the Act. Without RICO, insurers will be under-deterred from engaging in costly fraudulent schemes; defrauded policyholders will be inadequately compensated; and insurance regulators' anti-fraud efforts will be diminished. RICO must continue to be an available remedy for wronged consumers, victimized insurance companies, and state insurance regulators against systemic fraud, deceit, and corporate crime within the insurance industry.

195. For example, the Nevada Attorney General began an investigation into Humana's billing fraud and drafted a criminal complaint that alleged that Humana's co-payment billings violated Nevada's racketeering laws. Meanwhile, Humana persuaded the Nevada Insurance Commissioner to agree to a consent decree that imposed a $ 50,000 fine on Humana in return for the state dropping its racketeering charges. The Attorney General was forced to end his investigation, the policyholders were left without compensation, and Humana was left undeterred. *See* Respondent's Brief, *supra* note 59, at *5-6.

AN OVERVIEW OF FINANCIAL SERVICES REFORM 1998

*Susan Sirota Gaetano**

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INTRODUCTION

The financial services industry is swiftly headed towards consolidation as evidenced by the increasing number of mergers and acquisitions taking place. More than 1,800 banks and 345 thrifts have been acquired or merged over the past five years.[1] If this trend continues, the industry may end up being dominated by a few giants. This convergence in the industry is spurred by changes occurring in the marketplace, including advancing technology and expanding globalization.[2] As a result of these mergers, the regulatory framework will necessarily change. The present regulatory structure does not make sense in today's marketplace because the products and services of banks, insurers and securities firms can no longer be functionally separated.[3] The traditional lines that separated these three industries have crossed because of advanced new financial products.[4] To meet changing customer needs and the increasing global market, financial services firms want to sell a broad array of financial products and services.[5] However, the current laws stand in the way of a full blending of banking, insurance and securities.[6]

This year marks the tenth time over the past two decades that legislators have tried and failed to repeal the Glass-Steagall Act.[7] The country is trying to advance financial reform the best it can despite the lack of official financial services modernization legislation. The courts are responding to the pressure of the changing financial services industry through expansive interpretations of the existing laws.[8] Similarly, the Office of the Comptroller of Currency has been increasing the power of national banks through creative decisions that push the boundaries of current laws.[9] The Office of Thrift Supervision has been liberally granting thrift charters so that entities can enlarge their financial service offerings.[10] Even the industry leaders have moved ahead on their own. The merger of

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1. *See* Ellen Seidman, *H.R. 10 Is Not the Answer*, NAT'L MORTGAGE NEWS, June 1, 1998, *available in* 1998 WL 10162318.

2. *See* Jill Dutt & John M. Berry, *Citicorp-Travelers Deal to Test Old Regulatory View; Laws Ban Bank-Insurance Mixture*, WASH. POST, Apr. 7, 1998, at C1.

3. *See Id.*

4. An example of one such product is variable life insurance, which ties the value of a life insurance policy to the returns of an investment portfolio. *See Money*, USA TODAY, Oct. 26, 1998, *available in* 1998 WL 5740106.

5. *See supra* note 2.

6. *See infra* Part II.A-C.

7. *See Shattering Glass-Steagall*, WALL ST. J., June 22, 1998, at A22.

8. *See infra* Part II.A.

9. *See infra* Part IV.

10. *See id.*

Travelers and Citicorp marks the first combination of insurance, securities and banking since the passage of the Glass-Steagall Act.[11] The merger increases the pressure on Congress to pass financial legislation reform as the marketplace continues to charge ahead.

Congress came close this year to passing legislation that would allow the financial services laws to catch up with the marketplace. However, several provisions caused enough disagreement between different political and trade groups to prevent passage.[12] This paper examines the basics of the financial services reform proposals, the major sources of contention and the outlook for the future.

I. BACKGROUND

In order to understand the proposed financial reform legislation, it is helpful to examine the relevant existing laws. There are three areas which deserve particular attention because of their impact on the current proposed legislation. First, section 92 of the National Bank Act will be discussed because of its implications on state laws that restrict bank sales of insurance. Second, section 20 of the Glass-Steagall Act will be looked at to understand the prohibition it imposes on the affiliation between commercial and investment banking. Finally, the Bank Holding Company Act of 1956 will be examined because it creates a separation of banking and insurance underwriting.

A. Section 92 of the National Bank Act

Section 24 (Seventh) of The National Bank Act of 1864 permits banks to engage in the "business of banking" and to exercise "all such incidental powers as shall be necessary to carry on the business of banking."[13] However, traditionally insurance was not considered incidental to banking, so banks were prohibited from engaging in the business of insurance.[14] In reaction to the financial instability of nationally chartered banks in small towns, Congress enacted section 92 in 1916.[15] It authorizes national banks located in places of 5,000 people or less to act as agents in the sale of insurance policies underwritten by unaffiliated insurance companies.[16]

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11. *See infra* Part V.

12. *See infra* Part III.B.

13. 12 U.S.C. § 24 (Seventh) (1994).

14. *See* Linda Birkin Tigges, Comment, *Functional Regulation of Bank Insurance Activities: The Time Has Come*, 2 N.C. BANKING INST. 455, 458-59 (1998).

15. *See id; see also* 12 U.S.C. § 92 (1994).

16. *See* 12 U.S.C. § 92 (1994).

Section 92 has resulted in a number of lawsuits because of the ambiguity it creates regarding the extent of bank insurance powers. In 1945 Congress enacted the McCarran-Ferguson Act, which prohibits a federal statute from preempting any state law enacted to "regulate the business of insurance," unless the federal statute "specifically relates to the business of insurance."[17] In *Barnett Bank v. Nelson*,[18] the Court held that section 92 preempted a state law which prohibited a bank from selling insurance in a town with a population of less than 5,000. The Court found that the McCarran-Ferguson Act's reverse preemption rule did not protect the state law because section 92 is specifically related to the business of insurance.[19] It explained that if a state law "prevents or significantly interferes" with a national bank's insurance powers under section 92, then it will be invalid.[20] More recently, in *New York Bankers Ass'n v. Levin*,[21] the district court held that section 92 preempts a New York law that prohibits banking institutions from negotiating certain property insurance policies. In addition, Huntington National Bank has filed a suit to overturn an Ohio law that it claims illegally restricts bank sales.[22] This case is one more sign that litigation will likely continue until there is more clarification in interpreting Section 92.

B. Glass-Steagall Act

The Glass-Steagall Act[23] was enacted in 1933 in response to the Great Depression, which resulted in more than 10,000 bank failures or forced mergers.[24] The Act prohibits commercial banks from affiliating with securities firms and underwriting securities.[25] Specifically, section 20 of the Act prevents a commercial bank from affiliating with an entity that is "engaged principally in the issue, floatation, underwriting, public sale, or distribution" of bank-ineligible securities.[26] The Board of Governors of the

17. 15 U.S.C. § 1012 (1994).
18. 517 U.S. 25 (1996).
19. *See id.* at 26.
20. *See id.* at 33.
21. 999 F.Supp. 716 (W.D.N.Y. 1998).
22. *See* Jaret Seiberg, *Huntington, Trade Groups Battling Ohio Insurance Law*, AM. BANKER, Nov. 9, 1998, *available in* 1998 WL 13325789.
23. The Glass-Steagall Act refers to sections 16, 20, 21 and 32 of the Banking Act of 1933.
24. *See* John S. Barry, *Creating a Financial Services Industry for the 21st Century, Part 1: Tear Down the Walls*, THE HERITAGE FOUNDATION, June 5, 1996.
25. *See* 12 U.S.C. § 377 (1994).
26. *Id.*

Federal Reserve System ("Fed")[27] has interpreted this section as allowing bank holding companies to underwrite securities provided they are not "engaged principally" in the securities underwriting business.[28] Specifically, the Fed has said that bank holding companies can own non-bank subsidiaries as long as they do not derive more than twenty-five percent of their gross revenues from securities underwriting.[29] The remainder of the revenues must be derived from bank-eligible activities.[30] Aside from the twenty-five percent securities underwriting revenue limitation , these section 20 subsidiaries are also subject to firewalls created to separate the subsidiary from its bank affiliate.[31] Although the Fed has recently relaxed these firewalls in order to allow bank holding companies to acquire larger investment firms, they still may not control open-end mutual funds, which are considered to be engaged principally in 'bank-ineligible" securities activities.[32]

C. Bank Holding Company Act of 1956

In order to get around the Glass-Steagall Act, banks created holding companies that owned a part of several different companies.[33] Therefore, a holding company could own a commercial bank, an investment bank and an insurance company.[34] The arrangement was legal under the Glass-Steagall Act because the holdings were separate entities.[35] The Bank Holding Company Act of 1956 ("BHCA") put a stop to bank holding companies owning such diverse entities by limiting bank affiliates to acts that are "closely related to banking."[36] Such activities do not include insurance, so banking and insurance underwriting cannot be combined.[37]

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27. The Board of Governors of the Federal Reserve System is a federal government agency made up of seven members appointed by the President. The Board's responsibilities include supervising the Federal Reserve Banks, regulating the nation's payments system, and administering the consumer credit protection laws. *See* THE FEDERAL RESERVE SYSTEM: PURPOSES AND FUNCTIONS 4 (8th ed. 1994) <http://www.bog.frb.fed.us/aboutfrs.htm>.

28. *See* Securities Indus. Ass'n v. Board of Governors of Fed. Reserve Sys., 847 F.2d 890 (D.C. Cir. 1988).

29. *See U.S.: Financial Services Alert*, BUS. MONITOR, June 22, 1998, *available in* 1998 WL 9017816.

30. *See id.*

31. *See id.*

32. *See id.*

33. *See supra* note 24.

34. *See id.*

35. *See id.*

36. 12 U.S.C.A. § 1843 (c)(8) (1994).

37. *See id.*

However, the BHCA does permit subsidiaries of bank holding companies to broker insurance products.[38]

In 1982 Congress amended the BHCA by passing the Garn-St. Germain Act.[39] The Act was passed in reaction to the Fed's attempts to allow bank holding companies to sell certain types of insurance.[40] It states that the sale of insurance is not to be considered an activity that is "closely related to banking," although there are a few exceptions.[41] Consequently, the Fed may not permit bank holding companies to engage in the underwriting or sale of insurance.

D. Historical Arguments Against Reform

There are several historical arguments against reform that have proven to be more myth than reality. Traditionally, it was feared that financial services' consolidation would jeopardize individuals' life savings.[42] It was believed that if a bank's affiliate needed help, the bank's capital could simply be transferred.[43] Another fear was that the bank would buy securities from its affiliates at above-market prices or conversely sell securities to its affiliates at below market prices.[44] Also, it was speculated that a bank underwriting equity in a company would urge its depositors to invest in the company, regardless of the soundness of the investment.[45] These arguments were strengthened by the belief that bank owners would put their own financial interests before those of the depositors.[46] Such traditional arguments against consolidation rested on unfounded speculation about prospective bank behavior.

These historical misconceptions have been largely disproved by contemporary studies. For example, studies show that banks that engaged in stock market investment before the Glass-Steagall Act was enacted were less likely to fail than those that were not involved in investment activities.[47] This result is due to the fact that integrated banks have larger

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38. *See id.*

39. *See id.*

40. J. Virgil Mattingly & Keiran J. Fallon, *Understanding the Issues Raised by Financial Modernization*, 2 N.C. BANKING INST. 25, 29-30 (1998).

41. 12 U.S.C. § 1843 (c)(8) (1994).

42. *See supra* note 24.

43. *See id.*

44. *See id.*

45. *See id.*

46. *See id.*

47. *See id.* (referencing Eugene White, *Before the Glass-Steagall Act: An Analysis of the Investment Banking Activities of National Banks*, 23 EXPLORATIONS IN ECON. HIST. 33, 40 (1986). The study found that "while 26.3 percent of all national banks failed in this period [from 1930-1933], only 6.5 percent of the 62 banks which had [investment] affiliates

asset bases and are better able to diversify.[48] Furthermore, the evidence shows that securities issued by banks before the passage of the Glass-Steagall Act performed better than securities issued by investment banks.[49] This outcome is due to the fact that the depositors generally tended to closely scrutinize the bank's portfolio, so the bank was forced by the market to underwrite relatively safe securities.[50] Thus, the evidence shows that in reality consolidated banks were running safely and efficiently prior to the passage of the Glass-Steagall Act.

E. Current Arguments Against Reform

Consumer advocates fear that financial reform in today's marketplace will have negative implications for consumers. First, they worry that the one-stop shopping created by financial services mergers will end up costing consumers more than it will save them. They point to the risk of mis-selling products due to improperly trained salespeople combined with overly aggressive sales targets.[51] Consumer advocates also warn that using just one provider will weaken the customer's sense of control and power to negotiate.[52] Furthermore, some experts predict that customers will be charged higher fees and the level of service will decrease.[53] However, banks disagree, arguing that consumers will have the benefit of convenient one-stop shopping and lower costs.[54]

Consumer advocates also fear that a conglomerate's access to confidential customer information will lead to abuse. In order to effectively cross-market, it is expected that conglomerates will create unified databases that combine private customer information from their

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in 1929 and 7.6 percent of the 145 banks which conducted large operations through their bond departments closed their doors." *Id.*

48. *See id.*

49. *See id.* (referencing Randall S. Krozner and Raghurm G. Rajan, *Is the Glass-Steagall Act Justified? A Study of the U.S. Experience with Universal Banking Before 1933*, AM. ECON. REV., Sept. 1994, at 814-815). The study found that "investment bank underwritten issues experienced roughly 40 percent more defaults than [did] affiliate underwritten issues." *Id.*

50. *See id.*

51. *See Do Consumers Really Want to be Owned by a Citigroup "Big Brother?,"* RETAIL BANKER INT'L, Apr. 29, 1998, *available in* 1998 WL 10785482.

52. *See Citigroup Starts Damage Control on Consumer Complaints*, BANK MARKETING INT'L, Aug. 1, 1998, *available in* 1998 WL 12310670.

53. *See* Eileen Ambrose, *New World of Banking Fast Approaching: Experts Say Future Service Boils Down to Quality or Quantity*, INDIANAPOLIS STAR, Apr. 19, 1998 at E1, *available in* 1998 WL 8325253.

54. *See* Christine Dugas, *Consumers Win Some, Lose Some Banking Bill*, USA TODAY, May 15, 1998, *available in* 1998 WL 5724649.

various affiliates.[55] This compilation is possible because the Fair Credit Reporting Act of 1997 allows affiliates to share information.[56] Thus, consumer advocates worry that merged companies will inappropriately share and exploit customer information without informed consent.[57] Current privacy regulations are loose and only require that the consumer be given the right to "opt-out" of cross-marketing arrangements.[58] Many consumer advocates are pushing for stricter "opt-in" language which would place the burden on the company to obtain the customer's permission to share private information.[59] Privacy legislation is not being considered directly as part of the financial reform legislation, although numerous separate bills have been proposed.[60] However, companies want the public to trust them not to abuse private information without any formal legislation.[61] They claim that they have an incentive to maintain effective self-regulation in order to stay competitive and keep their customer base.[62]

II. THE PROPOSED LEGISLATION

It is generally accepted today that some type of financial services reform is necessary. However, passage of reform has been stalled by disagreements over specific provisions included in the proposed legislation. Although the 105th Congress was closer to passing a financial services reform bill than in prior years, the legislation ultimately failed this year. The bill, known as H.R.10,[63] passed in the House of Representatives by one vote.[64] However, the Senate failed to vote on the bill before it adjourned

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55. *See* Marcy Gordon, *Financial Privacy Bill Pushed*, ASSOCIATED PRESS, May 8, 1998, *available in* 1998 WL 6661958.

