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INSURANCE, RISK AND RESPONSIBILITY: TOWARD A NEW PARADIGM?

Conference Report and Introduction

*Tom Baker**

In April 1999, the Insurance Law Center at the University of Connecticut School of Law hosted a conference on "Insurance, Risk and Responsibility: Toward a New Paradigm?" The call for papers described the conference as follows:

> For most of the 20th century, insurance in the United States expanded dramatically. On the private side, the 20th century witnessed the creation of automobile and health insurance, workers compensation, and private pensions, as well as growth in older forms of insurance such as life, liability, property and disability insurance. On the public side, this century witnessed the creation of an entirely new social insurance sector, beginning with the New Deal and followed by Medicare, Medicaid, and natural disaster insurance, as well as a host of ventures directed at business risks. Indeed, "more insurance for more people" is as good a sound bite as any summing up domestic social policy well into the Reagan/Bush years.
>
> A series of developments suggests that this policy may be on the wane. These include:
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> - A shift of investment risk to consumers in return for the possibility of greater return in life insurance, annuities and pensions, including, possibly, a partial shift from a "defined benefit" to a "defined contribution" approach to U.S. Social Security retirement benefits;
> - The failure of universal health insurance, a decline in health insurance participation, and the emergence of a "defined contribution" approach to employment-based health care;

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- The development and growth of alternative risk mechanisms such as captive insurance, third party administrators, catastrophe bonds, and finite risk insurance, and a trend toward larger deductibles, self insured retentions, and retroactive premiums among the entities that continue to use traditional insurance; and
- An increased focus on the need to manage incentives to curtail the growth of public and private insurance programs.

Significantly, these developments are occurring in both public and private forms of insurance, so that they cannot be attributed solely to a reexamination of the role of government.

At the same time, however, the vocabulary of risk has moved well beyond insurance institutions. Money managers develop portfolios at the risk, reward frontier. Social service agencies track at risk children. Community policing efforts are targeted at high-risk areas. Extreme sports enthusiasts rate climbs according to risk and climbers according to the risks they are qualified to take. Judges and law reformers debate accident law in terms of the allocation and spreading of risk. And some have suggested that all of the civil law and the administrative state is now directed at the allocation and management of risk. Thus, if we understand risk management as an insurance technology, we might challenge the apparent decline of "more insurance for more people." Perhaps more insurance – of a certain kind – continues to be pressed upon more people, even as the risk assumed by traditional insurance institutions shrinks.

Participants at the conference included law professors, historians, sociologists, philosophers and economists. Many of the participants had been meeting regularly since 1997 as the New England Insurance and Society Study Group, an informal faculty study group sponsored by the Insurance Law Center. Others had written significant books or monographs relating to risk and insurance that came to the attention of the Study Group. The conference featured seven panels, each addressing different aspects of the history and present of what we came to describe as the "embrace of risk."

Many of the papers will appear shortly as chapters in the book *Embracing Risk*, edited by Tom Baker and Jonathan Simon. Several were adaptations of recently, or about-to-be, published books.[1]

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This issue of the Connecticut Insurance Law Journal features three articles that were among the highlights of the conference: "Insurance: How it Matters as Psychological Fact and Political Metaphor," by Thomas Morawetz; "Moral Opportunity and the Politics of Insurance," by Deborah Stone; and "The Return of the Crafty Genius: An Outline of a Philosophy of Precaution," by François Ewald.

These articles continue the Journal's tradition of pushing the boundaries of what it means to be an insurance law journal. From Seth Chandler's analysis of the economics of moral hazard in the first issue of the Journal[2] through Pat O'Malley's use of industrial life insurance regulation to explore what it means to be a responsible citizen in the most recent issue,[3] the Journal has featured at least one significant, interdisciplinary work in every issue.[4] At the same time, the Journal has not neglected its core legal constituency. Each issue has also included significant doctrinal work, such as the article by

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1. *See* GEOFFREY CLARK, BETTING ON LIVES: THE CULTURE OF LIFE INSURANCE IN ENGLAND, 1695-1775 (1999); CATHY FRIERSON, ALL RUSSIA IS BURNING: A CULTURAL HISTORY OF RURAL FIRE AND ARSON IN LATE IMPERIAL RUSSIA (forthcoming 2000); MICHAEL J. GRAETZ AND JERRY L. MASHAW, TRUE SECURITY: RETHINKING AMERICAN SOCIAL INSURANCE (1999).

3. *See* Seth Chandler, *Visualizing Moral Hazard*, 1 CONN. INS. L. J. 97 (1994-95).

4. *See* Pat O'Malley, *Imagining Insurance: Risk, Thrift and Industrial Life Insurance in Britain*, 5 CONN. INS. L. J. 675 (1998-99).

5. *See* Seth Chandler, *The Interaction of the Tort System and Liability Insurance Regulation: Understanding Moral Hazard*, 2 CONN. INS. L. J. 91 (1996) (law and economics); John G. Day, *Managed Care and the Medical Profession: Old Issues and Old Tensions, the Building Blocks of Tomorrow's Health Care Delivery and Financing System*, 3 CONN. INS. L. J. 1 (1996-97) (law and history); Elizabeth O. Hubbart, *When Worlds Collide: The Intersection of Insurance and Motion Pictures*, 3 CONN. INS. L. J. 267 (1996-97) (law and society); George M. Cohen, *Legal Malpractice Insurance and Loss Prevention: A Comparative Analysis of Economic Institutions*, 4 CONN. INS. L. J. 305 (1997-98) (law and economics); Jonathan Simon, *Driving Governmentality: Automobile Accidents, Insurance, and the Challenge to the Social Order in the Inter-War Years, 1919-1941*, 4 CONN. INS. L. J. 521 (1997-98) (law and history); Jeffrey E. Thomas, *An Interdisciplinary Critique of the Reasonable Expectations Doctrine*, 5 CONN. INS. L. J. 295 (1998-99) (law and psychology).

William Barker in this issue. In addition, beginning with Volume 4, every issue has featured Professor Jeffrey Stempel's Recent Case Developments, as well as abstracts of insurance-related articles published by non-specialty law reviews, prepared by Journal editors under the direction of Professor Jeffrey Thomas. Finally, the student notes and comments address significant recent cases and notable legislative or doctrinal developments in the field of insurance law. The goal is to provide our readers with an efficient means of tracking developments in the field of insurance law, as well as to challenge them to place insurance and insurance law in a broader perspective.

The three articles from the Risk conference each challenge our readers in different ways. The first article itself came about as a challenge. In planning the conference, we cast about for a film that would provide a break from the panel presentations and provoke a discussion on the image of insurance in popular culture. We decided on *The Rainmaker* and challenged Thomas Morawetz – University of Connecticut law professor, philosopher, advocate for law and literature, and connoisseur of detective novels and popular film – to comment on images of insurance in literature and film and to moderate the discussion of the film. As predicted, the film evoked strong reactions from the crowd of lawyers, law students, and insurance buffs. The result was a lively session that was one of the high points of the conference, as well as the wonderful meditation, "Insurance: How it Matters as Psychological Fact and Political Metaphor," that appears in this issue.