56. *See* Matthew Lubanko and Fran Silverman, *Merger Triggers Fears About Privacy; Travelers, Citicorp Would Have Wealth of Data on Customers*, HARTFORD COURANT, Apr. 17, 1998, at A1.

57. *See* Gordon, *supra* note 55.

58. *See Financial Firms Oppose New Privacy Laws*, INS. ACCT., June 29, 1998, *available in* 1998 WL 5100132.

59. *See id.*

60. The most recent bill was introduced by Jim Leach, Chairman of the House Banking Committee, and is called the Financial Information Privacy Act of 1999. *See Privacy Bill Makes Encore Appearance*, INT'L BANKER, Jan. 11, 1999, *available in* 1999 WL 5991894.

61. *See Financial Firms Oppose New Privacy Laws*, *supra* note 58.

62. *See id.*

63. H.R. 10, 105th Cong. (1998).

64. *See* Dean Anason, *Supporters of Reform Bill Rally for a Rematch*, AM. BANKER, Oct. 23, 1998, *available in* 1998 WL 13325252.

for the year.[65] There was simply too much powerful opposition to parts of the bill for it to come before the Senate in its present form.

A. The Basics

There are several core provisions of H.R.10 that are widely agreed upon by those involved and are likely to be part of any financial services reform legislation. First, the bill repeals section 20 of the Glass-Steagall Act.[66] Consequently, there would no longer be a prohibition between commercial banks affiliating with entities engaged principally in securities activities.[67] Next, the bill amends the Bank Holding Company Act of 1956 to exempt from its prohibition against interests in nonbanking organizations the shares of any company whose activities are "so closely related to banking as to be proper incident thereto."[68] The businesses conducted would have to be "financial in nature" or "incidental to financial activities."[69] The bill lists activities that are considered to be financial in nature including lending, insuring, underwriting and securities investing.[70] The holding companies could, however, take up to fifteen percent of their total revenues from nonfinancial activities.[71] Under the section describing the eligibility requirements for financial holding companies, the bill states that the subsidiary depository institutions of the financial holding companies would have to be well-capitalized, well-managed and achieve a satisfactory rating under the Community Reinvestment Act.[72] Finally, the bill provides that it would preempt state anti-affiliation laws restricting transactions among insured depositor institutions, wholesale financial institutions, insurance concerns and national banks, although there would be some exceptions such as the state regulation of business insurance.[73]

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65. *See Financial Services Reform Is Dead for This Year*, BEST'S INS. NEWS, Oct. 9, 1998, *available in* 1998 WL 19369890.

66. *See* H.R. 10, 105th Cong. Title I (1998).

67. *See id.*

68. *Id.*

69. *Id.*

70. *See id.*

71. *See id.*

72. *See id.* The Community Reinvestment Act is a 1977 federal law that has the goal of increasing access to credit in low and moderate income areas. *See* Christi Harlan, *Why Gramm Strangled Bank Bill: Opposition to Consumer Lending Reviews Doomed Plan to Mix Financial Services*, AUSTIN AM.-STATESMAN, Oct. 23, 1998, *available in* 1998 WL 3628874.

73. *See supra* note 66.

B. Sources of Contention

There are a number of provisions that are causing dissention among different political and trade groups. Some of the controversial items have been changed in the Senate's version of the bill. Other disputed provisions were major contributors to H.R.10's failure to pass this term. These contested provisions deserve a closer look because of the potential impact they may have on future financial reform proposals.

1. SEC Regulation

One major source of disagreement is the method of regulating the consolidated entity. Under the House version's functional regulation requirements, the states would regulate insurance, the Securities and Exchange Commission ("SEC")[74] would regulate securities and the Office of the Comptroller of Currency ("OCC")[75] would regulate banking.[76] However, the version of the bill introduced to the Senate differed from the one passed by the House because members of both the House and Senate committees overseeing the bill reached an agreement which would give the SEC broad-reaching authority over bank investment service programs.[77] The SEC would be given the authority to decide which investment products sold by banks to regulate.[78] Although the Fed would be able to challenge the SEC in court, a lot of the responsibility that the Fed and OCC currently have in regulating banks would be eliminated.[79] Predictably, there has been notable opposition to the agreement.[80]

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74. The Securities and Exchange Commission is a quasijudicial regulatory agency that administers the federal securities laws and regulates investment companies. *See The U.S. Securities and Exchange Commission: What It Is, What It Does* (last update: 11/18/96) <http:/www.sec.gov/asec/asecart.htm>.

75. The Office of the Comptroller of Currency is a bureau of the Treasury Department. It promulgates and oversees regulations governing the operations of national banks. *See The Duties and Functions of the Treasury Department, its Offices and Bureaus* (visited Mar. 1, 1999) <http://www.ustreas.gov/opc/opc0042.html>.

76. *See* H.R. 10, 105th Cong. Title II (1998); H.R. 10, 105th Cong. Title III (1998).

77. *See How Bank Securities Biz Figures into H.R. 10*, BANK MUTUAL FUND REP., Oct. 5, 1998, *available in* 1998 WL 5110490; *First Vote Monday on "Historic" H.R. 10 Bill*, INS. REG., Oct. 5, 1998, *available in* 1998 WL 5050001.

78. *See How Bank Securities Biz Figures into H.R. 10, supra* note 77.

79. *See First Vote Monday on "Historic" H.R. 10 Bill, supra* note 77.

80. *See Id.* Specifically, Representative John Dingell (D-Mich.) has voiced his strong opposition to the agreement.

2. Insurance Regulation

Under H.R.10 as it now stands, state insurance regulators retain their current authority.[81] Supporters of this present scheme of insurance regulation emphasize that exposure to the risk of bad regulation is spread out over all of the states.[82] However, the American Banker's Association insurance affiliate has suggested creating a federal insurance regulator, who would become the functional regulator of federally-chartered insurance companies.[83] The federal regulator would act as a counterweight to the OCC and the Fed.[84] The position would have a five-year term and would be under the Treasury Department.[85] In addition, the new regulatory structure would be a dual system, where the insurers would be able to opt into federal regulation.[86] However, supporters of state regulation say that such a system will increase the regulatory burden and costs to insurers due to inefficiency and duplication.[87] They also point out that the current regulatory system has resulted in very few disasters, especially compared to the savings and loan crisis.[88] Although the proposal is not likely to be a part of H.R. 10 directly, it is interrelated with discussions and provisions of the bill.[89]

3. Insurance Preemption Provisions

The House and Senate versions of the bill both provide that federal regulations preempt state laws that "significantly interfere" with banks' ability to sell insurance products.[90] In other words, the McCarran-Ferguson Act remains the law under H.R. 10.[91] However, the Senate version goes further and creates a safe harbor for certain types of state laws governing insurance sales.[92] The state insurance laws do not have to exactly duplicate

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81. *See* H.R. 10, 105th Cong. Title III (1998).

82. *See NAII Chief Fears a "Civil War" Over Reform*, INS. REG., Nov. 16, 1998, *available in* 1998 WL 5050117.

83. *See Federal Insurance Regulator Debated*, REG. COMPLIANCE WATCH, Sept. 28, 1998, *available in* 1998 WL 5059995.

84. *See* Stephen Piontek, *Is a Federal Insurance Regulator Only Wishful Thinking?*, NAT'L UNDERWRITER LIFE & HEALTH-FIN. SERV. EDITION, Nov. 2, 1998, *available in* 1998 WL 20199439.

85. *See supra* note 83.

86. *See id.*

87. *See supra* note 82.

88. *See supra* note 84.

89. *See Federal Insurance Regulator Debated*, *supra* note 83.

90. H.R. 10, 105th Cong. Title I (1998); H.R. 10, 105th Cong. Title I (1998).

91. *See supra* note 66.

92. *See* H.R. 10 RS, 105th Cong. Title I (1998).

the safe harbor provisions listed in the bill.[93] In order to be protected from federal preemption, the laws merely need to be "no more burdensome or restrictive" than the safe harbor provisions.[94] However, other state laws could be preempted if they "prevent or significantly interfere" with a national bank's activities.[95] These state laws that do not fall within the safe harbor provisions would be given a nondiscrimination test to determine if they have any adverse impact on banks selling insurance.[96] As part of the Senate's version of insurance provisions, the Comptroller of the Currency would no longer be given judicial deference in court disputes with state insurance regulators.[97]

4. Holding Company v. Operating Subsidiary

H.R. 10 provides that the merged entity operate under a holding company structure.[98] This provision has spurred a heated debate between the Fed and the Treasury.[99] Holding companies are regulated by the Fed, whereas operating subsidiaries are under the Treasury. Therefore, it is no surprise that the Secretary of the Treasury vehemently opposes the bill using the holding company structure rather than operating subsidiaries.[100] The regulatory power of the Comptroller of Currency would be severely limited.[101] According to proponents of the holding company structure, it has the advantage of insulating banks' insured deposits from the uninsured activities of its affiliates.[102] The capital is segregated among the different units owned by the parent firm.[103] So if the commercial bank is having a difficult time, it cannot strengthen its capital position by transferring money

93. *See id*; *First Vote Monday on "Historic" H.R.10 Bill*, *supra* note 77.

94. H.R. 10, 105th Cong. Title I (1998); *See also First Vote Monday on "Historic" H.R. 10 Bill*, *supra* note 77.

95. H.R. 10, 105th Cong. Title I (1998). The bill specifically refers to the Supreme Court decision in *Barnett Bank v. Nelson* in determining the "prevent or significantly interfere" standard. *See supra* Part II.A.

96. *See* H.R. 10 RS, 105th Cong. Title I (1998); *US: Financial Services Alert*, BUS. MONITOR, Sept. 16, 1998, *available in* 1998 WL 9018276.

97. *See* H.R. 10 RS, 105th Cong. Title I (1998); *US: Financial Services Alert*, *supra* note 71.

98. *See* H.R. 10, 105th Cong. Title I (1998).

99. *See* Carter H. Golembe, *Banking Agency Turf War: It's Not Like Wendy's and McDonald's*, 17 NO. 10 BANKING POL'Y REP. 1 (1998); Robert H. Gettlin, *Bank Regulators Lock Horns*, INV. BUS. DAILY, May 13, 1998, *available in* 1998 WL 11850481.

100. *See* Gettlin, *supra* note 99.

101. *See* Jane J. Kim, *Travelers, Citicorp Deal Seen Completed Sooner Than Expected*, DOW JONES NEWS SERV. PLUS, June 29, 1998.

102. *See id.*

103. *See* Gettlin, *supra* note 99.

from a non-bank affiliate.[104] In contrast, operating subsidiaries could create a moral hazard to brokers and insurers because they would not be fully responsible for their losses.[105] The government's insurance of bank deposits would in essence be extended to other financial businesses.[106]

Opponents of the holding company structure argue that by not allowing operating subsidiaries, the present system of national banking is weakened.[107] Banks currently have the ability to use the subsidiary structure outside of the United States to engage in a range of financial services.[108] However, H.R. 10 mandates only one corporate form, so that consolidated entities would not have the ability to freely choose their corporate structure.[109] Furthermore, opponents point out that the operating subsidiary structure allows bank policy to be set by elected government, rather than the unelected Fed.[110] Also, they see the free flow of capital permitted in operating subsidiaries as an advantage rather than a threat.[111] The opposition to this aspect of the bill is strengthened by the President's support of the Secretary of Treasury and his corresponding threat to veto the bill.[112]

5. Unitary Thrifts

The unitary thrift[113] issue has been forced to the forefront because about sixty-six companies applied for charters in 1998, more than triple the number of applications two years ago.[114] Unitary thrifts are viewed by some companies as the best means to expand into banking until financial modernization passes.[115] This view arises because unitary thrift holding

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104. *See id.*

105. *See* Richard Wolffe, *Greenspan and Rubin Urged to End Their Dispute on Bank Reform*, FIN. TIMES, June 18, 1998, *available in* 1998 WL 12245884.

106. *See id.*

107. *See* Golembe, *supra* note 99 at 10.

108. *See id.*

109. *See supra* note 105.

110. *See id.*

111. *See* Gettlin, *supra* note 99.

112. *See U.S.: Financial Services Alert*, BUS. MONITOR, Oct. 7, 1998, *available in* 1998 WL 9018940.

113. A unitary thrift is a company that controls a single savings association. *See* Steve Cocheo, *A Closer Look at Unitary Thrifts,* A.B.A. BANKING J., Oct. 1, 1998, at 64, *available in* 1998 WL 11679511.

114. *See* Kathleen Day, *Applications to Buy or Start Thrifts Increase*, AUSTINAM.-STATESMAN, Jan. 3, 1999, at J1, *available in* 1999 WL 7398425; *see also infra* Part V.B. (detailed discussion of unitary thrifts).

115. *See id.*

company parents are allowed to engage freely in business activities, including commerce and finance.[116] Thus, through a unitary thrift a financial firm is able to sell a full range of products. Opposition to unitary thrifts, including banking organizations and Fed Chairman Alan Greenspan, claim that there are soundness and safety issues.[117] They also point out that unitary thrifts prevent a level playing field for financial service providers because the limits Congress placed on thrift ownership are not as restrictive as the ones placed on banks.[118] Thrifts are regulated by the easy-to-deal-with Office of Thrift Supervision ("OTS")[119] and have liberal rules for retaining capital.[120] However, they are subject to some limitations, including the qualified thrift lender test, which requires them to hold at least sixty-five percent of their assets in mortgages, small business loans or other consumer loans.[121]

Unlike the House version of the bill which would preclude any new unitary thrift applications, the Senate version would allow new unitary thrifts to be created. The Senate version of the bill would allow existing unitary thrift companies to engage in banking, securities, insurance and commercial activities.[122] New unitary thrifts would not be permitted to engage in commercial activities.[123] However, existing unitary thrifts would be prohibited from being acquired by commercial companies.[124]

6. Community Lending Requirements

Disagreement over the scope of the Community Reinvestment Act[125] was a main reason H.R. 10 was not brought before the Senate this year. The Act requires banks to offer services in poor neighborhoods by ensuring

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116. *See supra* note 113.

117. *See* Jeffrey Marshall, *Taking Another Road into Banking*, U.S. BANKER, Dec. 19, 1998, *available in* 1998 WL 10220619.

118. *See id.*

119. The Office of Thrift Supervision is the successor to the Federal Home Loan Bank Board and is a bureau of the Treasury Department. It serves as the primary regulator of all Federal and state-chartered savings institutions. *See The Duties and Functions of the Treasury Department, its Offices and Bureaus* (visited March 1, 1999) <http://www.ustreas.gov/opc/opc0042.html>.

120. *See supra* note 117.

121. *See id.*

122. *See* H.R. 10 RS, 105th Cong. Title IV (1998).

123. *See id.*

124. *See id.* It should be no surprise that the banking industry has threatened to oppose H.R. 10 if this provision is removed from the bill. *See* Sheri Rothman, *Senate Committee Passes Better Version of Financial Reform*, BANK INV. MKT., Nov. 1, 1998, *available in* 1998 WL 11187645.