Our second author is Deborah Stone. She is a political scientist who writes about insurance, health care, and the political process, and she is an avid observer of the law and rhetoric of insurance. The co-founder of the New England Insurance and Society Study Group and a long time contributor to the Journal of Health Politics, Policy and Law, Stone has played an important role in conducting and promoting interdisciplinary research in the field of insurance. Her article, "Beyond Moral Hazard: Insurance As Moral Opportunity," identifies a new concept that helps explain the growth of insurance institutions. This concept, which she calls the "moral opportunity" of insurance, describes an expansionary social dynamic in insurance institutions that counters the individual-based forces of moral hazard and adverse selection that are of such concern to insurance and economic analysts. The moral opportunity of insurance is a social mechanism that tends to increase what gets perceived as insurable and deserving of collective support. Stone argues that moral opportunity is particularly strong in social insurance and that the moral opportunity of social insurance is a social and political

dynamic that fosters progressive social policies that improve both the well being of individual citizens and the democratic health of the polity.

Our third author is François Ewald. He is a political and legal philosopher, a professor of insurance, and the director of public affairs for the French Federation of Insurance Companies. Before assuming his present positions, Ewald spent many years working with Michel Foucault. Widely published in France, the two short essays he has published in the United States[5] have earned him a devoted following on this side of the Atlantic as well. His article, "The Return of the Crafty Genius: An Outline of a Philosophy of Precaution," argues that Western societies are engaged in a fundamental paradigm shift in their approach to risk. If the 19th century approach to risk was characterized by ideas of providence and individual responsibility and the 20th century approach by ideas of prevention and solidarity, perhaps the late 20th and early 21st century approach to risk will be characterized by ideas of safety and precaution. Ewald describes the shift from providence/responsibility to prevention/solidarity as driven by utopian ideas about the ability of science to manage, contain and perhaps even eliminate risk. The contemporary shift to safety and precaution follows from a recognition of the limits of science. This shift challenges the idea of progress that has animated insurance (and risk management more broadly) and, perhaps, presages the end of the age of insurance.

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6. François Ewald, *Insurance and Risk*, *in* THE FOUCAULT EFFECT: STUDIES IN GOVERNMENTALITY 197 (Graham Burchell et al. eds. 1991); François Ewald, *Norms, Discipline, and the Law*, *in* LAW AND THE ORDER OF CULTURE 138 (Robert Post ed., 1991).

INSURANCE: HOW IT MATTERS AS PSYCHOLOGICAL FACT AND POLITICAL METAPHOR

*Thomas Morawetz**

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I. THE DRAMATIC PROMISE OF INSURANCE

Insurance, like accounting, seems irreparably undramatic. While it plays an inevitable part in our collective experience, the work of insurance and its practitioners seems gray and faceless. Insurance is rarely at the heart of a novel, play, or movie. By contrast, the work of doctors, lawyers, police, and even government officials readily inhabits our cultural fantasies. In imagination, these working lives seem defined by crises in which life is at stake and morality is at issue; personalities involved in such crises can seem larger than life.

When Professor Tom Baker,[1] in planning a conference on the changing concept of risk in insurance,[2] had the inspiration to show a movie about insurance, his pickings were slim. He chose Francis Ford Coppola's

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1. Connecticut Mutual Professor of Law and Director, Insurance Law Center, University of Connecticut School of Law.

2. University of Conn. Sch. of L., Symposium, *Insurance, Risk & Responsibility: Toward a New Paradigm?*, University of Connecticut School of Law (Apr. 11-12, 1999).

adaptation[3] of John Grisham's *The Rainmaker*.[4] Because the story presents an insurance company as villainous, it conveniently serves as a lightning rod for opinions regarding the insurance industry. Is the portrayal realistic? Do real insurance companies, like the company in the movie, deny claims with little concern for their contractual obligations or even for basic humanity? Baker asked me to lead a discussion of the movie to explore not merely insurance in fiction but attitudes toward insurance companies in fact. The discussion at the conference took flight with strong opinions, passionately expressed. It served as an occasion for me and others to reflect on the psychological underpinnings of our attitudes toward insurance and also to think of insurance as political metaphor.

A preliminary question arises from the fact that the passions evoked by difficult encounters with insurance are so rarely the stuff of drama. If many of us have had troubling experiences with insurance, why are these concerns usually not expressed in the stories of culture? Insurance is indeed the stuff of drama, when crimes are committed in its shadow or when catastrophes make it exigent. Otherwise it is, like accounting, a paradigm of a background aspect of modern life that frustrates the imagination. This is so, I think, because the very genius of insurance is to tame life's crises and minimize the unpredictable. A life and mind given over to insurance are seen as the antithesis of a life of fantasy and imagination, a life that thrives on contingency.

Accordingly, generations of critics have labored to explain those rare figures who have inhabited both the world of insurance and the world of imagination. In his double life as a poet with a genius for inventing new ways to see experience and, in his day job, a successful insurance executive, Wallace Stevens seems to have been a living oxymoron.[5] The case of Franz Kafka is arguably a rare instance in which insurance fueled imagination, albeit with nightmare visions of dislocation and alienation. His fictional allusions to Byzantine, inhuman, and barely comprehensible institutions,[6] are

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3. *See* THE RAINMAKER (American Zoetrope 1997).

4. *See* JOHN GRISHAM, THE RAINMAKER (1995).

5. *See, e.g.*, THOMAS C. GREY, THE WALLACE STEVENS CASE: LAW AND THE PRACTICE OF POETRY (1991). This book is an intriguing and well-argued attempt to connect the various aspects of Stevens' life.

6. *See, e.g.*, FRANZ KAFKA, THE CASTLE (Willa & Edwin Muir, trans., Knopf 1962) (1930) and THE TRIAL (Willa & Edwin Muir, trans., Knopf 1960) (1937) (the best known and most influential examples of his posthumously published novels). The movie KAFKA is an

plausibly grounded in his own life, in his grim employment in the lowest ranks of insurance workers in Prague.[7]

The limited and occasional role of insurance in cultural attitudes and cultural products merits more analysis. In Section II, I will glance at a few ways in which insurance has served as a plot device or literary metaphor. Sections III and IV will look more closely at its role, not merely in our culture narrowly construed – culture as "the arts" – but in our culture broadly conceived, namely our collective experience, our shared thoughts and feelings. These sections will consider briefly both the psychology of insurance (ways in which it is associated with unease, fear, and the quest for security) and its politics (ways in which it serves as an occasion for rethinking the relationship of the individual and society).

II. TRUMAN BURBANK AND THE RAINMAKER

In *The Rainmaker*,[8] the perfidy of the insurance company is the perfidy of lawyers. Lawyers write the contracts, lawyers decide that valid claims are to be systematically denied, and lawyers defend those practices in court. Lawyers are familiar villains, and *The Rainmaker* trades shamelessly in such stereotypes. Perhaps we may infer insurance contracts may be benign until they become the tools of lawyers . . . but of course lawyers are *always* involved.

Unlike *The Rainmaker*, Peter Weir's recent movie, *The Truman Show*,[9] uses insurance as a complex and revelatory metaphor. Truman Burbank, the movie's protagonist, sells insurance. Understandably, he touts it as a means to find a bit of security in an insecure world of ordinary contingencies. But Truman Burbank's world is not in fact that kind of world. His world is planned, scripted, dramatized, and broadcast on national television; he, alone among his peers, is duped into thinking that his managed, artificial world is

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attempt to capture, in largely fictional form, the substance and ambiance of Kafka's experiences as an insurance examiner in Prague in the 1920s. *See* KAFKA (Miramax 1991).

7. *See* MAX BROD, FRANZ KAFKA: A BIOGRAPHY (G. Humphreys Roberts, trans., Schocken Books 1970) (1947). Brod quotes Kafka as writing that "insurance is like the religion of primitive peoples who believe they can ward off evil by all kinds of manipulations." *Id.* at 74.