125. *See supra* note 72.

that they make loans in communities where they receive deposits.[126] Banks must record and report annually the gender, race and income of loan applicants and recipients.[127] The Act is enforced by allowing regulators to fine directors and officers up to one million dollars a day, limit insurance or mutual fund sales by operating subsidiaries and restrict or shut down nonbank affiliates.[128] The White House has threatened to veto any legislation that does not contain the provision, but some key Republicans strongly oppose widening the scope of the Act to encompass financial holding companies.[129] It should be noted, however, that the American Bankers Association supports H.R. 10 despite the Community Reinvestment Act provision.[130]

III. OUTLOOK FOR THE FUTURE

An updated version of the legislation for 1999, known as the "Son of H.R. 10," has already been reintroduced to the House after passing the Senate Banking Committee.[131] The new bill acts as a placeholder for early consideration in the next Congress.[132] Many groups, including the American Insurance Association, the American Council of Life Insurance and the American Bankers Association have pledged their commitment to passing financial services reform next term.[133] Nevertheless, there are serious roadblocks to passage that still remain.

The recent election may have created additional challenges to the passage of a financial services reform bill. Senator Alfonse D'Amato (R-N.Y.), chairman of the Senate Banking Committee, was defeated. His successor is Senator Phil Gramm (R-Texas), who remains committed to

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126. *See* Harlan, *supra* note 72.

127. *See id.*

128. *See* Dean Anason, *Threat of Senate Floor Fight Over CRA Expansion*, AM. BANKER, Sept. 25, 1998, at 2, *available in* 1998 WL 13324381.

129. *See* Harlan, *supra* note 72. Senator Phil Gramm (R-Texas) said the Act "has become a rich source for extortion and kickbacks." *Id.*

130. *See id.*

131. The bill is named H.R. 4870. *See* Arthur D. Postal, *Election Results Steer Bank Legislation's Course*, BANK MUTUAL FUND REP., Nov. 9, 1998, at 1, *available in* 1998 WL 5110561; *Leach Re-Introduces H.R. 10 as "Placeholder" for 1999*, INS. REG., Oct. 26, 1998, at 1, *available in* 1998 WL 5050045.

132. *See Financial Services Reform*, INS. REG., Nov. 16, 1998, at 1, *available in* 1998 WL 5050120; *Leach Re-Introduces H.R. 10 as "Placeholder" for 1999*, *supra* note 131.

133. *See supra* note 82.

keeping the Community Reinvestment Act provisions out of the bill.[134] Furthermore, Gramm's constituency consists of a large number of small and medium sized banks, which oppose the proposed holding company structure because it is too expensive.[135] Thus, Gramm in essence supports the Office of Comptroller's fight for power.[136] However, despite the difficulties Gramm has with the current form of the bill, he has professed his commitment to financial services reform.[137]

Gramm's apparent backing of the OCC is expected to give the agency renewed energy with which to fight its battle for power.[138] The OCC is likely to be active over the next few months in extending the boundaries of national bank authority. It will probably continue issuing rulings overturning restrictive state laws regulating bank insurance sales.[139] For example, it recently ruled that after establishing itself in a place of 5,000 or fewer people, a bank's insurance agency could conduct its business in the same fashion as non-bank insurance agencies.[140] Also, it is likely to rule shortly on a 1996 application to pre-empt a Rhode Island law that restricts bank sales of insurance.[141] Furthermore, the OCC recently granted underwriting powers for municipal bonds in an operating subsidiary.[142] This action may be a sign that the agency's next step will be to permit banks to underwrite insurance in operating subsidiaries.[143] In response to

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134. *See* Dean Anason, *Senate Banking Shake-Up Could Hinder Reform Bill*, AM. BANKER, Nov. 5, 1998, at 1, *available in* 1998 WL 13325704. *See also supra* Part III.B.6.

135. *See* Arthur D. Postal, *Election Shows Bias Is Shifting Now to Banks*, INS. ACCT., Nov. 9, 1998, at 1, *available in* 1998 WL 5100363.

136. *See id. See also supra* Part III.B.4.

137. *See Election Results Mean Reform Slowdown*, INS. REG., Nov. 9, 1998, at 1, *available in* 1998 WL 5050101.

138. *See id.*

139. *See Demise of H.R. 10 Calls for Some Hard Thinking*, NAT'L UNDERWRITER LIFE & HEALTH-FIN. SERV. EDITION, Oct. 26, 1998, *available in* 1998 WL 20199393.

140. *See* Elizabeth Festa, *New Powers: No Shrinking Violets at OCC*, INS. REG., Nov. 9, 1998, at 1, *available in* 1998 WL 5050107. This OCC letter ruling was directed at a banking attorney in Louisiana and further interprets 12 U.S.C. §92 (1994). *See id.; see also supra* Part II.A.

141. *See* Elizabeth Festa, *OCC Ready to Grant New* Powers, CFO ALERT, Nov. 9, 1998, at 1, *available in* 1998 WL 5283699; Arthur D. Postal, *Hawke Appointment Imminent, Rhode Island First on List*, CFO ALERT, Nov. 2, 1998, at 1, *available in* 1998 WL 5283681.

142. *See* Festa, *supra* note 140. The OCC acted on an application from the National Bank of Commerce in Memphis, ruling that the bank is permitted to underwrite and sell municipal revenue bonds in an operating subsidiary.

143. *See id.*

the OCC's actions, it is expected that there will be litigation aimed at defining the extent to which states can regulate these activities.[144]

An example of how such litigation can affect the passage of reform legislation is seen in Ohio. Ohio bankers have filed suit in federal court in an attempt to have three restrictive state laws dealing with the sale of insurance pre-empted under the *Barnett* standard.[145] Because H.R. 10 shifts power away from the Comptroller of Currency and to the state insurance regulators, the bill is unfavorable to Ohio's national banks. This consequence is forcing Ohio Republicans to reevaluate if it is appropriate to pass legislation that their state bank's do not support.[146] Also, if Ohio bankers win their suit, they will no longer need to compromise with the insurance agents.[147] Thus, this litigation will have a strong impact on whether financial services modernization passes next year.

Another agency which has not been idly sitting around and waiting for financial reform legislation to pass is the OTS. The agency has been actively granting thrift charters to insurance companies.[148] Therefore, insurers will be moving into banking activities through their unitary thrift charters. This will result in the OCC issuing insurance regulations for banks.[149] Also, although the OCC will be pre-empting state regulation in favor of national banks, unaffiliated insurance agencies will have to comply with state laws.[150] Without a formalized regulatory structure such as the one provided in H.R. 10, there will be inequality and uncertainty.

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144. *See supra* note 139.

145. *See supra* note 22. The litigation is aimed at a state law which bars the sale of title insurance by lending institutions and two controlled business statutes which bar the sale of property/casualty and life insurance products by banks or affiliates if those sales are principally to the bank's own customers. The title insurance law is likely to be argued under *Barnett Bank v. Nelson* and the controlled business statutes under *New York Bankers Ass'n v. Levin*. *See Financial Modernization's Fate Runs Through Ohio*, BANK MUTUAL FUND REP., Nov. 2, 1998, *available in* 1998 WL 5110540; *Ohio Bank Lawsuit May Foil H.R. 10*, INS. REG., Nov. 2, 1998, *available in* 1998 WL 5050052. *See also supra* Part II.A.; Barnett Bank v. Nelson, 517 U.S. 25 (1996); N.Y. Bankers Ass'n, Inc. v. Levin, 999 F.Supp. 716 (W.D.N.Y. 1998).

146. *See Financial Modernization's Fate Runs Through Ohio*, *supra* note 145.

147. *See id.*

148. *See War Between Banks, Insurers Is Only Certainty*, BEST'S INS. NEWS, Oct. 12, 1998, *available in* 1998 WL 19369911. For example, State Farm Mutual Automobile Insurance Co., the nation's largest property-casualty insurer, was recently granted a charter to operate a federal savings bank. *See* Deborah Lohse, *State Farm Gets Federal Thrift Charter, Heating Up Insurance-Banking War*, WALL ST. J., Nov. 13, 1998, *available in* 1998 WL-WSJ 18992052.

149. *See War Between Banks, Insurers Is Only Certainty*, *supra* note 148.

150. *See id.*

IV. THE TRAVELERS-CITICORP MERGER

Perhaps nothing can be credited more for the renewed surge of interest in financial services reform than the recent merger of Citicorp and Travelers into the single entity, Citigroup.[151] Specifically, Travelers converted into a bank holding company and acquired Citicorp.[152] The new entity combines Citicorp's banking services, Travelers' and Primerica's insurance business, and Salomon Smith Barney's brokerage firm.[153] The company is now able to cross-sell products to its customers. For example, Travelers can sell annuities and mutual funds through Citicorp and offer life, home and long-term care insurance to Citicorp cardholders and branch customers.[154] Similarly, Citicorp can originate student loans, set up banking relationships with Travelers clients, sell mortgage loans to Salomon Smith Barney customers and offer trust services through life insurance agents.[155] The company has more than 100 million customers in 100 countries, as well as more than 700 billion in assets under management.[156]

A. Limitations on the Merger

Although the merger was approved by the Fed in September and finalized in October, the Fed made it clear that its current approval is subject to existing laws.[157] If appropriate financial services legislation does not pass, Citigroup will be required to divest its impermissible activities.[158] Thus, Citigroup would eventually have to sell Travelers' insurance underwriting. The Fed's approval also requires that Citigroup divest its distribution of mutual funds immediately.[159] Furthermore, the Fed stated that the securities and insurance activities conducted by Citigroup must represent less than fifteen percent of the company's total assets and less than twenty percent of its revenues.[160] Thus, the Fed sent a message that

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151. *See* Marcia Vickers, *"Citigroup" Boosts Financial Modernization*, ON WALL STREET, May 1, 1998, *available in* 1998 WL 11649422.

152. *See* Jaret Seiberg, *Fed Expected to Act Soon on Citigroup Deal Approval*, AM. BANKER, Aug. 18, 1998, *available in* 1998 WL 13323271.

153. *See supra* note 51.

154. *See supra* note 52.

155. *See id.*

156. *See* Matthew Lubanko, *Travelers and Citicorp Can Pair Up: Federal Agencies O.K. Mega-Merger of Insurer, Bank*, HARTFORD COURANT, Sept. 24, 1998, at A1.

157. *See Citigroup: Historic Barriers Erode*, INS. REG., Sept. 28, 1998, *available in* 1998 WL 5049990.

158. *See id.*

159. *See id.*

160. *See id.*

this benchmark will be used in the future to measure nonconforming activities.[161] There is only one unit of Citigroup that violates section 20 of the Glass Steagall Act by deriving more that twenty-five percent of its total revenue from bank-ineligible securities.[162] The Fed said that this unit, Robinson Humphrey in Atlanta, must scale back its bank-ineligible securities activities.[163]

However, immediate action is not required under the Bank Holding Company Act. Banks that acquire prohibited activities through mergers are given two years to divest those lines of business.[164] Furthermore, the Fed has the discretion of granting banks up to three, one-year extensions to complete the divestitures.[165] Therefore, in reality Citigroup has five years to make the required changes, many of which would be eliminated if financial services reform legislation is passed.

B. Options if Legislation Does Not Pass

If financial modernization legislation does not eventually pass, Citigroup has several less attractive back-door options that would enable the new entity to keep its insurance underwriting. First, although Citigroup would have to divest itself of its domestic insurance underwriting, it would still be able to underwrite insurance offshore.[166] Thus, Citigroup could move all of their underwriting overseas. There is also the possibility that at some point the OCC will decide to allow operating subsidiaries to engage in insurance underwriting.[167] Thus, Travelers would be able to keep its underwriting powers through the operating subsidiary rule. Finally, Citicorp could become a unitary thrift under Travelers.[168] As mentioned earlier, a unitary thrift is a company that controls a single savings association and current regulations allow unitary thrift holding company parents to engage freely in business activities, including commerce and finance.[169] In addition, thrifts do not operate under the banking industry's

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161. *See Industry Reaction Mixed to Citigroup Approval*, INS. REG., Sept. 28 1998, *available in* 1998 WL 5049993.

162. *See supra* note 157.

163. *See id.*

164. *See Fed's Meyer Comments on Proposed Citicorp/Travelers Merger*, CAP. MKT. REP., Apr. 29, 1998 at 2.

165. *See id.*

166. *See* Amy S. Friedman, *Implications of FRB's Approval of Citigroup Deal Detailed by Experts*, NAT'L UNDERWRITER LIFE & HEALTH-FIN. SERV. EDITION, Oct. 12, 1998, *available in* 1998 WL 20199317.

167. *See id.*

168. *See id.*

169. *See supra* note 113.

tighter geographic regulations which apply to interstate and intrastate branching.[170] Nor do they have strict capital requirements.[171] However, thrifts do face some limitations. They can only make commercial loans up to twenty percent of their assets, with any amount above ten percent necessarily in small business loans.[172] Furthermore, they must meet the qualified thrift lender test.[173] This test requires holding sixty-five percent of its assets in mortgages or mortgage related investments, small business loans and certain consumer loan types.[174] Also, they cannot lend to any affiliate engaged in activities not permitted by bank holding companies, and there are limitations on the transactions that are permitted with affiliates.[175] Finally, their ability to dividend money to the parent is limited by law.[176] Thus, a unitary thrift charter would allow Citigroup to hold onto its insurance underwriting activities, but with numerous restrictions.

These back-door possibilities for consolidation demonstrate two things. First, they show that a bill such as H.R. 10 would provide a more straightforward and less restrictive method of accomplishing financial services mergers. Second, they exemplify the manner in which current laws can be manipulated in an attempt to keep pace with the rapidly advancing marketplace. There is no question that new legislation would greatly facilitate financial services reform, but even without it the market will find a way to advance its goals.

CONCLUSION

The pressure is on for the 106th Congress to pass some form of financial services modernization legislation. As the Senate squabbles over certain provisions of the bill, the rest of country is proceeding ahead with a step by step system of reform. The OCC is making rulings that expand the boundaries of current banking laws, while the OTC continues to liberally grant thrift charters. Individual banks are filing lawsuits in attempts to expand bank powers in their respective states. The Citigroup merger demonstrates that industry leaders are moving ahead without regard to financial modernization legislation. If Congress wants to stop the disorderly eroding away of the financial service laws, it needs to

170. *See id.*
171. *See supra* note 117.
172. *See supra* note 113.
173. *See id.*
174. *See id.*
175. *See id.*
176. *See id.*

compromise and pass legislation. Without official legislation to provide structure to financial services reform, the current system will continue to be chipped away at from all of these different angles. Congress needs to take action and allow our country's laws to catch up to the marketplace or risk an inefficient expansion of the current laws that does not allow our country to keep pace with the advancing global economy.

FROM THE JOURNALS: INSURANCE LAW ABSTRACTS

*Edited by Jeffrey E. Thomas**

INSURANCE – GENERAL

Gregory S. Bailey, Note, *Competing "Other Insurance" Clauses Under Iowa Law: A New Direction?*, 46 DRAKE L. REV. 835 (1998).

This Note discusses issues surrounding "other insurance" clauses that dictate apportionment between insurers when there is more than one policy covering a single loss. Bailey describes the types of other insurance clauses used by insurance companies: the pro rata clause (making the insurer liable only for the proportion of the loss represented by the ratio between its limit and the total of all limits of all available insurance), the escape clause (allowing the insurer to avoid liability if there are other valid and collectible insurance policies), the excess clause (triggering insurer liability only after all other valid and collectible insurance has been exhausted), and the combination pro rata and excess clause.

The Iowa Supreme Court adopted the "Oregon" or "Lamb-Weston Rule" that insurance policies should be construed in light of the underlying negotiations of the policy, its terms and declarations. Iowa also uses the "proration approach" to resolve problems with conflicting other insurance clauses. This approach allows for the proration of conflicting policies by the proportion of each policy's limit to the total of all applicable limits.