8. *See* THE RAINMAKER, *supra* note 3.

9. *See* THE TRUMAN SHOW (Paramount 1998).

real. Contingency, the main reason why insurance is needed, has apparently been squeezed out of his world. Paradoxically, he sells the one commodity that has no possible use for himself or those around him.

The opposite is also true. Truman's world is radically contingent. The movie shows us how the most careful choreography and scripting of Truman's life *cannot* in fact eliminate contingency. The contingency here is the possibility of Truman discovering that his world is artificial, manipulated. The facade is fragile, and its creators are fallible. Thus, Truman is radically at the mercy of contingent events, radically naive and unprepared in the face of the unplanned and unpredictable. Both realistically and metaphorically, he lacks insurance against whatever he meets in the unscripted world as it really is – the world that surrounds his artificial world.

Does Truman have free will? On one hand, it seems he cannot have free will when every choice is anticipated and guided by a master director/manipulator. He is a puppet. On the other hand, he seems the only resident of the fictional village of Seahaven who *does* have free will. He alone is not reading lines, not acting a part scripted by others. The efforts of the director are constantly given over to anticipating how Truman will use his will, and to keep him from using it to discover the true nature of his existence. This very struggle, between Truman's free choices and the need to control their consequences, gives the Truman television show – the show within the movie – its dramatic tension.

Thus, *The Truman Show* entertains two antithetical notions of freedom, and it suggests two attitudes toward insurance as well. On one view Truman is altogether unfree; in a world that is perfectly ordered, controlled, and determined, insurance has no meaning. On a second and contrasting view, Truman is the only free person in his domain. Since he can ultimately realize that freedom, his world cannot be ordered perfectly. Truman's world can and does come apart at the seams. Contingency will out – and insurance will always be needed.

The Truman Show is a rare, perhaps unique, exploration of insurance as a metaphor. More commonly, insurance serves as a straightforward plot element. Frequently and understandably it can motivate crime. *Double Indemnity*[10] is perhaps the best known of many movies, novels, and television episodes in which insurance offers a motive for homicide. Life, in this sense, imitates art. Real police investigators keep insurance in mind not only as a

10. *See* DOUBLE INDEMNITY (Paramount 1944).

reason to kill, but also as a motive behind arson for profit, staged accidents, false reports of theft, and so on.

The role of insurance as a trigger for crime has been apparent to crime novelists. Most mystery series tend to have the police, private investigators, or lawyers as their protagonists because no one else is likely to face puzzles of criminality with the requisite frequency.[11] At the same time, insurance investigations offer mystery writers an alternative kind of hero. One of the most graceful and compelling recent series is Joseph Hansen's little-known corpus of crime novels about David Brandstetter,[12] who runs his own insurance firm in southern California and is thus led to various underworlds in which insurance motivates deception and fraud and corrupts human relationships.

In general then, the literary portrayal of insurance is hardly one-sided – and hard to discuss in generalities. For every corrupt and maligned insurance company, as in *The Rainmaker*, there are others – in fiction as in life – that more or less meet clients' expectations. The overriding fact is that, these various examples notwithstanding, insurance is not a major theme of literature or popular culture. It is, as we have seen, a condition which most of us take for granted while attending to other things.

But, as the response to the movie *The Rainmaker* demonstrated at the risk conference, there is more to our spontaneous attitudes toward insurance than disinterest or passive acceptance. Anger and frustration colored the remarks of *The Rainmaker*'s audience. These responses were triggered by the company represented in the film, but they were emphatically directed at insurance companies in actual experience. We shall see in the next two sections that these feelings have provocative psychological and political explanations.

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11. Series in which chefs, hoteliers, or doctors are amateur investigators are fundamentally implausible. Their heroes seem to live in a world where one cannot go out for groceries without being implicated in murder and a couple of thefts.

12. *See, e.g.*, JOSEPH HANSEN, THE BOY WHO WAS BURIED THIS MORNING (1990), A COUNTRY OF OLD MEN (1991), DEATH CLAIM (1973), EARLY GRAVES (1987), FADEOUT (1970), GRAVEDIGGER (1982), THE LITTLE DOG LAUGHED (1986), THE MAN EVERYBODY WAS AFRIAD OF (1978), NIGHTWORK (1984), OBEDIENCE (1988), SKINFLICK (1979), TROUBLEMAKER (1975).

III. THE PSYCHOLOGY OF FEAR AND DEPENDENCE

There are two moments when we have occasion to reflect on insurance and make choices accordingly: when we take out insurance and when we make claims. Taking out insurance is not always a matter of choice. Having auto insurance may be a legal condition of being a licensed driver. Health insurance coverage may be a condition of one's employment. But whether opting for insurance is voluntary or mandatory, we acquire it in anticipation of adversity and disaster. We are forced to contemplate our physical and economic vulnerability, even our death. We are forced to imagine ourselves as victims of accidents and predators.

Assessing such risks is only marginally a rational process. Of course, we have access to relevant actuarial and other data. We can find out the incidence of violent crime in our community, in the various places where we live, work, travel, and play. We know our family histories and the kinds of illnesses and breakdowns to which we are most susceptible. We can assess the effects of our various precautions and indiscretions accordingly. In the end, we spend more and more time seeking information that is ever less useful.

All the statistics we can possibly find, all we can possibly know about our own personal histories and predispositions, can never make the future predictable. The errant cancer cell, the drunk driver in the oncoming lane, the cerebral aneurysm, and the attack by the mental patient who is dangerously off his medication can never be anticipated. The choices we make about insurance, and our attitudes toward such choices, will always be beyond rational prediction and determination.

The second and more important moment in which insurance plays a central role is the claim itself. In other words, the two difficult moments in which we think about insurance are first, the contemplation of suffering and adversity, and second, the actual experience of it. To be sure, in this second moment there is a positive role for insurance. Its very purpose is to ameliorate loss, compensate victims, and if possible, make them whole.

This ideal is often compromised, in our anticipation of it and in fact. For one thing, there is the fear – often a realistic one – that the satisfaction of expected claims will be delayed and denied. Even when we are ostensibly made whole promptly and fully, the precipitating events themselves are often lastingly traumatic. The notion of being "made whole" is a euphemism. Our lives are disrupted and torn by accidents, illness, crime, and death in ways

that no insurance settlement can undo. Both the anxieties and genuine losses in such circumstances leave their permanent marks.

Aware that insurance is associated with both the contemplation and experience of the worst events in life, insurance companies aim to project an image of personalized concern and care. The advertising campaigns of insurance companies obsessively stress that they are like wise, omniscient, and omnipotent care-givers, that we can trust and depend on them as young children trust their parents.[13] But, just as we know that children can be abused and betrayed, we know that insurance companies do not exist simply to undo adversity. They exist, like all businesses, to stay in business and succeed by the criteria of profit and growth. Selflessness, altruism, and generosity are, one inevitably suspects, the sheep's pelt that hides the wolf.

The underlying economic reality and business necessity is that claims are always scrutinized and always run the risk of being challenged and denied. The charitable guardian, the surrogate all-powerful parent, becomes, in easily imaginable circumstances, the potential legal adversary. Thus, our psychological response is paradoxical: our final solace is most plausibly our impersonal betrayer, no more concerned with our well-being than the cancer cell or the mugger. Paradoxically, these feelings about the institution that exists to spread risk and insure that we are *not alone* in our plight are ones that underscores the extent to which we are *indeed* alone.

Thus, there are basic psychological reasons why we find it distressing to think about insurance. It is associated with the most dreaded eventualities of life and with fantasies (and realities) of need, dependence, and betrayal. Moreover, the way we think and feel about insurance has political as well as psychological dimensions, issues I explore in the next section.

IV. THE POLITICS OF CARE AND DEPENDENCE

Insurance is both a fact and a metaphor. As metaphor, it implicates the basic purposes for which government and the state exist. Thomas Hobbes famously contrasts a state of nature, in which each is at war with all others, with an organized state, a political entity in which persons give up some

13. *See* Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1403-07 (1994) (discussing advertising efforts).

power to create a central authority to enforce general rules of security.[14] What Robert Nozick calls the "night-watchman state"[15] is one in which all persons, conscious of extremes of vulnerability and risk, trade freedom for risk-control. That is the principle behind all voluntary political structures, and it is essentially an insurance principle: one considers the worst that can happen, and its likelihood, and then draws upon present resources to control and ameliorate that possibility.

Attitudes toward insurance, toward the need for state intervention for risk management in general, will be colored by one's disposition to optimism or pessimism. To the extent that rational persons may disagree about degrees of risk, the rational optimist will tend to discount the risk and be less likely to invest in precautionary arrangements. The pessimist will do the opposite.

If one dimension of politics is the *opportunity* to insure against the vulnerability and the risk of catastrophe, another dimension is *compulsion* to do so. Many of the ways in which the state "insures" us are non-optional. We cannot choose to live without the police or the armed forces and to withhold our tax investment in them. But we are accustomed to reserving the term "insurance" for non-compulsory arrangements. Traditionally, health, life, and property insurance are commodities that we can buy in the market. We assume, as good capitalists, that the market will work appropriately, that the choices we are offered will meet our needs and be fairly priced.

The line between insurance as a commodity, as an option, and insurance as a compulsory part of government regulation is always a moving target. There are reasons for this. The market for insurance inevitably exists in a context in which the scope of the market is determined politically through many considerations. Some are economic, such as efficiencies of scale; others, such as egalitarianism, may not be. Consumer protection and health care are only two of the most obvious areas in which the role of a free market in insurance and protection are politically controversial and significantly in flux.

The essential political question is whether a free market in insurance – insurance-as-a-commodity – produces a dangerous, even intolerable, misallocation of relevant resources. With regard to health insurance and delivery of health care, that question is affected by the demise of illusion of unlimited capacity. Until recently, we have entertained the expectation, the

14. *See* THOMAS HOBBES, LEVIATHAN 63-74, 87-96 (Everyman's Library ed. 1962).
15. ROBERT NOZICK, ANARCHY, STATE, AND UTOPIA 25-27 (1974).

myth, that medicine merely had technological and not economic limits. With technological progress we would get ever closer to a system that meets fully (whatever *that* might mean) the health needs of all. The present generation is the first to question this conviction and to explore the political implications of hard economic choices – indeed, of triage – in health care. Does a generous system of insurance (and health care distribution) for those who are well off, a system based on treating health care as a commodity, necessarily mean that those who are least well off will have their health opportunities diminished?[16]

Thus, insurance recapitulates politics. The health care debates show, perhaps better than other debates in our history, that we cannot address questions about insurance – what options should we have? – what arrangements should be compulsory? – without revisiting *all* of the main questions of politics: how much freedom should persons have? How much risk should they bear? How should responsibilities and rights be allocated between individuals and the state? How should the liberal ideal of autonomy be reconciled with egalitarian ideals and goals?

In these ways, insurance intersects with the political imagination more immediately than is reflected in culture in the narrow sense, the arts. The drama of *The Rainmaker* veils the harder issues that cannot be resolved by going after villains in court and by holding insurers to the terms of their contracts and the promises of their ads. The political lesson echoes the psychological one, that the promise of insurance – to defuse the risks inherent in our mortality and vulnerability – can only be satisfied incompletely and modestly. The jerry-built structures of the state and private insurance hardly allow us to leave behind the dangers that we first meet in Hobbes's state of nature.

CONCLUSION

Insurance is a rich metaphor, notwithstanding the fact that it has rarely inspired novelists and dramatists. Conceptually, we can imagine insuring against anything that we fear, any aspect of vulnerability. But insurance is

16. Note that in *A Theory of Justice*, a fundamental criterion of justice is that those who are worst off not be subjected to a scheme in which their position is made even worse. *See* JOHN RAWLS, A THEORY OF JUSTICE 60-75 (1971).

always inadequate armor. It cannot prevent, forestall, or even delay the things we fear. It can only begin to ameliorate their effects. Thus, while it expresses the hope of controlling what is uncontrollable in the human condition, it is also a constant reminder of that predicament.

The Rainmaker does not get to the heart of the metaphor of insurance. We can always imagine a benign rather than an evil insurance company. However, even the most caring and altruistic insurance scheme cannot prevent Truman Burbank, or the rest of us, from discovering the limits of our (or anyone's) control over our destiny, from knowing fear in a radically contingent world.

BEYOND MORAL HAZARD: INSURANCE AS MORAL OPPORTUNITY

*Deborah A. Stone**

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* A.B., University of Michigan, 1969; Ph.D., Massachusetts Institute of Technology, 1976. Ms. Stone is an independent scholar, Fellow of the Open Society Institute, and a former Professor of Politics and Social Policy at Brandeis University. The author wishes to thank the participants in the April 1999 University of Connecticut School of Law Symposium entitled *Insurance, Risk & Responsibility: Toward a New Paradigm?* for helpful ideas, and especially Tom Baker, Ross Cheit, and James Wooten for encouragement and thoughtful discussions.

INTRODUCTION

A basic dictum of insurance holds that insurance does not change the probability of an adverse event – it can only mitigate the financial consequences of the event. However, a long and strong tradition of economic thought holds that insurance may indeed change the likelihood of adverse events through a phenomenon known as "moral hazard."[1] According to the moral hazard argument, insurance actually increases the occurrence of adverse events through its incentives to people who have insurance. When people are insured (the argument goes), they are less careful to avoid or prevent accidents, diseases, thefts and other losses, and thus, insurance indirectly increases the number of losses. Insurance also operates directly to increase adverse events by giving insured people an incentive to bring about the very harms and damages for which they are insured so they can collect financial proceeds. In this view, insurance works like a pawnshop; it enables people to get cash for possessions.

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1. [T]he existence of insurance can have the perverse effect of increasing the probability of loss. For example, if a mechanic knows that in the event his or her tools are stolen the insurer will reimburse in full, the mechanic may be less likely to suffer the inconvenience of putting tools in a locked storage area at the end of each day. This phenomenon is called *moral hazard.*

ROBERT H. JERRY II, UNDERSTANDING INSURANCE LAW 15 (2d ed. 1996). For the most comprehensive history of the concept of moral hazard, see Tom Baker, *On the Genealogy of Moral Hazard*, 75 TEX. L. REV. 237 (1996). *See also* CAROL HEIMER, REACTIVE RISK AND RATIONAL ACTION: MANAGING MORAL HAZARD IN INSURANCE CONTRACTS (1985) (providing a comprehensive analysis of how insurers think about moral hazard and try to regulate it).