Bailey then compares Iowa's approach with approaches used in other jurisdictions: "first in time," specific versus general, primary versus secondary, clause-oriented (either pro-rating or allowing the activation of one insurer's escape clause), and the "closest to the risk" approach. Analyzing this last approach in particular, Bailey concludes that Iowa, as well as other jurisdictions, should adopt the closest to the risk approach as the most equitable.

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John H. Bauman, *Emotional Distress Damages and the Tort of Insurance Bad Faith*, 46 DRAKE L. REV. 717 (1998).

Bauman discusses the historical development of the torts of negligent and intentional emotional distress and then focuses on the use of emotional distress damages for an insurer's bad faith breach of contract. The tort of insurance bad faith was first recognized in a third-party context in *Crisci v. Security Ins. Co.*, 426 P.2d 173 (Cal. 1967), where the California Supreme Court equated the breach of a liability insurer's fiduciary duty to settle within the policy limits with a breach of the implied duty of good faith and fair dealing. The *Crisci* court allowed recovery for extra-contractual damages, including punitive damages and damages for emotional distress. This new tort was later extended, in *Gruenberg v. Aetna Ins. Co.*, 510 P.2d 1032 (Cal. 1973), to a first-party insurance contract—where there is no fiduciary duty–based on a duty not to "withhold unreasonably" or "without proper cause" payments for a covered loss.

Bauman's thesis is that courts should not expand an insurer's liability for breach of contract to include tort liability for emotional distress, absent clearly tortious conduct on the part of the insurer. He contends that unless the insurer denied patently valid claims or committed an independent tort, contractual remedies are adequate. Bauman specifically advocates the use of forms of consequential damages for foreseeable economic loss caused by wrongful denial of a claim. Moreover, Bauman argues that damages for emotional distress are not necessarily appropriate even in situations where the insurer negligently denied a valid claim; such "excessively severe" damages should be reserved for more egregious or intentional conduct on the part of the insurer.

Craig M. Collins, *Flood Insurance Is Not All Created Equal*, 74 N.D. L. REV. 35 (1998).

Collins describes the difficulties of insureds in sustaining causes of action for claims under flood insurance. He identifies the primary difficulties as the lack of access to adequate counsel and circumstantial defects in proofs of loss. According to Collins, the current judicial treatment of flood insurance policyholders reduces insureds' already negligible bargaining power and discourages equitable treatment of insureds by insurers.

Kimberly M. Inman, Comment, *The Mutual Holding Company: A New Opportunity for Mutual Insurance Companies?*, 42 ST. LOUIS U. L.J. 677 (1998).

This Comment argues that the mutual holding company ("MHC") reorganization of mutual insurance companies makes them more flexible and competitive, and thereby benefits consumers. Inman details the process whereby a mutual insurance company is transformed into an MHC, in which a separate holding company is formed, and then the mutual insurance company becomes an MHC subsidiary.

Inman acknowledges that concerns about potential detrimental effects on policyholder rights and protections, but contends that MHC structure can have a positive effect on the competitiveness of mutual insurers. Nevertheless, she cautions that these positive effects must be balanced with considerations regarding the protection of mutual insurance company policyholders, who stand to be inadequately compensated when their entitlement to mutual benefits is transformed into stockholders' shares.

Gregory N. Racz, Note, *No Longer Your Piece of the Rock: The Silent Reorganization of Mutual Life Insurance Firms*, 73 N.Y.U. L. REV. 999 (1998).

This Note details the background and development of the mutual holding company ("MHC") concept, and explains current legislation and the process whereby a mutual insurance company is absorbed into a MHC. Racz then analyzes the benefits of MHC restructuring and compares those benefits against the public policy concerns of such restructuring. He concludes that current laws allowing for MHCs are flawed and allow policyholders to be inadequately compensated, weaken policyholders' due process protections, and unjustly enrich and insulate MHC managers from market controls. Racz therefore calls for legislators to either repeal enact, or vote down proposed MHC laws, or to improve or adopt regulations to better protect policyholders.

Ken Swift, *How Special Is Special? An Insurance Agent's Duty to Advise*, 21 HAMLINE L. REV. 323 (1998).

Swift maintains that the current law as to what circumstances may trigger an insurance agent's duty to advise a customer of the appropriate level of coverage is vague and inefficient, resulting in a lower level of service to customers. Some jurisdictions, including Minnesota, require an agent to exercise the skill and care which a reasonably prudent person engaged in the insurance business would use under similar circumstances. In practice, however, Minnesota courts generally apply only the usual duty of an agent "to act in good faith and follow instructions." Only in "special circumstances" do Minnesota courts impose an affirmative duty to advise upon insurance agents. In other jurisdictions, courts impose an affirmative duty to advise where there was an explicit agreement for the agent to advise the customer, coupled with an additional fee for that service. A few jurisdictions may find an affirmative duty if there existed an implied agreement to advise. Some jurisdictions impose an affirmative duty only when the agent has held himself or herself out to be an expert. And in one jurisdiction, New Jersey, the agent has a statutory duty to advise a customer as to the appropriate level of auto coverage.

Swift maintains that courts are reluctant to impose an affirmative duty on insurance agents for several policy reasons: the competitive nature of insurance sales, the belief that customers are in the best position to know their financial needs and capabilities, and the concern that imposing such an affirmative duty will result in many post-loss suits by insureds claiming that they would have purchased sufficient coverage if they had been so advised. Swift, however, contends that the current standard is inefficient, encouraging agents to withhold advice and forgo investigation of customers' coverage needs, so as not to create any "special circumstances" triggering an affirmative duty. Instead, Swift argues that courts should replace the "special circumstances" analysis with an ordinary professional negligence standard, which would require agents to provide a reasonable level of service to customers in selecting the appropriate level and type of coverage. Initially the imposition of such a standard would result in increase liability on the part of agents; but, according to Swift, the eventual result would be improved insurance marketing and customer service, and better informed customers.

HEALTH INSURANCE

Thomas D. Bixby, *Network Adequacy: The Regulation of HMOs' Network of Health Care Providers*, 63 MO. L. REV. 397 (1998).

Bixby analyzes regulatory efforts in Missouri to ensure adequate numbers of providers in managed care plans to ensure quality care for participants. Using network adequacy criteria based on the National Association of Insurance Commissioners' model legislation, legislative committees drafted House Bill 335 ("HB 335"), which was enacted by the Missouri General Assembly.

Arguing that the current regulatory structure of the health insurance industry encourages the enrollment of healthy patients and discourages the enrollment of unhealthy patients, Bixby lauds HB 335 as appropriately giving the Missouri Department of Insurance the broad authority required to ensure network adequacy. However, he concludes that quality of care and provider network adequacy is still predominately and inadequately addressed by market forces, and that the Department of Insurance should promulgate rules to define its policy concerning determination of network adequacy in order to ensure that plan participants' rights are protected.

Deborah W. Larios, *Barbarians at The Gate? An Essay on Payor Liability in an Era of Managed Care*, 65 TENN. L. REV. 445 (1998).

Larios examines the changing roles of physicians, third-party payors, and the government in the management of health care costs and access to treatment. She includes a discussion of the methods used by private managed care companies to reduce costs and control access to health care and analyzes current cases and legislation expanding payor liability.

Larios considers theories of managed care entity liability and the impact of Employment Retirement Income Security Act of 1974 on the industry, and recently enacted or proposed legislation designed to expand the liability of managed care payors in Texas, Missouri, New Jersey, Connecticut, and at the federal level. She concludes that the trend towards expansion of managed care entity liability should be curtailed because it is likely to cause increased third-party payor interference in treatment decisions, and to compromise quality and access. According to Larios, health care providers and the government should be held at least partly responsible for insuring health care accessibility and quality.

Colleen E. Medill, *HIPAA and its Related Legislation: A New Role for ERISA in the Regulation of Private Health Care Plans?*, 65 TENN. L. REV. 485 (1998).

Medill describes the interrelation of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and its related legislation (i.e., the Newborns' and Mothers' Health Protection Act and the Mental Health Parity Act of 1996), with the Employee Retirement Income Security Act of 1974 ("ERISA"). Medill describes HIPAA and its related legislation as broadening ERISA's Title I protective provisions concerning disclosure, fiduciary administration, benefit, and coverage requirements.

Detailing the concerns regarding the abuse of plan assets by plan fiduciaries that lead to the enactment of ERISA and its COBRA and OBRA amendments, Medill describes the provisions that allow for ERISA-based preemption of state law. She describes HIPAA and related legislation and analyzes the ensuing changes to Title I of ERISA, which limit private health care plans' ability to impose pre-existing condition coverage exclusions on plan participants.

Observing that HIPAA's requirements preempt any related but inconsistent or less favorable state law standard or requirement, including state insurance laws, and that HIPAA amended ERISA, Medill predicts that Congress is likely to incorporate state insurance law mandates for certain types of benefits as ERISA requirements applicable to private health care plans. As ERISA will then preempt less stringent state law requirements for insured health care plans while preserving state law requirements for plans that offer greater benefits and protections, this preemption may effectively create minimum national standards for the managed care industry.

S.A. Somers, K. Brodsky and V. Harr, *The Coverage of Chronic Populations Under Medicaid Managed Care: An Essay on Emerging Challenges*, 65 TENN. L. REV. 649 (1998).

This article by three members of the Center for Health Care Strategies provides an overview of recent initiatives by private agencies to analyze the issues faced by the chronically ill in light of the movement towards Medicaid managed care. The authors summarize statistics describing Medicaid managed care trends for disabled and special needs populations, and conclude that current practices will limit the successful expansion of

Medicaid managed care to people with disabilities or chronic health problems.

Although several states that have implemented quality assurance and rate-setting measures, current policy studies indicate that Medicaid managed care enrollees with special needs will severely challenge both Medicaid managed care and state health care systems. The studies revealed a number of problem areas: interagency and intergovernmental relationships, complexity in purchasing and contracting for managed care for special needs populations, and an absence of Medicaid managed care models for these populations.

The authors announce that the Center will fund future efforts to foster development of managed care models, involving private agency-based feasibility studies, technical assistance, and the publication and distribution of how-to manuals.

Jeffrey O'Connell and James F. Neale, *HMOs, Cost Containment, and Early Offers: New Malpractice Threats and a Proposed Reform*, 14 J. CONTEMP. HEALTH L. & POL'Y 287 (1998).

Neale and O'Connell state that the current medical malpractice system offers inadequate compensatory and deterrent value, and prohibitively high transactional costs. Reviewing George Anders' book *Health Against Wealth: HMOs and the Breakdown of Medical Trust* (1996), the authors analyze Anders' arguments that HMO cost control measures compromise the quality of medical care and that tort law remains the most effective remedy. While acknowledging that Anders accurately describes the risks inherent in the managed care system, the authors counter Anders' argument by describing how HMO efforts at cost-containment have been effective in lowering expenses and curbing the trend of providing unnecessary care. They contend that these benefits outweigh the risks associated with managed care, and that a tort law solution will be ineffective.

Furthermore, they analyze "early offer" legislation. Such proposals would allow an insurer to offer compensation solely for a claimant's economic loss within 120 days of the claimant's loss in exchange for the claimant's surrender of all tort remedies, including those pertaining to non-economic losses. The authors specifically examine the early offer proposal in the Legal Reform and Compensation Act of 1996, and propose the adoption of such legislation as an effective means of compensating for and deterring medical malpractice.

Lawrence E. Smarr, *A Comparative Assessment of the PIAA Data Sharing Project and the National Practitioner Data Bank: Purpose, Policy, and Application*, 60 LAW & CONTEMP. PROBS. 59 (1997).

Smarr, the president of the Physician Insurers Association of America ("PIAA"), explores the nature and scope of the differences between the Data Sharing Project ("DSP") conducted by his organization and the National Practitioner Data Bank ("NPDB") operated by the U.S. Department of Health and Human Services. Both data collection and disclosure services are set up to gather data on medical practitioners, and are used by insurers and state agencies to check on physician credentials and quality - but, according to Smarr, the similarities diminish from there.

Smarr describes the diverging point between the two programs as being one of design: the DSP was set up to provide clinical loss prevention data for physician evaluation; the NPDB was initiated to identify problem practitioners. The NPDB specifically identifies each practitioner in the system and shows the data concerning each individual's privilege restrictions, licensure status, disciplinary history, and other relevant data. The DSP does not report data on the basis of individual practitioners; rather the data is collated and analyzed.

Smarr contends that the NPDB is more limited than the DSP regarding reporting and analysis of the substance of malpractice claims. Smarr concludes that the DSP more accurately captures industry trends than the NPDB does.

Elizabeth C. Price, *The Evolution of Health Care Decision-Making: The Political Paradigm and Beyond*, 65 TENN. L. REV. 619 (1998).

According to Price there are three traditional paradigms for healthcare decisions in the United States: the provider model, the free market model, and the political model. The provider paradigm was dominant until the 1980s, when the provider-induced demand for care, coupled with an absence of cost and quality comparison mechanisms, as well as virtually unlimited indemnity, resulted in rising healthcare costs. Beginning in the 1970s, and gaining momentum in the 1980s, the free market/managed care model gradually became more prominent, and has now become the dominant paradigm. Price notes that 75% of the population with health

care benefits is now enrolled in managed care, with fully 80% of physicians participating in some form of managed care.

A new, political paradigm is beginning to encroach on the market model, however. As a result of judicial decisions and legislative actions, Price identifies an emerging political approach to health care. These political decisions are intended to remedy what are perceived as the most egregious failures or excesses of the free market model - e.g., the legislative proscription of "drive-thru deliveries." Price cautions, however, that such political interference risks tipping the balance back toward a provider market with its increased costs and decreased access. Although she agrees that some political intrusion into the healthcare decision process is both warranted and desirable, Price contends that such political interference has the potential to disrupt the efficiencies of the managed care system.

As an alternative, Price advocates assigning a fiduciary duty for patient care to a neutral third party who could effectively maintain the delicate balance between access, quality care and cost. The role of fiduciary could be assigned to a governmental agency, or subcontracted to a private organization specifically qualified by the state or to a managed care organization. According to Price, the latter possibility would be the most cost-effective, and could be accomplished if there were explicit statutory fiduciary obligations on the part of the insurer to determine what care is medically necessary.

LIABILITY INSURANCE

Tom Baker, *Liability Insurance Conflicts and Defense Lawyers: From Triangles to Tetrahedrons*, 4 CONN. INS. L.J. 101 (1997-98).

Using a three-dimensional conceptual model, Baker analyzes liability insurance conflicts and the nature of the defense attorney's representation of the insured as part of the insurer's contractual duty to defend. Extending the "triangular" relationship among insurer, insured and defense attorney to include the plaintiff, Baker examines the four-way relationship among insurer, insured, defense attorney and the plaintiff within the analytical framework of a tetrahedron. This geometric figure comprises four "triangles": the "jury" triangle, consisting of the three players whom the jury would see, i.e., the defense attorney, the insured and the plaintiff; the "settlement" triangle, composed of the lawyer, the insurer and the plaintiff;

and the "professional responsibility" triangle, including the attorney, the insurer and the insured; and the "plaintiff's choice" triangle representing the plaintiff, insured, and insurer.

Within the context of this analytical framework, Baker explores the role of the defense attorney in fulfilling the insurer's duty to defend in situations in which there has been an "incomplete transfer" of the claim risk from insured to insurer because of policy limits or exclusions. Such situations give rise to conflicts among participants that do not arise when there is full coverage of a claim under the policy. Baker concludes that an insurance company is entitled to limit the scope of the defense counsel's representation of the insured when there is likely to be full coverage, but that in shared-risk cases the insurer has a good-faith obligation to require counsel to give primary consideration to the interests of the insured when a conflict arises.