In this essay, I turn both parts of the conventional wisdom upside down. I argue that insurance *does* change the likelihood of adverse events, but not through its influence on individual behavior. Rather, through its effects on political culture and collective political action, insurance increases the number and kinds of events that we consider adverse and worthy of collective responsibility. Thus, insurance has an inherent expansionary dynamic: insurance tends to beget more insurance. This dynamic occurs in both private insurance and social insurance, but as I will show, the mechanisms are sometimes different in the two sectors.

At first blush, my argument may seem to be just a variant of the moral hazard argument, so I want to make three important distinctions. First, the moral hazard argument holds that insurance creates *individual incentives* at least to be lax about avoiding harms and maybe even actively to cause harms.[2] Moral hazard works through the individual psyche. By contrast, I argue that insurance creates *social mechanisms* that tend to increase what gets perceived as insurable and deserving of collective support. Both phenomena could be said to lead to an increasing reliance on insurance, but I argue that complex institutional and cultural forces, rather than simple rational calculations by individuals, are the engines driving this expansion.

Second, the moral hazard argument regards the kind of individual behavior it describes as immoral – hence the name. Insurance creates a temptation into evil, though evil runs the gamut from mere carelessness and indifference through intentional failure to prevent loss, all the way to deliberate and active destruction. Within the literature of insurance and economics, moral hazard is sometimes treated as a matter of "bad character," and sometimes as a matter of rational decision-making in response to incentives, and presumably therefore morally neutral.[3] However, even when economists describe moral hazard as a phenomenon

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2. As one popular insurance text defines it: "A *moral* hazard stems from the mental attitude of the insured. Because of indifference to loss or owing to an outright desire for the loss to occur, the individual either brings about his own loss or intentionally does nothing to prevent its occurrence or to alleviate its severity even if he could do so." MARK R. GREENE, RISK AND INSURANCE 9 (4th ed. 1977).

3. *See* HEIMER, *supra* note 1, at 29-30 (distinguishing these two kinds of moral hazard as 'moral hazard' (the kind due to bad character) and 'morale hazard' (the kind due to economic incentives)). As Heimer notes, however, insurers and economists tend to blur the distinction and refer to both processes under the name of moral hazard. *See id.*

of purely rational behavior, there is usually a pejorative undertone. After all, rational behavior is always self-interested, so even this form of moral hazard is motivated by greed, selfishness, and personal gain at the expense of others. In short; moral hazard describes immoral motives.

In contrast, I believe the act of participating in insurance can be and often is a highly moral choice, because (following another long line of thought), insurance is a form of mutual aid and collective responsibility.[4] To participate in a risk-pooling scheme is to agree to tax yourself not only for your own benefit should you incur a loss, but also for the benefit of others who might suffer from loss when you do not. Insurance thus creates what might be called "moral opportunity," the opportunity to cooperate with and help others. The political mechanisms of insurance expansion I describe call forth moral motives – motives of charity, compassion, civic responsibility, and justice.

Third, the moral hazard argument is often used to denigrate the value of insurance as a social institution and to limit its development. The moral hazard argument is a form of conservative, anti-reform, anti-redistributive thinking that economist Albert Hirschman dubbed "the perversity thesis."[5] In this form of argument, opponents of a reform claim that although the reform is intended to ameliorate a social problem, it will in fact make the problem worse. Insurers, of course, promote the social value of insurance, but they too, use the idea of moral hazard to justify limits on the amounts and conditions of coverage they offer, the kinds of people and risks they are willing to insure, and the amount of cross-subsidy they build into their pricing.[6] Many economists and policy analysts use the concept of moral hazard to argue against broad social provisions of insurance and any kind

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4. *See generally* Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL. POL'Y & L. 287 (Summer 1993). Defenders of social insurance have always taken this positive moral view of insurance. *See* DAVID MOSS, SOCIALIZING SECURITY: PROGRESSIVE ERA ECONOMISTS AND THE ORIGINS OF AMERICAN SOCIAL POLICY (1996). To a large extent, promoters of private insurance have also regarded it and promoted it as altruistic and socially beneficial. *See* SOLOMON S. HUEBNER, LIFE INSURANCE (3d ed. 1935) (1915); *accord* GREENE, *supra* note 2.

5. ALBERT O. HIRSCHMAN, THE RHETORIC OF REACTION (1991).

6. *See* HEIMER, *supra* note 1 (detailing the strategies contemporary insurers use to counteract the effects of moral hazard). *See also* Baker, *supra* note 1 at 244-70 (describing the historical evolution of these strategies, especially in the fire insurance industry).

of assistance to the needy.[7] The general lesson of moral hazard, as Tom Baker has shown, is "less is more:" less insurance and less social assistance mean more security, welfare, safety, productivity, well-being and general social good.[8]

By contrast, I see the expansionary effect of insurance as a social welfare gain rather than a loss. The social and political dynamic I describe fosters social policies that improve both the well being of individual citizens and the democratic health of the polity. Insurance is one of the main mechanisms by which modern societies define problems as amenable to human agency and collective action. Insurance is not only an institution of repair, but also of social progress. Insurance is a major way that communities can make life better for their individual members. As a mechanism for providing security and fostering collaboration, insurance offers polities the moral opportunity to strengthen the sense of community and collective well-being.

Much could be said about the empirical and normative validity of the moral hazard argument but the purpose of this essay is not to analyze moral hazard. Instead, I ask why insurance, once introduced, has a tendency to expand in society. What mechanisms operate to enlarge the range of different kinds of losses that people believe *ought* to be brought under the umbrella of insurance? In this essay, I explore six mechanisms underlying the expansionary dynamic I have called moral opportunity of insurance.

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7. For example, Richard Epstein claims that "[s]ome individuals eligible for treatment under [a federal law guaranteeing emergency care] have taken excessive risks because they know that some of their costs are borne by others." RICHARD A. EPSTEIN, MORTAL PERIL 102 (1997). He also claims that the new federal/state children's health insurance program "reduces parental incentives to prevent accidents or illness." Richard A. Epstein, Letter to the Editor, *Health Care Law Shows Big Government Lives*, N.Y. TIMES, Aug. 10, 1997, at E14. *See also* Richard Arnott & Joseph E. Stiglitz, *Moral Hazard and Non-Market Institutions: Dysfunctional Crowding Out or Peer Monitoring?*, 81 AM. ECON. REV. 179 (1991) (arguing that when family and friends provide help and support to someone, that support is a form of "non-market insurance" that distorts the person's incentives and makes him less careful to avoid accidents).

8. *See* Baker, *supra* note 1, at 238-40.

I. INSURANCE INVITES MORAL CONTEMPLATION AND LEGITIMATES MUTUAL AID

Political institutions resolve conflicts and make policies, but they also play another more fundamental role. They shape public discourse about deep moral questions: What is justice? What is fairness? What causes bad or harmful events? What kinds of detriments are "natural" – what we call accidents of nature, God or fate – and what kinds are humanly caused or at least humanly preventable?

Insurance is a social institution that particularly invites moral contemplation about questions of suffering, compassion, and responsibility. In so doing, it enlarges the public conception of social responsibility. Insurance serves as an arena for this kind of reflection and deliberation because it is kept in the public consciousness by the private marketing activities of commercial insurers, the bargaining activities of unions and workplaces, and the public debates over social insurance. The basic premise of insurance is collective responsibility for harms that befall individuals, because insurance pools people's savings to pay for individuals' future losses.[9] Thus, whenever insurance is discussed, questions of allocating responsibility between individuals and society are barely beneath the surface.[10]

Much of the collective nature of insurance is disguised, or at least not readily obvious to the policyholders, especially in private insurance.[11]

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9. **The characteristic of risk distribution sets insurance contracts apart from other kinds of contracts.** It can be said, then, that *a contract of insurance is an agreement in which one party (the insurer), in exchange for a consideration provided by the other party (the insured), assumes the other party'' risk and* ***distributes it across a group of similarly situated persons, each of whose risk has been assumed in a similar transaction.***

ROBERT H. JERRY, II, *supra* note 1, at 17. (italics in original)(emphasis added).

10. *See generally* Tom Baker, Address at the University of Conn. Sch. Of L., Symposium, *Insurance, Risk & Responsibility: Toward a New Paradigm?*, University of Connecticut School of Law (Apr. 11-12, 1999).

11. In fact, I would argue that private insurers deliberately work to mask the collective nature of the insurance enterprise in the way they market insurance and frame it in public debates, because it is not in their interest to have policyholders unite as a collective interest. *See generally* Deborah A. Stone, *Ad Missions: How Insurance Companies Sell Ideology*, THE AM. PROSPECT, Winter 1994, at 19.

Unlike the fraternal organizations and mutual aid societies of the late nineteenth and early twentieth centuries, the modern insurance company is so huge that individuals rarely have any face-to-face contact with managers and virtually never have any contact with other policyholders. Much like the transformation elsewhere in American civic life,[12] insurance organizations are no longer primarily membership associations where people actually interact and work toward common goals. They are instead highly centralized and professionally managed bureaucracies, with no opportunity to get to know and cooperate with one's fellow citizens.

Nevertheless, several factors highlight the collective, mutual-aid aspects of insurance and promote conversation about the contours of moral responsibility in a community. Private insurers market their policies chiefly by trying to induce a sense of vulnerability in their target audiences. Therefore, much insurance advertising portrays or just alludes to some kind of terrible harm that can befall people. For example, Blue Cross/Blue Shield ran a series of advertisements for health insurance with the theme of "What if?" One ad in the series pictures the face of a middle-aged woman, surrounded by smaller images of problems, as if she were imagining each of them in a cartoon bubble. Each image has a "what if?" caption, such as "What if I need a new heart?" or "What if I get sick when I'm away on business?"[13] Another ad in the same series pictures a man, presumably an executive, asking "What if I want low premiums?" and "What if our welder needs prenatal care?"[14] An Equitable advertisement for life insurance aimed at healthy older people pictures a couple standing on a beach, dressed for rugged weather. The caption reads: "We can finally be relaxed about life. But can you ever be relaxed about money?"[15] Allstate advertisements picture a lone house struck by a giant lightning bolt,[16] and an ambulance speeding down a highway late at night, with the caption, "Who's picking your kid up after the prom?"[17] An AIG advertisement for commercial insurance pictures a disheveled, worried man behind bars; the large caption reads, "Your foreign export manager is

12. *See generally* Theda Skocpol, *Associations Without Members*, THE AM. PROSPECT, July-Aug. 1999, at 66.

13. TIME, Apr. 29, 1996, at 104.

14. BUS. WEEK, May 6, 1996, at 21.

15. NEWSWEEK, May 13, 1996, at 48-49.

16. BUS. WEEK, May 12, 1997, at 9.

17. U.S. NEWS & WORLD REPORT, May 12, 1997, at 26.

in a foreign jail. No one knows where. Or Why? . . . . Who Insures You?"[18] This advertisement is one of a series, all featuring a story in which a business experiences some unanticipated trouble. In another ad of the series, a construction worker is on the ground, holding his head. The text reads: "On time. On budget. Then the crane collapsed. Who Insures You?"[19]

This kind of advertising that highlights vulnerability has several subtexts. It is designed to make people feel they need help, even though currently they are perfectly fine. It tells people that even when we think we are self-sufficient, strong, and successful, we are vulnerable to severe harms and losses, and we need to line up help while we still can.

Another implicit but very important message of these advertisements is that insurance is a helping institution – it will be there when you need it, and it is a reliable and effective place to turn for help.[20] For example, the text of the AIG ad with the executive in prison reads: "You sent him halfway around the world to mine opportunity. He's a valuable employee. He's in trouble. What should you do? Do you know the laws? The culture? The courts? . . . . [W]e have people who bring a local understanding to your business, who grasp the intricacies of a foreign culture, who can negotiate foreign law."[21] Indeed, many insurance advertisements explicitly portray their company's main purpose as helping people. In 1993, CIGNA adopted the motto "a business of caring."[22] Some advertisements for its property and casualty, international, and personal lines feature the word "Help" in large print over photographs of people giving help.[23] An advertisement for long-term care insurance

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18. ATLANTIC MONTHLY, Aug. 1999, at 2-3.

19. ATLANTIC MONTHLY, Oct. 1999, at 2-3.

20. *See* Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1403-07 (1994).

21. ATLANTIC MONTHLY, Aug. 1999, at 2-3.

22. In 1993, the company changed its logo and adopted the motto "A Business of Caring." U.S. NEWS & WORLD REPORT, Oct. 11, 1993, at 39 (advertisement announcing the change in logo).

23. INC., May 1997, back cover (ad for CIGNA Property and Casualty showing a fireman covered with soot, and saying "Fire Departments, Ambulances, Rescue Squads . . . . Do you ever wonder who protects them?"); U.S. NEWS & WORLD REPORT, May 19, 1997, back cover (ad for CIGNA International showing apparently Asian men in hard hats crouched around some dangerous-looking industrial equipment, saying "Moving your business away from home opens a world of new opportunities . . . . CIGNA can help you

suggests that the company is like a warm, nurturing grandmother. It pictures a classic grandmotherly woman in a printed house dress, sitting at her kitchen table, peering out over her reading glasses and stirring a cup of tea. The text alongside reads, "If you think she was overprotective, you should see our long-term care insurance."[24] An advertisement for Prudential Insurance Company tells overwhelmed young parents that the company can help them get through parenthood.[25]

Still another message of insurance marketing is that it is legitimate to need and get help in many situations and that insurance is a form of help that does not rob you of your dignity and independence. That message is explicit in an advertisement of Lincoln Financial Group showing a young man kayaking in the wilderness: "I have a MOTHER. I have a FATHER. I even have a BIG BROTHER. I DON'T need someone else looking out for me. I NEED someone who can help me look out for myself."[26] An ad for The Hartford shows a young woman in a wheelchair, dressed in hiking gear. She has just wheeled across a wooden bridge over a river rapids, and is holding her arms outstretched, embracing the joy of the outdoors. The text reads: "Careers happen. Accidents happen. Second careers happen. Life happens," and goes on to say the company offers programs to "help you take on what life has to offer" and to "help people get back to work again."[27]

This last message is particularly important, since so much of American political culture valorizes independence and self-sufficiency and teaches that needing and accepting help is shameful.[28] Insurance, even private insurance for businesses and for professional, well-off classes, legitimates the very idea of help and mutual interdependence. The insurance

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feel like you're not so far from home."); INC., May 1996, at 19 (ad for CIGNA Group Insurance showing man snuggling twin little girls, one in each arm, saying "You never thought you'd have kids. Now you have two . . . . Keeping [their future] safe is what CIGNA Group Insurance is about.").

24. NAT'L UNDERWRITER, Nov. 15, 1993, at 9 (advertisement for Transamerica Life Companies).

25. FAMILY LIFE, March/April 1994 ("When you were a kid, you never understood what your parents were going through. Now you'd just like to know how they got through it . . . . [A]lthough you didn't know it then, they probably had someone helping them out. Namely, an insurance agent.").