Tom Baker, *Reconsidering Insurance for Punitive Damages*, 1998 WIS. L. REV. 101

Baker contends insurance marketing and claims practices sufficiently restrict insurance coverage for punitive damages that courts do not need to provide further restrictions as a matter of public policy. Baker identifies the dual purposes of punitive damages as retribution and prevention. Although compensatory damages serve a preventative function, they do not provide retribution. In theory, allowing insurance coverage for punitive damages effectively nullifies both the preventative and retributive purpose of punitive damages. The preventative effect is reduced by cushioning the financial impact of the damages, and the retributive effect is mitigated by permitting the tortfeasor to escape the consequences of his actions. For these reasons, courts tend to restrict the availability of coverage for punitive damages.

Baker identifies several marketing and claims practices that restrict insurance coverage for punitive damages. He cites underwriting practices, policy limits and claims which are likely to result in punitive damages. While excess and umbrella policies may have specific exclusions for punitive damages, Baker notes that for marketing reasons, many primary liability insurance policies do not have such exclusions. These primary policies, however, do have other exclusions that effectively eliminate coverage for punitive damages. The most significant of these exclusions is the intended harm exclusion (excluding coverage for harm "expected or intended" by the insured), which Baker says fulfills the preventative—and

to a lesser extent—the retributive function of punitive damages. In addition, some policies also include claim-specific exclusions for activities that are likely to involve punitive damages, such as pollution, asbestos manufacturing, assault, or sexual harassment.

William T. Barker, *Insurance Defense Ethics and the Liability Insurance Bargain*, 4 CONN. INS. L.J. 75 (1997-98).

Rather than adapting professional responsibility rules to cover the realities of insurance defense, Barker advocates a contractual approach to defining the respective responsibilities of insurer, insured and defense attorney. Analyzing the tripartite relationship from this perspective, Barker concludes that the traditional two-client model best achieves the purposes of the contractual agreement between insured and insurer. Where the insurer's contractual rights must be limited in order to protect the insured, Barker supports an approach which construes the policy as requiring the insurer to accept such a limitation. Those cases which present a "substantial risk" of an adverse effect on the insured would require defense counsel to obtain the insured's informed consent at a point when there is still "adequate opportunity" to address the conflict. Barker contends that if the insured refuses such consent, a contractual issue is created between the two parties to the insurance policy, which should be resolved without the involvement of defense counsel.

Randall R. Bovbjerg, Frank A. Sloan and Peter J. Rankin, *Administrative Performance of "No-Fault" Compensation for Medical Injury*, 60 LAW & CONTEMP. PROBS. 71 (1997)

This article discusses the failure of the tort system to adequately compensate for medical injuries. The authors describe the tort system as offering insufficient compensation and inadequate accountability (as resolution is expensive and few claims are brought in proportion to those that could potentially be brought), and having a poorly-focused deterrent effect (often resulting in the ill effect of the practice of defensive medicine). The authors propose that a reformed no-fault system would offer more compensatory and deterrent value, especially if coupled with

comprehensive risk management, and that accountability would improve with the increased practice of investigation.

In supporting their thesis, the authors focus on two no-fault programs in Virginia and Florida concerning birth-related neurological injury. Enacted in response to the threatened withdrawal of liability insurance coverage for those practitioners delivering babies, these states established administrative and claims systems to allow for no-fault coverage for these practitioners. The authors analyze the claims filings, the nature of claims disputes, the speed of dispute resolution, and the administrative costs of the two states' systems.

While the programs examined are of a small-scale (only a total of 220 cases for both states' programs over the course of 8 years), the authors conclude that the administration of a no-fault system concerning a narrow medical issue is more efficient and economical in terms of claims resolution than the tort system. However, the authors acknowledge that risk-management and administrative capabilities will have to be expanded for any larger scale no-fault system to be equally effective. Furthermore, efforts will have to be made to increase no-fault system utilization, as access to the tort system and consumer ignorance of the no-fault system continue to be significant impediments to the success of no-fault programs.

Brady W. Dunnigan, Note, *Misguided Principles and Discarded Rights: The Case for Extending Insurance Indemnification to Compensate Victims of Sexual Abuse in Public Schools*, 36 BRANDEIS J. FAM. L. 407 (1997-98).

This Note advocates extending liability insurance coverage to the victims of sexual abuse in public schools as a matter of public policy. This policy could be effected financially by employing insurance coverage purchased by schools—which can afford the premium increases it would entail—rather than relying on homeowners policies for coverage. Insurance indemnification could be effected judicially, according to Dunnigan, by adoption of a "victim's viewpoint" analysis in interpreting insurance coverage exclusions for intentional acts. Under this analysis, the court considers whether the injury was expected or intended from the victim's viewpoint, rather than the more common approach of assessing whether or not the injury was (or should have been) expected or intended from the standpoint of the insured. Compensation to victims of sexual abuse could also be achieved legislatively, through statutory schemes

mandating victim coverage. Finally, Dunnigan argues that victims of sexual abuse in public schools may have a potential cause of action under 42 U.S.C. § 1983, if they are considered to be in the "functional custody" of school officials at the time of the injury.

Grace M. Giesel, *The Kentucky Ban on Insurer's In-House Attorneys Representing Insureds*, 25 N. KY. L. REV. 365 (1998).

In an advisory opinion in *American Insurance Association v. Kentucky Bar Association*, 917 S.W. 2d 568 (Ky. 1996), the Kentucky Supreme Court adopted the position that use of employee-attorneys to represent insureds constituted the unauthorized practice of law by the corporation, as well as an impermissible conflict of interest. Giesel examines this ban on the use of in-house counsel to defend insureds within the context of historical precedent and current practice in Kentucky and other jurisdictions.

Rendered in response to a request by Kentucky insurers and insurance groups, the advisory opinion adopted an Advisory Ethics Opinion (E-368) of the Kentucky Bar Association Board of Governors that 1) a lawyer may not contract to do all an insurer's defense work for a set fee; and 2) a lawyer may not agree to accept cases from an insurer with the understanding that the lawyer will be responsible for all expense without reimbursement from the insurer. The Kentucky Supreme Court stated that such fee and expense arrangements interfered with an attorney's independence of judgment and created an impermissible conflict of interest, whether the attorney was an employee or an independent agent. In addition, the court did not disturb the Kentucky Bar Association's earlier Unauthorized Practice of Law Opinion (U-36), on which E-368 relied, regarding the propriety of using in-house counsel to represent insureds. The court noted that, based on historical precedent and the Kentucky Supreme Court Rules, a corporation's use of in-house counsel to represent insureds constituted the unauthorized practice of law.

Giesel asserts that this opinion fails to account for the "ever-changing practice of law and the provision of legal services in Kentucky and elsewhere." She discusses the historical development and rationale of the unauthorized practice of law in Kentucky and in other jurisdictions, concluding that the trend is toward the de-regulation of unauthorized practice. Specifically, Giesel notes that most jurisdictions do not find that use of employee-attorneys to represent insureds constitutes either the unauthorized practice of law or an impermissible conflict of interest. She

contends that rules of unauthorized practice or conflict of interest must be based on "a principled rationale that can survive challenge in the world of the 1990s;" and that the opinion in *American Insurance Association* fails to provide such a rationale. Noting that the court's opinion seems to be based in part on an "appearance of impropriety" standard independent of its rules of conduct, Giesel suggests that if the court wishes to apply such a standard, it should amend the rules to include it.

James F. Hogg, *The Tale of a Tail*, 24 WM. MITCHELL L. REV. 515 (1998).

Hogg explores the nature and operation of occurrence and claims-made insurance policies in the context of recent efforts by insurers to reduce their liability under existing occurrence policies. Because exposure on occurrence policies can be many years for latent claims such as asbestos, in 1986 the insurance industry introduced "claims-made" coverage, which provided coverage only for claims made during the policy period. In claims-made policies, both the injury and the event causing the injury may predate the policy period, but coverage is limited since it is triggered only by the filing of a claim during the policy period.

In addition, insurers are trying to progressively reduce their liability for these pre-1986 contracts based on policy ambiguities. Focusing on developments in Minnesota, Hogg's thesis is that courts should not allow insurers to thus adversely and progressively reduce coverage available to insureds, and that under the doctrine of *contra preferentem*, insurers should be held responsible for any ambiguities as to the definition of "occurrence" or the allocation of risk. In addition, Hogg argues that prior to approval, insurers represented to state regulatory agencies that the new time claims-made policies would not affect the operation of occurrence policies. He also contends that allowing such a reduction in coverage would defeat the reasonable expectations of the insured.

Robert E. Keeton, *Taking Professional Risks*, 4 CONN. INS. L.J. 405 (1997-98).

According to Keeton, the legal profession has arrived at a time of deeper conflict of interests than ever before, and the development of new and problematic conflicts of interest will continue, while the pace of

change will quicken. In this article, he explains that as economic, social, and personal relationships become more complex, clashes of interest produce controversies more complex than paradigm tort, contract, and property controversies that constituted the regular fare of court dockets well into the 20th century.

Keeton's solution to this problem is the development of a culture and practice of respect that fosters mutual cooperation. He proposes that we develop a unifying "presumptive rule of mutual respect" for the interests of all parties who are likely to be affected by one's conduct in a context of multi-party conflicts of interest. A presumptive rule of mutual respect is one that is rebuttable, but imposes a burden of persuasion to rebut the applicability of the presumptive rule. If the burden of rebuttal is not satisfied by one of the persons (or entities) in the complex liability insurance defense relationship, that party loses its effort to shift all responsibility to others and is legally responsible for any harm that it causes while acting in its own best interests. Keeton calls this a tailored-multiple-cause-in-fact rule. The objective for his proposal is to create beneficial incentives for mutual respect in practice, instead of relying on threatening harmful consequences as incentives.

David N. May, Note, *In-House Defenders of Insureds: Some Ethical Considerations*, 46 DRAKE L. REV. 881 (1998).

This Note suggests that because of cost savings and other benefits, the practice by insurers of using in-house counsel to represent insureds is a permanent feature of the legal landscape. In addition to saving money, in-house counsel can provide subject matter expertise and specific business knowledge that outside counsel cannot supply. This practice, however, raises various ethical considerations regarding confidentiality, advice, competency, professional independence, and aiding a non-lawyer in the unauthorized practice of law.

Some of these ethical considerations involving employee-attorneys arise from potential conflicts of interest between the insurer and insured. Other ethical concerns are implicated as a result of the uncertainty as to who is the client when an employee-attorney is assigned to represent an insured. If both the employer and the insured are clients, then that presents one set of ethical problems. If only the insured is the client, that presents another set of problems.

May recommends that insurers who wish to use in-house counsel to represent their insureds do so with the realization that although such a

practice may enhance profitability, it also presents certain risks. In cases where coverage is undisputed and is sufficient to cover liability, the risks are minimal, and may be outweighed by the benefits. Otherwise, according to May, the use of in-house counsel is not advisable, especially where insurance agents or multiple insureds are involved. In such cases, May suggests that insurers employ alternative means of representation for their insureds.

Nancy J. Moore, *The Ethical Duties of Insurance Defense Lawyers: Are Special Solutions Required?*, 4 CONN. INS. L.J. 259 (1997-98).

Moore addresses a number of issues concerning the ethical responsibilities of insurance defense attorneys, including the nature of their relationships with the insured and the insurer. In addition, she discusses several specific practices, including bundled flat fees and the use of in-house counsel. Moore contends that in-house attorneys must clearly disclose their employee status to the insured at the outset of the defense. She also argues that the relatively recent practice of charging the insurer a flat fee for representing its insured may undermine the attorney's loyalty to the insured.

After discussing the various models for describing the tripartite relationship among insurer, insured and attorney, Moore argues that neither the one-client nor the two-client model operates satisfactorily under current professional ethics codes. She finds that the practical exigencies of the insurance defense relationship warrant some accommodation in determining compliance with ethical codes. Specifically, she suggests that at the outset of representation, defense counsel should clearly define the parameters of the relationship in a letter to the insured. This initial written statement should be supplemented as necessary by additional in-person disclosures. Moore cautions that such accommodations should not be extended to other types of third-party payment situations—such as employer-employee relationships where the employee has been sued for employment-related conduct—because she believes those situations pose more significant potential for conflicts than insurance defense representation.

Thomas D. Morgan, *What Insurance Scholars Should Know About Professional Responsibility*, 4 CONN. INS. L.J. 1 (1997-98).

Morgan addresses whether a lawyer retained to represent an insured is also (or should be) representing the insurer. On one hand, representing both may be a conflict of interest. On the other hand, calling the insured a client and the insurer a non-client frustrates the insurance companies and undermines the insurers' rights to sue for malpractice if the lawyer proves to be incompetent. Morgan suggests that in most cases there will be no material difference in result depending on which characterization is shown, and that more often than not, the one-client approach (representing the insured only) gives all parties better guidance on how to handle concrete issues as they arise in each case.

In the first section of the article, the relevant sections of the ABA Model Rules of Professional Conduct are highlighted, including a lawyer's obligations to be competent and diligent. These two obligations taken together describe the lawyer's duty to serve each client's interest loyally and well. Morgan notes other key obligations in order to stress that lawyers owe significant duties to "clients," duties such as diligence, loyalty, confidentiality, and faithfulness to client objectives. He makes it clear that the ABA Model Rules never specify whom a lawyer represents.

Morgan then discusses the benefits and conflicts of the one-client and two-client models. He considers the draft of the Restatement section 215, which deals specifically with any situation in which one person proposes to pay another's legal bills. He also considers ABA Formal Opinion 96-403 (August 2, 1996), which recognizes that courts have gone both ways on whether the lawyer represents both the insurer and the insured. Morgan concludes that "nothing fundamental" turns on which characterization is chosen.

Stephen L. Pepper, *Applying the Fundamentals of Lawyers' Ethics to Insurance Defense Practice*, 4 CONN. INS. L.J. 27 (1997-98).

Pepper's article examines the ethical issues confronting insurance defense attorneys when hired by an insurance company to represent their insured, from the perspective of both a single-client and a joint-client model. Although he notes that each model implicates certain ethical

concerns, he concludes that the single-client relationship is preferable because it is less fraught with ethical dilemmas.

Pepper describes three models of client representation: the joint model; modified joint-model; and the single model. Pepper argues that, under the Model Rules of Professional Conduct, the ordinary joint model requires informed consent from the insured, but that informed consent is not possible for legally unsophisticated insureds - and it is unlikely for legally-cognizant ones, given the clear potential for conflicts of interest between insured and insurer. In the modified joint-client model, the lawyer represents both insured and insurer in the absence of a specific conflict of interest; but if an actual conflict arises, the insured becomes the primary client to whom the attorney owes undivided allegiance. Under the single-client model, the lawyer represents the insured's interests exclusively, despite the fact that the insurance company is paying for the attorney's services. Pepper believes this model reflects the underlying substance of the actual relationship among the three participants, while recognizing the reality of potential conflicts of interest. He also contends that because of its expertise in claim investigations and its access to staff counsel, the insurer is capable of protecting its own interests, and does not require the undivided allegiance of the defense attorney whom it hires to represent its insured.

Rob S. Register, Comment, *Apportioning Coverage Responsibility of Consecutive Insurers When the Actual Occurrence of Injury Cannot Be Ascertained: Who Has to Contribute in a Settlement?*, 49 MERCER L. REV. 1151 (1998).

This Comment addresses the issues faced by courts in determining the appropriate apportionment of a settlement amount among contributing insurers when multiple policies are implicated. The author focuses on the situation where multiple insurers have agreed to a settlement amount, but have asked the court to apportion liability among them. In such cases, the court must determine issues such as contribution and subrogation, and whether or not liability is joint and several. First, however, the court must decide which policies are triggered, based on applicable jurisdictional criteria (i.e., whether the policy trigger is exposure, manifestation, injury-in-fact or continuous). Register directs his attention to the situation in which the trigger is determined to be continuous.