26. TIME, Nov. 8, 1999, at 82-83 (capitalization in original).

27. INC., May 1997, at 30.

28. *See generally* Nancy Fraser & Linda Gordon, *A Genealogy of Dependency: Tracing a Keyword of the U.S. Welfare State*, 19 SIGNS 309 (Winter 1994).

industry's need to expand their markets is, subtly, a strong cultural force inculcating the value of mutual aid.

Insurance's legitimization of mutual aid and dependence is not unambiguous, however. Most insurance marketing is aimed at elites: those at the upper end of the income and status scales are encouraged to lean on others through insurance, while the poor are told that needing and getting assistance is shameful and degrading.[29] Moreover, insurance legitimates the idea of help in part because we construct it as "self-help," distinct from welfare and other means-tested assistance, which we construct as "handouts" and "dependence."[30] For example, many insurers market life insurance by appealing to a professional man or woman's obligation to provide for his or her family. A long-running advertisement series by Massachusetts Mutual Life Insurance Company ("MassMutual") typically lists three poignant promises the parent makes to his or her child – for example, "A promise not to tell your sister whose books you've been carrying home. A promise that Miss Applegate's algebra homework will never be faced alone. A promise to make life easier for you than it's been for me."[31] The tag line of these ads is "MassMutual — We help you keep your promises." One message of such advertisements is that each person is no longer responsible for the economic well being of his or her own nuclear family. Nothing in these promises, or in most life insurance advertising, suggests that one is responsible for the well-being of one's friends and neighbors, much less one's larger social community or those less fortunate.

Yet even the family-responsibility theme so prevalent in life insurance advertising promotes a message of altruism. Solomon Huebner, perhaps the leading and most influential scholar of life insurance in the first half of the century, framed life insurance as an act of altruism and a moral obligation. "Failure of a head of family to insure his life . . . amounts to gambling . . . and the gamble is a particularly mean one since in case of loss, the dependent family and not the gambler must suffer the

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29. *See generally* Martha McCluskey, Rhetoric of Risk and the Neoliberal Redistribution of Social Insurance (March 30, 1999) (unpublished manuscript, on file with the Law Library at the University of Connecticut School of Law); *see also* Fraser & Gordon, *supra* note 28.

30. *See* Fraser & Gordon, *supra* note 28.

31. NEWSWEEK, Oct. 28, 1991

consequences."[32] "Emphasis should be laid on the '*crime of not insuring*,' and the finger of scorn should be pointed at any man who, although he has provided well while he was alive, has not seen fit to discount the uncertain future for the benefit of a dependent household."[33] Huebner, in essence, reversed the moral hazard argument: the moral wrong of insurance consisted not in the temptation to bad behavior created by insurance, but rather in the temptation to avoid insurance and squander one's money on immediate pleasures.

In contemporary marketing, life insurance is still often portrayed as a way of meeting one's family obligations and even as a way of strengthening family ties. "Another way to say 'I love you' is with good insurance protection," declares one of the Metropolitan Life Insurance Company ads, showing Lucy (from the Charles Schulz Peanuts comic strip) knitting a pair of baby booties.[34] Husbands and fathers, and more recently wives and mothers, are exhorted to provide for their loved ones if they should die. "Life insurance isn't for the people who die. It's for the people who live," explains an advertisement sponsored by the Life and Health Insurance Foundation for Education.[35] The MassMutual series mentioned above extols the role of "promises" in maintaining social cohesion.[36] Each MassMutual ad, no matter what the specific family situations and promises it portrays, concludes: "Nothing binds us one to the other like a promise kept. Nothing divides us like a promise broken. At MassMutual we believe in keeping our promises. That way all the families and businesses that rely on us can keep theirs."[37]

Thus, private insurance marketing is a cultural force that legitimates social obligation and mutual aid. To be sure, private insurance marketing also includes a strong strand of individual responsibility and self-help.[38] For example, a Prudential advertisement extols self-reliance with the motto "Be Your Own Rock" and a genial-looking man saying, "I worked long hours. I never turned down overtime. And I invested in the future. I want my children to remember me as the man who sort of inspired them to stand

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32. HUEBNER, *supra* note 4, at 13.
33. *Id.* at 26 (emphasis added).
34. PARENTS, Jan. 1998, at 222.
35. NEWSWEEK, Oct. 18, 1999, at 58.
36. *See* NEWSWEEK, *supra* note 31.
37. BUS. WEEK, Nov. 16, 1992, at 122.
38. *See, e.g.*, *supra* note 26 (Lincoln Financial Group advertisement).

on their own two feet."[39] Nevertheless, the subtexts of insurance advertising necessarily legitimate help, portray insurance as a helping institution, and teach the virtue of providing assistance to others. Thus, the Prudential ad, after encouraging the reader to "be your own rock," says that Prudential offers a variety of products that "can *help you* manage your life."[40]

Social insurance plays a similar role in legitimating collective responsibility and mutual aid, though there are big differences in how legitimation occurs and in the relative emphases on the themes of self-help and helping others. Importantly, American social policy is molded on an insurance model. As Jonathan Simon and others have argued, the replacement of tort liability with insurance (workers' compensation) as a regime for governing work accidents in the early twentieth century became the "blueprint for the governing of mature industrial society."[41] According to some scholars, the American welfare state should really be known as an "insurance-opportunity state"[42] or a "security state,"[43] because its overwhelming mode of providing for citizens' well-being is through insurance programs rather than through means-tested assistance programs. As David Moss notes, workers' compensation, unemployment insurance, old age and disability insurance "have much more in common with deposit insurance and pension insurance" than they do with Aid to Families with Dependent Children, the archetypal welfare program. Insurance has a different purpose and targets a different population than welfare. The goal of insurance is to "offer security to individuals who have something to lose [e.g. a job, savings, earning potential] rather than assistance to the needy, who have little or nothing to lose."[44]

One measure of the importance of insurance in social policy is the fact that public spending on social insurance is about two-and-a-half times

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39. U.S. NEWS & WORLD REPORT, May 6, 1996, at 26.

40. *Id.* (emphasis added).

41. Jonathan Simon, *Driving Governmentality: Automobile Accidents, Insurance, and the Challenge of Social Order in the Inter-War Years, 1919-1941*, 4 CONN. INS. L.J. 521, 524 (1997-98).

42. *See generally* THEODORE MARMOR ET AL., AMERICA'S MISUNDERSTOOD WELFARE STATE ch. 2 (1990).

43. *See* MOSS, *supra* note 4, at 4.

44. *Id.*

spending on assistance.[45] Another measure is that private insurance analogies were central to the design, promotion and ultimate passage of New Deal social insurance,[46] and the imagery of personal contributions, individual accounts, and earned entitlements is crucial to the vigorous public support Social Security programs continue to enjoy in the face of strong efforts to scale them back. Through these analogies, social insurance, like private, is cast as "self-help," as providing for oneself and one's family by contributing to insurance while one is working.[47] Even though beneficiaries' payments into the system rarely, if ever, cover the costs of their benefits, there is a widely sustained public belief that social insurance benefits are earned and are not "handouts."