According to Register, an increasingly accepted criterion courts use to apportion liability in continuous exposure cases is "time on the risk," where

insurers pay a pro rata share of the total liability based on their length of time covering the risk. Once the court has determined the relative liability of each contributing insurer, any of those contributing more than their share toward the settlement amount may have a cause of action for equitable subrogation against any non-contributing insurer for any overpayment. In addition, Register notes with approval that some jurisdictions also allow these contributing insurers to recover defense and settlement costs against non-contributors in a subrogation action.

LIFE INSURANCE

Miriam R. Albert, *Selling Death Short: The Regulatory and Policy Implications of Viatical Settlements*, 61 ALB. L. REV. 1013 (1998).

Albert examines regulatory efforts concerning the relationships and transactions between viators (terminally- and chronically-ill individuals who sell the interest in their life insurance policies) and viatical settlement providers (companies and brokers who buy policies for their investment values). She surveys state legislative efforts, and focuses on the model regulations promulgated by the National Association of Insurance Commissioners. Alberts argues that in addition to the regulations controlling transactional power imbalances, minimum payouts should be imposed to protect viators who outlive their expected life expectancies (and can reduce the sale value of their policy). Deeming viators to be in a especially weakened position in relation to viatical settlement providers, Alberts argues that further regulation is necessary to protect viators, and concludes that regulation of the viatical industry is economically justified.

Hannah E. Greenwald, Comment, *What You Don't Know Could Save Your Life: A Case for Federal Insurance Disclosure Legislation*, 102 DICK. L. REV. 131 (1997).

This Comment examines insurance companies' failure to disclose medical information to prospective and actual insureds that concerns life-threatening conditions. Greenwald discusses several non-disclosure cases, in particular *Deramus v. Jackson National Life Insurance Co.*, 92 F.3d 274 (5th Cir. 1996). In that case the Fifth Circuit ruled that a life insurance

company had no obligation to disclose to an applicant that he had tested positive for the AIDS virus.

Greenwald finds that twenty-one states and the federal government have not imposed a legal obligation on insurance companies to disclose the results of applicants' medical tests. Greenwald then considers whether the Medical Privacy in the Age of New Technologies Act ("MPANT"), a Congressional bill that would require insurance companies to disclose the results of mandatory examinations to policyholders and applicants, would fill that void. She argues for passage MPANT, concludes that the benefits of a mandatory disclosure system, mainly concerning health risks, outweigh the costs to the insurance industry, especially when such a system is coupled with confidentiality protections.

Joy D. Kosiewicz, Comment, *Death for Sale: A Call to Regulate the Viatical Settlement Industry*, 48 CASE W. RES. L. REV. 701 (1998).

This Comment argues that further regulation is necessary to ensure confidentiality and to protect viators. Kosiewicz begins by explaining the viatical settlement transaction (whereby a viator—a terminally or chronically–ill insured—sells his or her life insurance policy to another party, either to or through a viatical settlement provider), and the entities involved. She also examines the growth of the viatical settlement industry and efforts at regulation. Kosiewicz contends that the benefits of mandatory minimum payouts pursuant to regulation outweigh the negative effects on the viatical settlement industry.

Jennifer A. Lann, Note, *Viatical Settlements: An Explanation of the Process, an Analysis of State Regulations, and an Examination of Viatical Settlements as Securities*, 46 DRAKE L. REV. 923 (1998).

This Note provides a detailed, state-by-state analysis of viatical regulations in terms of licensing and disclosure requirements, contract provisions, minimum price regulations, and statutory penalties. Even though viatical settlements have yet to be deemed securities, Lann also discusses efforts by the Securities and Exchange Commission to regulate viatical settlements as securities transactions. Finally, Lann analyzes the

National Association of Insurance Commissioners' Model Act and Model Regulation concerning viatical settlements.

David G. Newkirk, *An Economic Analysis of the First Manifest Doctrine*: Paul Revere Life Insurance Co. v. Haas, 644 A.2d 1098 (N.J. 1994), 76 NEB. L. REV. 819 (1997).

Newkirk examines the "first manifest" doctrine, which allows insurers to deny a specific claim for a concealed condition, while allowing the insured to keep coverage under the policy in effect for any condition that was unknown to the applicant, in terms of its discouraging fraud facilitated by incontestability clauses. Focusing on a leading case in this area, *Paul Revere Life Insurance Co. v. Haas,* Newkirk analyzes the effectiveness of the doctrine in countering the problem of insurance fraud.

In *Haas*, the insurer sought a declaration that a policy issued to an insured was void, or in the alternative, that the policy provided no coverage for a condition concealed on the application. The *Haas* court held that the conditions known to, but concealed by, the insured were excluded by the incontestability clause at issue. Newkirk finds that the application of the doctrine by the *Haas* court adequately prevents either insured or insurer from taking undue advantage of the other.

Newkirk also compares the *Haas* decision with decisions from other jurisdictions, and surveys the historical development of the concept of incontestability and the common concerns in first manifest cases. From this information he develops an equation from the variables affecting incontestability and insurance fraud policy concerns (e.g., the transactional cost of litigation, evidentiary costs, fraud costs, and frequency of fraud, etc.). Utilizing this equation to economically analyze the application of the doctrine by the *Haas* court, Newkirk determines that the doctrine adequately satisfies the concerns of economic efficiency and pareto-optimality (in which efficiency is achieved by parties gaining advantages without any other party being disadvantaged).

Newkirk concludes that by reducing the complexity and numerosity of issues, the doctrine reduces the power differential between insurer and insured in terms of litigational and transactional power imbalances. He further concludes that the rising incidence of insurance fraud can be effectively countered only by judicial use of the doctrine, and not by legislative efforts.

LITIGATION INSURANCE

Lisa A. Small, Note, *Offensive and Defensive Insurance Coverage for Patent Infringement Litigation: Who Will Pay?*, 16 CARDOZO ARTS & ENT. L. J. 707 (1998).

This Note discusses the strategic and financial implications of patent litigation when used as a tool by high-tech companies in order to undercut their competition. In some cases, according to Small, it has become more profitable for companies to exploit their patents by collecting damage awards than marketing their patented products directly. As a result of all this litigation, high-tech companies need both offensive and defensive patent infringement insurance to protect their intellectual property.

Since 1986, however, courts have consistently denied coverage under advertising injury provisions of standard Commercial General Liability policies. Previously, under the 1973 version of the CGL policies, a few jurisdictions allowed recovery of the costs of patent infringement suits as advertising injury because advertising injury was defined to include "piracy." The term "piracy" was removed from the definition in the 1986 standard CGL policy, which left companies involved in infringement suits without general liability coverage. Several insurers do offer separate coverage for either offensive or defensive patent infringement, but the high cost of underwriting these policies translates into prohibitively high premiums. (For example, Lloyd's of London offers annual offensive coverage of up to $1,000,000 to cover 80% of legal fees incurred, for an annual premium of $25,000. In addition, Lloyd's charges a one-time fee of $25,000 to screen all patents before accepting the risk.) Small concludes that it is incumbent upon businesses, courts and insurers to address this problem jointly, in order to ensure that high-tech companies - particularly the smaller ones who cannot afford to underwrite their own legal costs - will have adequate protection for their intellectual property.

Kent D. Syverud, *What Professional Responsibility Scholars Should Know About Insurance*, 4 CONN. INS. L.J. 17 (1997-98).

Noting that professional responsibility law views the relationship among insured, insurer and defense counsel from the perspective of the insured client, Syverud discusses both the theoretical and practical implications of such a perspective. He suggests that because the

professional responsibility law focuses on the individual client, and "elevates (some would say enshrines) that client's goals as the uncompromisable absolute," that the economic and contractual realities of the tripartite relationship are subordinated to that absolute. Syverud contends that one result of this tendency to concentrate on the relationship between the individual client and the lawyer is the failure to recognize the earlier bargain between the insured and the insurer that is reflected in the insurance contract between them. Moreover, Syverud suggests there is a tendency in professional responsibility law to view the insured client as always requiring protection from overreaching by the insurance company.

According to Syverud, the danger of the client-centered viewpoint is that it ignores the economic realties of liability insurance. He argues that tying a duty to indemnify to a right to control the defense is an economically rational approach. Moreover, he suggests that restricting rights of insurers to control the defense of claims would create conflicts where none now exist, and would add hidden costs which could price liability insurance out of the market.

RECENT CASE DEVELOPMENTS

*Jeffrey W. Stempel**

UNDER FEDERAL EMPLOYEES' INSURANCE PROGRAM, CHANGE OF BENEFICIARY FORM INEFFECTIVE ABSENT SIGNATURE OF INSURED; WITNESS AFFIDAVITS IMMATERIAL

Hightower v. Kirksey, 157 F.3d 528 (7th Cir. 1998).

Pink Kirksey, a U.S. Postal Service employee, obtained a life insurance policy from Metropolitan Life under the Federal Employees' Group Life Insurance Act (FEGLIA). FEGLIA is a group life insurance program available to federal employees administered by the U.S. Office of Personnel Management, which purchases private life insurance policies under the program for the employees. Pursuant to FEGLIA and his coverage under the Metropolitan Life policy, Mr. Kirksey named his wife Maude beneficiary in a 1978 designation of beneficiary form.

Maude Kirksey died in June 1989. Under the terms of the policy, if a designated beneficiary predeceased the insured, the proceeds of the policy belong to any children of the decedent insured. When Pink Kirksey died in 1995, his daughter Charlene Hightower sought benefits but was opposed by Lessie Kirksey, sister of Pink Kirksey. To support her claim for benefits, Lessie Kirksey relied on a designation of beneficiary form dated July 19, 1989 naming her beneficiary in replacement of Mr. Kirksey's widow, Maude. Although two witnesses had signed the form, Mr. Kirksey

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himself had not. The court ruled this omission to absolutely bar any effect of the form. The court consequently upheld Ms. Hightower's claim as daughter–beneficiary.

According to the court, the statute establishing the FEGLIA program requires that any beneficiary change form be signed by the insured. The statute, 28 U.S.C. § 8705(a), provides that a beneficiary designation be "in a signed and witnessed writing received before death in the employing office," and expressly provides that beneficiary designations in wills or other documents have no force or effect. *See Hightower*, 157 F.3d at 530. The Seventh Circuit Court of Appeals enforced the language literally, stating that both signature *and* witnessing were required to designate a beneficiary. In the absence of a valid change of beneficiary from the deceased wife to the sister, the policy was to be paid to the insured's children by default as provided in the statutory scheme. The court further ruled that the insured's intent to designate a beneficiary could not be legally established by affidavits of the witness or other extrinsic evidence of insured intent. Without a signature, the beneficiary change was a nullity.

In addition to basing its decision on the literal language of the statute, the court noted that the current language of Section 8705(a) was enacted in a 1966 amendment to the FEGLIA statute. Prior to the amendment, the statute "did not specifically require that insurance policies issued to federal employees covered by FEGLIA be signed and witnessed." *Id.* at 530. Prior to the 1966 amendment, courts had found "substantial compliance" with beneficiary designation procedures to be sufficient, a view in accord with the common law of life insurance beneficiary designation in most states. According to the Seventh Circuit, the "substantial compliance" precedents of FEGLIA were "no longer valid" because of the express language of the 1966 amendment.

The court reasoned that if Congress had wanted to adhere to the pre–1966 precedents, it would not have added the relatively clear words "signed and witnessed" to the statute. Other recent federal court decisions support this aspect of the *Kirksey* holding. *See, e.g., Thomas v. Metropolitan Life Ins. Co.*, 111 F.3d 963 (D.C. Cir. 1997) (partially completed beneficiary change form ineffective absent insured's signature); *Ward v. Stratton*, 988 F.2d 65, 67 (8th Cir. 1993) (by adding requirement of signature in 1966 amendment, Congress intended to eliminate practice of permitting beneficiary change by less formal documentation such as unwitnessed holographic note); *Metropolitan Life Ins. Co. v. Sullivan*, 897 F.Supp. 65 (E.D.N.Y. 1995) (beneficiary designation completed by

insured's brother under power of attorney after insured's death invalid under 28 U.S.C. § 8705(a)).

Although it stated that extrinsic information was irrelevant to the issue of valid beneficiary designation, the *Kirksey* court itself made use of a form of extrinsic information to buttress its view that the statute absolutely required the insured's signature to change beneficiaries. In particular, the *Kirksey* court noted that the Code of Federal Regulations applicable to the administration of FEGLIA required that the insured sign any beneficiary designation. *Hightower*, 157 F.3d at 531 (citing 5 C.F.R. § 870.902(a)). The Code of Federal Regulations is obviously not the statute itself but is formulated by the agency administering a statute. Although agency regulations may be overturned by judicial review if the regulation exceeds agency authority, or by legislative overruling if Congress disagrees with the regulation, the Code reflects the responsible agency's reading of the statute and understanding of the congressional intent underlying the statute. Under relevant U.S. Supreme Court precedent, the statutory interpretation of an agency charged with administering the statute is given considerable deference and normally takes precedence over competing interpretations whenever the agency's construction of the statute is "reasonable". *See* Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 104 S.Ct. 2778 (1985). Reading the express language of the FEGLIA statute as requiring, without exception, the insured's signature, was clearly a reasonable interpretation even if not the only possible interpretation.

The *Kirksey* court also found that strict construction of the statute made sense as a means of minimizing error or fraudulent claims. Consequently, the requirements of the statute do not permit "any exceptions, equitable or otherwise." *See Hightower*, 157 F.3d at 531 (citing Metropolitan Life Ins. Co. v. Christ., 979 F.2d 575, 578 (7th Cir. 1992)). In the instant case, of course, the Seventh Circuit's literalism may have made particularly good sense. A grieving insured in the month after his wife's death could have been pressured by a sibling to designate her as beneficiary and may have been vulnerable to such pressure, even at the expense of his child. Further, witnesses may be disinterested in that they do not stand to profit personally from a beneficiary change but may be allies of the would–be beneficiary. Consequently, some caution is required before permitting witness affidavits to take the place of a signature.

Even if the insured went so far as to prepare a beneficiary designation, the *Kirksey* case itself suggests some wisdom in requiring the insured to travel the last yard and sign the form to make a beneficiary designation

effective. For a large and far–flung insurance program such as FEGLIA, where the insured often is not well–known to those processing the policy, an absolute signature requirement may make particularly good sense both as an efficient rule of easy administrative application and as a check on error. For ordinary life insurance products sold "closer to home", through an agent and an individualized underwriting and administration process, permitting "constructive" change of beneficiary based on the totality of the circumstances may make more sense. However, the enthusiasm of the federal courts in enforcing the absolute signature requirement of FEGLIA suggests that courts would be receptive to state legislation or clearly written insurance policy provisions imposing similar requirements for beneficiary designation in non–FEGLIA life insurance.

WASHINGTON FINDS POLLUTION LIABILITY COVERAGE UNDER PERSONAL INJURY PORTION OF COMMERCIAL GENERAL LIABILITY POLICY

Kitsap County v. Allstate Insurance Co., 964 P.2d 1173 (Wash. 1998).

The standard commercial general liability ("CGL") policy is best known for the defense and indemnity coverage it provides for "bodily injury" and "property damage" (Part A of the standard CGL drafted by the Insurance Services Office). Part B of the CGL provides coverage for "personal injury" and "advertising injury". Personal injury is defined as matters such as false arrest, malicious prosecution, defamation, and "wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy."

In the early years of significant pollution liability claims, coverage litigation focused on the so–called "qualified" pollution exclusion (which was in effect from 1970 to 1985) which excluded coverage for pollution claims unless the release of the pollutant was "sudden and accidental". Courts split roughly in half regarding whether the qualified exclusion precluded coverage for gradual but unintended pollution. In response, the insurance industry adopted the "absolute" pollution exclusion found in today's CGL, which precludes coverage for any claim arising out of a contaminant discharge. Although courts have divided regarding application of the exclusion to events such as carbon monoxide poisoning and lead paint ingestion, the absolute exclusion has been very successful in

prompting courts to bar coverage for traditional environmental degradation claims.

The success of the current pollution exclusion to the bodily injury coverage in Part A of the CGL has driven policyholders to seek coverage for contamination claims under the personal injury provisions of Part B of the CGL, which provides coverage for "wrongful entry" type claims and in the past contained no pollution exclusion. In the typical CGL, the absolute pollution exclusion was first included only in the bodily injury and property damage section (Part A). The current standard CGL Part B now also excludes personal injury and advertising injury claims arising out of pollution discharges. However, policyholders holding occurrence policies predating the Part B pollution exclusion have, when faced with effluent liability claims by neighbors or the public, asserted that the claim alleges wrongful entry by the pollutants onto the property of the third party. For the most part, these policyholder attempts to obtain personal injury CGL coverage for this type of claim have been unsuccessful.

However, policyholders seeking to find "back door" coverage for pollution claims via the personal injury section of the CGL recently received a shot in the arm in *Kitsap County v. Allstate Insurance Company*, in which the Washington Supreme Court held certain pollution claims against the policyholder County constituted covered wrongful entry and invasion of the right of occupancy under the personal injury provisions of the applicable liability policies.

The declaratory judgment action over coverage began in the Federal District Court for the Western District of Washington, which certified to the Washington Supreme Court the question:

> Whether the claims against Kitsap County constitute "personal injury" under each of the subject liability insurance policies.

The court responded by answering "yes to the question insofar as it relates to policies that provide coverage for a personal injury arising from a 'wrongful entry' and/or other invasion of the right of private occupancy" but answered "no as it relates to policies that provide coverage only for a personal injury arising from a 'wrongful eviction'." *Allstate Ins. Co.*, 964 P.2d at 1175.

The claims arose out of suits by the owner and residents of a mobile home park who alleged that their property and health were damaged by odors and other contamination from a waste disposal site once owned by

the County. The claims sounded in trespass and nuisance. The County tendered defense of the suits to 19 insurance companies that had written liability coverage for the County in 23 separate policies over a 30–year period. The insurers agreed to defend subject to a reservation of rights, prompting the County to assume its own defense. The actions were settled and the County then sought coverage.

The policies at issue contained varying language that in different degrees provided coverage for "wrongful entry", "wrongful eviction", and "other invasion of the right of private occupancy." One policy also provided coverage for a "violation of property rights". The personal injury provisions of the policies also provided coverage for the usually included personal injury components of false arrest, malicious prosecution, and defamation.

The Washington Supreme Court noted that some cases refuse to find coverage under the personal injury provisions because the structure of the policy and these provisions suggest that personal injury coverage is designed to cover a species of intentional torts and not duplicate coverage for bodily injury claims. The court also noted that some decisions favoring insurers found a policy's absolute pollution exclusion to apply to the personal injury section of the policy as well as to the bodily injury coverage. However, concluded the court, where there is no clearly attached pollution exclusion, the "wrongful entry" and "invasion of property" language is susceptible to construction in favor of the policyholder. Thus, under the rule of contra proferentem, a provision capable of reasonable construction against the insurer and in favor of coverage is so construed. In particular, the court rejected the view that the "intentional tort" nature of personal injury coverage required a finding that any physical injury claims were the exclusive province of the bodily injury section of the policy (that contained a pollution exclusion). The court found that:

> no rule of law that we are aware of that prevents an insurance company from providing overlapping coverage in any policy that it issues. By the same token, we know of no authority for the proposition that an insured must elect which coverage it chooses if it has been furnished with overlapping coverage in a policy. . . . If the claims against Kitsap County constitute "personal injury" as that term is defined in any policy, then coverage is available under that policy, notwithstanding the fact that additional coverage may be provided to the insured by other provisions in the policy.

Id. at 1180.

The Washington Supreme Court directly disagreed with *County of Columbia v. Continental Insurance Co.*, 634 N.E.2d 946 (N.Y. 1994), a New York high court case limiting personal injury coverage to intentional torts and similar causes of action. The Washington Supreme Court also noted that some insurers had placed pollution exclusions in the personal injury segments of their liability policies. To the court, this suggested that the liability policies could have been more clearly drafted to preclude coverage, thus bringing about sufficient ambiguity to support a reading of the "wrongful entry" and "property invasion" terms that was favorable to the policyholder. The court also rejected insurer arguments that Washington law envisioned a separate tort of wrongful entry that was distinct from mere damage to property from the introduction of something from outside the property.

As a matter of contract construction, the court rejected the insurer suggestion of applying the canon of construction "ejusdem generis" (which advocates construing a set of related terms similarly) because the wrongful entry provisions were followed by a catchall "or other invasion of property" clause that made it inappropriate to limit coverage solely to things similar to wrongful eviction. Finally, the court agreed with the County that a nuisance claim was essentially a claim for wrongful entry or invasion of the right of use of private property.

The *Kitsap County* holding is certainly debatable and many would regard it as a victory for hyperliterally broad construction rather than a reasonable reading of the liability policy as a whole. However, the decision was a unanimous one from a court noted for its insurance opinions. *Kitsap County* may breath new life into policyholder efforts to obtain pollution coverage through the personal injury provisions of the CGL or similar liability policies.

TEXAS SUPREME COURT IN 5–4 DECISION RULES FOR POLICYHOLDER CONTRACTOR IN POLLUTION–RELATED CASE

Kelly–Coppedge, Inc. v. Highlands Ins. Co., 980 S.W.2d 462 (Tex. 1998).

Kelley–Coppedge, Inc. ("KCI"), an oil and gas pipeline contractor, struck an existing oil pipeline while laying pipe along an easement. Some

1600 barrels of crude oil spilled, giving rise to a claim by the property owner against KCI. KCI notified Highlands, its commercial general liability ("CGL") insurer, as well as mitigating damage and resolving the claim by paying cleanup costs. Highlands denied coverage, asserting that the claim was barred under the pollution exclusion of KCI's liability policy.

The KCI policy, like the standard CGL, contained a pollution exclusion that barred coverage arising from a discharge of contaminants "[a]t or from any premises, site or location which is or was at any time owned or occupied by" the policyholder. 980 S.W.2d at 464. Highlands took the position that while laying pipe, KCI "occupied" the property on which the spill took place. KCI prevailed before the trial court while the intermediate appellate court accepted the insurer's position. The Texas Supreme Court rejected the insurer's view in a 5–4 decision, holding that occupation of property within the meaning of the CGL's pollution exclusion requires more than mere temporary, transitory presence on the property on which a pollution discharge takes place.

The majority at one point suggested that to "occupy" land, an entity must have something close to "exclusive control" of the premises but need not be constantly physically present. However, the court stopped short of using an exclusive control definition of occupancy and required only that the entity "keep or hold the property for use" to be an occupier. The court majority cited a federal district court case giving a similar reading to the "occupancy" requirement on the ground that the insurer's broad construction of this term did not fit with the language and structure of the pollution exclusion. *See United States Fidelity & Guaranty Co. v. B & B Oil Well Service, Inc.*, 910 F. Supp. 1172 (S.D. Miss. 1995). The *KCI v. Highlands* court observed:

> We agree with KCI that if the [insurer] was correct that any presence, no matter how transitory, constitutes occupancy under section f.(1)(a), then section f.(1)(d) is rendered meaningless. Subparagraph (a) applies to releases at or from premises owned or controlled by the contractor. Subparagraph (d) broadens the scope of the exclusion to include releases at or from premises owned by a third party at which the contractor is performing operations, but only if the contractor brings the pollutants onto the site. By negating coverage for a contractor's entire operations at a job site, the [insurer's] interpretation leaves section f.(1)(d)

> nothing to exclude. Under the [insurer's] interpretation, there would be absolutely no reason to include (d) since (a) already excludes all the contractor's operations, whether or not the contractor owns or controls the premises on which it is performing operations. Under that reading, a contractor's off–premises coverage is completely eliminated.
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> * * *
>
> In short, we agree . . . that to "occupy" means "to hold or keep for use," and we concluded that KCI's interpretation of the word "occupy" . . . is the only reasonable interpretation [and that the pollution exclusion] unambiguously does not apply to exclude coverage for KCI's cleanup costs.

Highlands Ins. Co., 980 S.W.2d at 467.

The four dissenting justices argued for a broad reading of "occupy" to include any type of presence, however brief. But the dissenters also argued that the it was reasonable under the circumstances to view KCI as an "occupier" of the land as they were granted a contractual right to wide–ranging use of the land and worked on the property for 19 days with workers and equipment. According to the dissent:

> Based on any of the preceding definitions [of occupancy used by in other cases], KCI clearly "occupied" the easement.
>
> * * *
>
> Based on the plain, ordinary, and generally accepted meaning of occupied, a person or thing occupies a space if it is there. One may occupy a vehicle, a hotel room, or even an airplane seat or bathroom for a short period of time without ever possessing or controlling it. The term occupy and its cognates are routinely defined as indicating physical presence or proximity in the automobile insurance context.

Id. at 469.

The dissent also disagreed with the majority regarding the relation of subparagraph (d) of the exclusion (the subcontractor exception) to the

entire exclusion, finding that the subcontractor exception was not rendered meaningless if "occupy" is read broadly because:

> The policy indemnified KCI for any vicarious liability it might incur for pollution–related damages caused by a KCI subcontractor who did not bring the pollutants to the site, but it excluded it for any damages for which KCI was directly responsible.

Id. at 469.

The textual analysis of both the majority and the defense is impressive but the majority decision is more persuasive because of factors in addition to text. The Court's decision provides a more reasonable interpretation of the CGL and the exclusion that better comports with the intent and purpose of the pollution exclusion. The exclusion was designed to eliminate coverage for Superfund–type land mediation costs imposed on landowners or lessees and to bar coverage for policyholders releasing contaminants as a part of business operations. KCI did not pollute by discharging contaminants—it negligently damaged a pipeline, which consequently resulted in despoiling of land. Thus, the KCI tort liability does not fit the notion of pollution underlying the exclusion, a factor that argues for a narrow reading of the "occupy" term in the exclusion under the facts of the case.

In addition, it is hornbook insurance law in Texas and elsewhere that the terms of an exclusion are strictly construed against the insurer because, to state the obvious, exclusions narrow coverage. Indeed, any term drafted by the insurer (which usually is every word in the policy) is construed against the insurer under the doctrine of contra proferentem (ambiguous words are construed against the contract drafter) unless the words are sufficiently clear. Although the majority labored to find "occupy" a facially unambiguous term as did the dissent, the diametrically opposed interpretations of the same word given by the Justices suggest that both camps of the Texas court were being unrealistic to suggest the absence of ambiguity. It might more realistically be said that both the "temporary presence" and the "keep or hold for use" interpretations of the term "occupy" are reasonable. But if there are competing reasonable constructions of a term, the term is construed against an insurer that drafted the policy. Consequently, the contra proferentem principle could easily have been applied to the case and supports the majority holding.

Furthermore, although the dissent presents its position well, it may be charitable to call such a broad definition of "occupy" reasonable. Recall that the dissent states that one occupies a bathroom with even a brief visit. Although this is true in a dictionary sense, it seems not to be the notion of "occupy" applicable to a liability insurance policy. For example, if a KCI employee visits a bathroom at the jobsight and negligently causes a toilet backup, does it make sense to treat KCI as a polluter and deny coverage for what appears to be mere negligence that does not take place on anything resembling KCI's property?

If even transitory presence is enough occupancy to invoke the broadly drafted absolute pollution exclusion, there could be considerable potential for absurd results in the context of liability insurance. For that reason, the dissent's invocation of automobile insurance precedents seems inapposite to construing the CGL as there may be good reasons to construe "occupy" broadly in the auto context but not in the CGL context. In addition, the term "occupy" is part of the automobile policy coverage provisions and not part of an exclusion, a segment of the policy normally construed against the insurer.

Because *KCI v. Highlands* was a 5–4 decision in which both majority and dissent focused heavily on policy text rather than other interpretative factors, presumably the Texas court would enforce a broad definition of "occupy" if it were specifically defined in the policy. Liability insurers for contractors may accordingly rewrite their policies in response to the *KCI v. Highlands* decision.

"PROFESSIONAL SERVICES" WITHIN MEANING OF ATTORNEY MALPRACTICE POLICY INCLUDES BREACH OF FIDUCIARY DUTY FOR FAILING TO DISCLOSE CONFLICT OF INTEREST EVEN IF BREACH DID NOT OCCUR DURING ACTUAL PERFORMANCE OF PARTICULAR LEGAL SERVICES FOR CLIENT

In re Estate of Corriea; Avianca, Inc. et al., 719 A.2d 1234 (D.C. 1998).

Beginning in 1980, Avianca, S.A. retained attorney Mark Corriea to represent it in aircraft leasing, corporate financing, and government relations matters. By 1985, the relationship had soured sufficiently that

Avianca sued Corriea in United States District Court for breach of fiduciary duty, fraudulent misrepresentation, and violation of the federal Racketeer Influenced and Corrupt Organizations Act ("RICO"). Avianca prevailed in the suit, obtaining summary judgment against Corriea, with the trial court finding that Corriea had violated his fiduciary duty as counsel to Avianca because he had "allowed his professional judgment on behalf of his clients to be adversely affected by acquiring and maintaining interests potentially or actually in conflict with those of his clients." 719 A.2d at 1235.

The gravamen of the Avianca claim was that Corriea failed to disclose to it that he had financial interests in companies with which he was conducting transactions on behalf of Avianca. Corriea consequently stood to profit from the completion of these transactions even if the arrangements were not in the best interests of Avianca. As a result, the federal trial court found that Corriea lacked the independent judgment and freedom from adverse incentive required of attorneys. The Avianca–Corriea litigation spawned subsequent insurance coverage litigation in the District of Columbia courts (not to be confused with the United States Courts operating in the District of Columbia), with Corriea's malpractice insurer unsuccessfully attempting to avoid coverage.

The insurer, INAPRO, argued that Corriea could not have malpractice coverage because his liability to Avianca resulted from failure to disclose conflicts rather than the negligent provision of legal services such as the drafting of defective documents, failure to meet a statute of limitations, or shoddy prosecution of a claim. The D.C. Court of Appeals rejected this argument, noting that the INAPRO policy covered "professional services," which were defined in the policy as

> services rendered for others as an attorney, notary public, title insurance agent pursuant to a written agency agreement with a licensed title insurance company, and an administrator, conservator, executor, guardian, trustee, or in any similar fiduciary capacity, provided that such services are connected with and incidental to the insured's profession as an attorney.

Id. at 1237.

Reversing the District of Columbia Superior Court, the Court of Appeals found that Corriea's activities fell clearly within the zone of professional services coverage since his failure to inform his client of the

conflict of interest was clearly connected with and incidental to his legal activity on behalf of Avianca.

The Court of Appeals also found that coverage was not precluded because the federal trial court in the underlying action had ordered disgorgement of Corriea's fees and entered a judgment in favor of Avianca of $1.4 million, an amount apparently larger than Avianca's actual out–of–pocket losses in connection with the challenged transactions. The Court of Appeals ruled that despite any disproportionality, the disgorgement remedy was compensatory and not a fine or penalty, which was excluded under the INAPRO policy. The court ruled that the presence of some degree of punishment of the wrongdoer in a civil remedy does not make the damage award an uninsurable fine. Disgorgement in particular has long been a popular remedy against attorneys who overcharge, breach a fiduciary duty, or perform services incompetently. Although disgorgement may overcompensate the former client, the remedy is viewed as more compensatory than punitive in that it is designed to reverse the transaction, prevent unjust enrichment of the attorney, and provide an easily applied damages formula that does not require courts to apply a micrometer to the degree of value that may have been conferred through legal services tainted with malpractice or ethical violations. Unlike a true punitive damages award, which has no fixed limit (but must be proportional to the wrongdoing and the defendant's wealth), fee forfeiture is limited to the total amount of fees.

The Court of Appeals also reversed the Superior Court finding that Corriea's conduct was committed with dishonest purpose or intent. Because a determination of dishonesty involves an evaluation of the defendant's state of mind, the Court of Appeals found this determination inappropriate for summary judgment and remanded to the Superior Court for further factfinding on the issue. In addition, Corriea had filed an affidavit in opposition to summary judgment denying any dishonest motive, thereby emphasizing the conflicting issue of fact regarding his state of mind. Although the matter of fiduciary duty and breach could be decided as a matter of law, the issue of dishonesty was too fact–intensive to be determined without a trial on the issue. Because the dishonest purpose prohibition is contained in a policy exclusion, the Court noted that the insurer on remand must prove dishonest intent by the attorney in order to avoid coverage.

POLICYHOLDER'S FAILURE TO IDENTIFY ERROR IN DRAFTING PRENUPTIAL AGREEMENT IS NOT FAILURE TO DISCLOSE POTENTIAL MALPRACTICE CLAIM AND DOES NOT PRECLUDE COVERAGE FOR LAW FIRM

Shaheen, Cappiello, Stein & Gordon, P.A. v. The Home Ins. Co., 719 A.2d 562 (N.H. 1998).

In 1984, Deborah Coffin retained Dorothy Bickford and the law firm of Shaheen, Cappielo, Stein & Gordon to represent her in formulating a prenuptial agreement. A draft of the prenuptial agreement prepared by Coffin's Connecticut lawyer contained a provision providing for the distribution of certain property to the spouse who contributed the funds to buy the property. "Inexplicably, this provision was omitted from the final agreement." *Id.* at 564. Sure enough, the subsequent marriage foundered and in Fall 1990, Coffin sought legal advice from the Shaheen firm, filing for divorce in December 1990.

At or shortly after the initiation of the divorce action, the Shaheen firm was aware that the final prenuptial agreement did not contain the provision for property division based on spousal contribution toward purchase. However, the firm informed Coffin that she had a plausible argument for such a property division even in the absence of such an express prenuptial provision. "Coffin expressed confidence in [Firm partner] Stein and his legal abilities, and approved the firm's continuing representation in her divorce action." *Id.* at 564.

In November 1991, approximately a year after the divorce action began, the Shaheen firm applied to renew its professional liability policy with Home Insurance and was asked in the application whether any lawyer in the firm was "aware of . . . any incident, act or omission which might reasonably be expected to be the basis of a claim or suit arising out of the performance of professional services for others." *Id.* at 564. The firm did not disclose the Coffin prenuptial omission "because the firm believed that no claim would arise pending resolution of the interpretation of the prenuptial agreement." *Id.* at 564.

In August and September of 1992, the firm's arguments on behalf of Coffin proved unsuccessful, and the presiding marital master concluded that the marital home would be divided according to the equitable division principles generally governing marital property. In practical effect, this meant that Deborah Coffin would be required to split assets down the

middle, even if her funds had purchased the property originally. According to the court, the potential malpractice claim accrued at that time.

The Shaheen firm informed the insurer in October 1992, a time found reasonable by the court. The insurer sent a reservation of rights letter to the firm in March 1993 and in late 1993 indicated it would close its file since no claim had been made.

A malpractice action was eventually brought against Bickford, who had subsequently left the firm but was part of tail coverage purchased by the firm. Home declined to defend, eventually denying coverage in an April 1994 letter. The firm filed a declaratory judgment seeking a judicial determination of coverage and prevailed both at trial and before the New Hampshire Supreme Court.

The high court accepted the expert testimony proferred by the firm that a reasonable attorney would not have reasonably expected a malpractice claim to result from the Coffin prenuptial agreement problem as of late 1991 in view of the firm's belief that it could prevail for its client and the client's apparent satisfaction with her representation at that time. The court rejected the insurer's attempts to exclude the expert testimony, finding that it involved technical or specialized knowledge for which expert opinion could be helpful to the court. Thus, the court's use of the expert testimony was not an abuse of discretion.

As to the adequacy of the Shaheen firm's disclosure to the insurer, the court found no need to disclose until the adverse ruling in the Coffin divorce, or perhaps not even until Coffin revealed inclination to make a claim. The court's narrow holding was simply that the firm had no obligation to disclose when it renewed coverage in November 1991. The policy stated that the insured was to give notice when it became aware of a problem that could "reasonably be expected to be the basis of a claim." Applying the reasonableness yardstick, the court noted that the determination was a question of fact for the trial court. The Supreme Court accepted a commentator's view that the proper inquiry poses the question:

> [I]s it more likely than not that an incident will lead to a claim? Certain circumstances are clear–cut, as in the cases of blown statutes of limitations or the late filing of a Subchapter S election. Most cases are less clear–cut, however, and require that the attorney exercise his professional judgment in evaluating the possibility that an adverse development will give rise to a claim.

Id. at 566 (quoting RONALD E. MALLEN LEGAL MALPRACTICE: THE LAW OFFICE GUIDE TO PURCHASING LEGAL MALPRACTICE INSURANCE § 5.14, at 32 (2d ed. 1997)).

The court turned a deaf ear to the insurer's argument that the policyholder was given too much discretion under the trial court's ruling. The court noted that "[b]y using the phrase 'reasonably be expected,' Home Insurance apparently requires that its insureds exercise professional judgment at several critical junctures." 719 A.2d at 566. Having chosen this language, Home could not complain when the attorney insureds enjoyed the benefit of prevailing professional sentiment as to the bounds of reasonableness in anticipating a client's malpractice action.

The *Shaheen* case suggests that professional liability insurers may wish to revise their notice and disclosure provisions to require applicants to disclose any incidents that "might" result in a claim. However, this broader language may overinundate the insurer with details of minor arguable errors by counsel. In addition, *Shaheen* suggests insurers may need to give more serious thought to proferring expert testimony favorable to the insurer's coverage position. It appears that Home made no attempt to counter the expert testimony submitted by Shaheen but instead only attempted to exclude the testimony. When the attempt at exclusion failed, the insurer was left with a factual record highly favorable to the policyholder and no contrary evidence from the insurer.

FAMILY MEMBERS LACK AUTOMATIC CONSTRUCTIVE PERMISSION TO USE FAMILY CAR; UNDERAGE SON'S JOYRIDING OUTSIDE SCOPE OF AUTO INSURANCE COVERAGE

Close v. American Economy Ins. Co., 583 N.W.2d 794, (N.D. 1998).

The lure of a Fall jaunt in the countryside near Devils Lake was simply too much for 15–year–old Dominic Ebertz, who on Oct. 12, 1992 skipped school, took the family van (which had been insured by American Economy for only 12 days), and went joyriding with friends throughout the day, concealing his activities from his parents. The adolescent prank took a sour turn when Dominic and friends fled an off duty police officer, colliding with another vehicle and seriously injuring passenger Clifford Close.

Dominic's father, the policyholder, sought coverage for the accident but was rebuffed by the insurer. The North Dakota Supreme Court agreed with the insurer, finding that Dominic was uncovered because he was using the vehicle without his father's permission.

The automobile policy in question specifically stated that the insurance did "not provide Liability Coverage for any person . . . [u]sing an 'auto' without a reasonable belief that person is entitled to do so." 583 N.W.2d at 794. Although "person" was not defined in the policy, the Court gave the term its ordinary meaning as including without restriction any human being. The policyholder argued that "person" should not be construed to include a "family member", an argument accepted by the trial court but rejected by the Supreme Court.

Although there are decisions reading the "driving without permission" exclusion as not applying to family members, the North Dakota Court found these a clear minority. The court stated that a majority of courts have concluded that the "any person" language unambiguously includes a "family member", barring coverage where the family member uses the insured automobile without the permission of the policyholder. *See id.* at 796. The court found the majority reasoning "sound", both for linguistic reasons (the "any person" language was unambiguous) and also for reasons involving the structure of the insurance agreement and public policy.

The Ebertz's automobile insurance specifically exempted family members from the "business pursuits" exclusion of the policy but made no such exemption to the "any person" permission requirement exclusion, buttressing the literal reading of the "any person" exclusionary language. In addition, the court noted that excepting family members from the permission requirement would violate public policy by mandating coverage for car thieves, albeit car thieves in the family, and by providing liability coverage for intentionally wrongful acts.

UNEXPECTED DEATH RESULTING FROM INSURANCE FRAUD SCHEME MAY BE "ACCIDENTAL" IF NOT INTENDED BY PERPETRATORS

Fox v. Country Mutual Ins. Co., 964 P.2d 997 (Or. 1998).

Perhaps adolescent boredom is even more acute in Oregon than in North Dakota. Unfortunately, it also proved more tragic in the *Fox* case.

Like the joyriding in *Close v. American Economy*, discussed above, the irresponsibility took a wrong turn. In 1990, Vincent, a high school student, "decided to wreck his pickup truck intentionally in order to collect the insurance proceeds." *Id.* at 999. William Fox, a classmate and friend of Vincent, agreed to accompany Vincent, although Fox's involvement in the matter was subject to conflicting evidence. Fox either agreed to be in the truck at the time of the arranged crash or, having agreed to serve as a lookout, was unable to leave the car when Vincent refused to stop. In any event, Fox was unexpectedly killed in the resulting crash.

The Fox estate sued Vincent for wrongful death and settled the action. Fox then sought uninsured and underinsured motorist ("UM") coverage under the Fox family's own auto policy. The insurer denied, claiming the loss was expected or intentionally caused and hence was not a covered "accident" under the policy. The policy provided that the insurer

> will pay damages which an insured is legally entitled to recover from the owner or operator of an uninsured or underinsured motor vehicle because of bodily injury sustained by an insured and caused by an accident.

Id. at 999, n.3.

Both the trial court and the Court of Appeals found for the insurer, reasoning that it was indisputable that Fox intended to ride off the road in Vincent's truck. Even if these facts were uncontested (which they were not), the Supreme Court found it indisputable that Fox never intended to cause himself injury. According to the Court, it

> must view the event from the perspective of Fox, not Vincent. This is a first–party claim for recovery of damages for personal injury to Fox under a policy that his parents purchased from defendants. This is not a claim for coverage to protect Fox against liability claims asserted against him by a third party. The purpose of UM coverage is not protection from liability, [the UM portion of the auto policy] resembles an accident policy for the victim of the uninsured motorist."

Id. at 1000 (quoting Davis v. State Farm Mut. Auto Ins. 507 P.2d 9,11 (Or. 1973).

Reviewing Oregon precedent on intentionally caused injury, the *Fox* Court concluded that the fortuity requirement for insurance is satisfied so long as the insured did not intend injury even if the conduct that led to injury was volitional on the part of the insured. *Id.* at 1004.

The Fox holding is surely correct, although many modern courts at the urging of insurers appear to have narrowed their concept of fortuity. However, if the position of some insurers equating intentional conduct with intentional injury were accepted, absurd results would be in the offing. For example, a driver planning to commute to work acts intentionally. It would be ludicrous to suggest that an accident during rush hour is excluded because the policyholder's commute was a planned event.

Negligence often occurs during the course of intentional activity and lawsuits alleging negligence are surely covered under a liability policy. Similarly, UM benefits, although more in the nature of first–party coverage, are designed to provide compensation to the policyholder when a negligent tortfeasor is uninsured or underinsured. Consequently, even injuries resulting from reckless or stupid conduct are not barred from coverage unless the injury itself was intended. Under *Fox* and most cases on this point, a loss is sufficiently fortuitous, accidental, unexpected, and insurable if it was not the product of a specific design to cause harm to self or others.

CIVIL LIABILITY MAY BE IMPOSED ON INSURERS WHO CLOAK AGENTS WITH INDICIA OF APPARENT AUTHORITY EVEN ABSENT ACTUAL AUTHORITY WHERE RELIANCE INDUCED

Almerico v. RLI Ins. Co., 716 So.2d 774 (Fla. 1998).

J.R. Pliego was the owner of J.R. Insurance Agency and a licensed insurance agent who sold insurance to the Collado family for several years, arranging an umbrella policy for the Collados with American Mutual Fire Insurance Company. When American stopped writing umbrella coverage, Grace Collado requested that Pliego arrange substitute coverage. Pliego eventually arranged for umbrella coverage with RLI. After 18–year–old Daron Collado was involved in an auto accident giving rise to substantial claims involving death and serious injury, RLI sought to rescind coverage on the basis of omitted or incorrect information in the application. The

Collados asserted that RLI was constructively aware of full and accurate information because Pliego was aware of the information in question.

RLI took the position that Pliego was an agent or broker for the Collados while the Collados asserted that Pliego was RLI's agent. The trial court found for the Collados while the intermediate appellate court found for RLI, setting up the Florida Supreme Court's review and determination of Pliego's agency.

The Supreme Court held that Pliego was RLI's agent because he was clothed in apparent authority from RLI. Applying general agency law principles, the Court set forth a three–factor test for determining the existence of agency by apparent authority:

> 1) whether there was a representation by the principal;
> 2) whether a third party relied on that representation;
> 3) whether the third party changed position in reliance upon the representation and suffered detriment.

716 So.2d at 777.

The court also observed that an intermediary may have dual agency, representing the applicant/policyholder for some purposes and the insurer for other purposes. According to the court:

> Under the circumstances presented here, there appears to be a complex, interwoven relationship between RLI, Poe [another intermediary], Pliego, and the Collados which precludes a finding that, as a matter of law, Pliego was at all times acting as the agent of the Collados and not as RLI's agent in his transactions with the Collados. Indeed, there is evidence that Pliego may have been acting in the dual roles of RLI's insurance agent and the Collados' insurance broker. Further, if a fact–finder reached that conclusion, then the actual knowledge that Pliego possessed about the Collados' insurance matters while wearing his hat as an RLI insurance agent and dealing with them in that capacity may be imputed to RLI as his principal.

Id. at 782.

The court's review of the record found no evidence from the insurer to suggest that the Collados were aware of any limitation on Pliego's actual authority to act on RLI's behalf. Based on state common law and statute (Fla. Stat. Ann. § 626.342(2)), the court concluded that binding apparent authority could exist if the agent was sufficiently cloaked in indicia of agency "to induce a reasonable person to conclude that there is an actual agency relationship." Unable to decide this issue on the record before it, the court remanded to the trial court for further factfinding.

The *RLI* opinion appears to place Florida in accord with the majority of states on the question of apparent authority and agency, including possible dual or divided agency. However, prior to this decision, the leading cases appear to have been those of intermediate appellate courts. The *RLI* decision thus provides a modern Florida Supreme Court precedent on the issue of agency that resolves the doctrinal question in an essentially mainstream fashion but one that may provide significant benefit to applicants aggrieved by unclear or misleading insurer–agent relations.