Even while proponents of social insurance portray it as self-help, however, they, like the marketers of private insurance, inevitably rely on and appeal to notions of altruism, collective responsibility and mutual aid. Just as early promoters of private life insurance had to overcome the stigma of insurance as gambling and the fear that insurance would tempt people into irresponsible dependence,[48] early advocates of social insurance had to overcome the stigma of social insurance as the paternalistic invention of an autocratic state (Germany) and the fear that social insurance would undermine workers' initiative, effort, and productivity.[49] Old-age pensions, warned Prudential Life Insurance Company's chief actuary, by removing the prospect of poverty in old-age, would abolish

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45. *See id.* at 179 n.9 (providing the figures for 1990) (citing Ann Kalman Bixby, *Public Social Welfare Expenditures, Fiscal Year 1990*, 56 SOC. SEC. BULL. 70-76 (Summer 1993) and 57 SOC. SEC. BULL. 91-92 (Summer 1994).

46. *See* JERRY CATES, INSURING INEQUALITY (1983).

47. *See id.* at 57 ("The reformers argued that social insurance benefits did not constitute charity because the recipients (or their employers) contributed in advance to pay for them.")

48. *See generally* Geoffrey Clark, *Reckoning with Death: Virtue, Gambling and Life Insurance in Eighteenth-Century England* (April 11, 1999) (unpublished manuscript, on file with the Law Library at the University of Connecticut School of Law); *see also* VIVIANA ZELIZER, MORALS AND MARKETS: THE DEVELOPMENT OF LIFE INSURANCE IN THE UNITED STATES (1979).

49. *See* ROY LUBOVE, THE STRUGGLE FOR SOCIAL SECURITY, 1900-1935 (1968) (especially chapter 1); *see also* THEDA SKOCPOL, PROTECTING MOTHERS AND SOLDIERS: THE POLITICAL ORIGINS OF SOCIAL POLICY IN THE UNITED STATES 160-76 (1992).

"the most powerful incentive which makes for character and growth in a democracy" and strike a blow at the "root of national life and character."[50]

In promoting social insurance, the early advocates set forth two arguments that continue to undergird social insurance today. First was the argument that industrial society creates risks which the individual cannot possibly ameliorate or compensate for himself. If the individual cannot mitigate these risks, then he cannot and should not be held responsible for them.[51] Isaac Rubinow, one of the leading Progressive social insurance advocates, set forth this argument in his 1913 classic book, *Social Insurance*: "For social insurance, when properly developed, is nothing if not a well-defined effort of the organized state to come to the assistance of the wage-earner and furnish him with something he individually is quite unable to attain for himself."[52] Social insurance, he said, represented "a new concept of the state as an instrument of organized collective action, rather than of class oppression."[53] The paternalistic and authoritarian state became the ethical and rational state.

Second was the argument that social insurance, properly structured, far from inducing people to be lazy, careless, or dependent, could actually motivate them to be careful and enable them to work.[54] John Commons, who might be called the intellectual father of social insurance, put it thus: "I wanted all employers to be compelled by law to pay accident compensation as an inducement to accident prevention."[55] These early proponents believed that individual workers did not have the ability to prevent the common hazards of industrial economies – work accidents and injuries, involuntary unemployment, and sickness – but that employers did have it within their powers to prevent many of these ills. As David Moss says, they reasoned that "an employer required to compensate all workers

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50. *See* Frederick L. Hoffman, *State Pensions and Annuities in Old Age*, 11 A. STAT. ASS'N 363, 368, 389 (1909), *quoted in* LUBOVE, *supra* note 49, at 117.

51. *See, e.g.*, CRYSTAL EASTMAN, WORK ACCIDENTS AND THE LAW (1910).

52. I. M. RUBINOW, SOCIAL INSURANCE, WITH SPECIAL REFERENCE TO AMERICAN CONDITIONS 11 (Leon Stein & Philip Taft eds., Arno Press 1969) (1913), *quoted in* SKOCPOL, *supra* note 12, at 174-75.

53. RUBINOW, *id.* at 500, *quoted in* SKOCPOL, *supra* note 12, at 175.

54. *See* MOSS, *supra* note 4, at 60-61.

55. *See* JOHN R. COMMONS, MYSELF 141 (1934), *quoted in* MOSS, *supra* note 4, at 69.

who were injured on the job, fell sick, or were laid off would take great pains to prevent the occurrence of such contingencies."[56]

Just as Solomon Huebner flipped the moral argument in life insurance, casting as morally suspect the person who failed to buy insurance rather than the one who did buy it, early social insurance advocates flipped the moral argument as well. Opponents of social insurance (and of public charitable aid more generally) typically depicted the poor and needy as "social dependents" or "social parasites," and worried that the mere prospect of aid would induce even the working poor into lazy reliance on aid, thus dragging them down into pauperism.[57] The advocates, instead, cast those who resisted social insurance as the real social parasites: "[A] business which does not make good, as far as indemnity in money can do it, the losses of human energy as well as of broken and worn out machinery, is parasitic and socially bankrupt," wrote Charles Henderson, another leading figure of the social insurance movement.[58]

One could trace similar themes in the discussion of most new forms of social and private insurance. The important point is that in promoting either private or social insurance, advocates frame it as a legitimate helping institution. Of course, marketing, promotion and advocacy serve the direct purposes of those who conduct these activities, but indirectly, they also serve as a kind of moral education of the citizenry.

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56. MOSS, *supra* note 4, at 60-61.

57. *See* JOEL F. HANDLER & YEHESKEL HASENFIELD, WE THE POOR PEOPLE: A SOCIAL HISTORY IN WELFARE IN AMERICA 21-26 (1997); *see generally* MICHAEL KATZ, IN THE SHADOW OF THE POORHOUSE (10th ed. 1986).

58. *See* CHARLES RICHMOND HENDERSON, INDUSTRIAL INSURANCE IN THE UNITED STATES 244 (1909), *quoted in* MOSS, *supra* note 4, at 61-62.

II. INSURANCE EMBODIES THE NORM THAT COMMUNITIES ARE RESPONSIBLE TO THEIR MEMBERS FOR ALLEVIATING CERTAIN HARMS AND IT EDUCATES CITIZENS IN THESE RESPONSIBILITIES.

The existence of insurance as a fundamental and ubiquitous aspect of both commercial and personal life means that an organized system of help is also something people take for granted, even if they do not think terribly hard about or even understand the way insurance is organized. Social insurance programs – workers' compensation, old age, survivors, and disability insurance – because they are government-run, have an obvious public character and appear very obviously as communal forms of assistance. Private insurance, especially those segments that are marketed and organized as individual policies instead of group, may appear more as bilateral market contracts rather than any kind of community-sponsored aid system. But even the marketing of private insurance emphasizes to consumers that in buying insurance, they are buying the promise of help from a large organization with the fiscal capacity to remedy even huge losses.[59]

Perhaps the aspect of insurance that most strongly establishes a public expectation of community aid is liability or "third-party" insurance. That is, insurance that one party carries for the express purpose of paying for injuries and losses that he or she causes to others. In life insurance, most property insurance, or the old age, medical care and disability components of Social Security, people contribute to insurance in order to protect themselves and their families. In third-party coverage, they purchase insurance for the express benefit of strangers – anyone who might happen to be injured by the insured's activities. Of course, liability coverage protects the insured person against financial loss from adverse tort judgments, and in that sense, third-party insurance is self-protection. But third-party insurance can also be seen as a way of organizing and ensuring responsibility to others. Liability in the absence of insurance would mean that many people would be unable to pay the full costs of damage awards against them, so that their responsibility would be formal but hollow. Liability insurance, especially when it is mandatory, is thus a social mechanism for enforcing common law obligations to others.

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59. *See generally* Baker, *supra* note 20 and *supra* notes 21-27.

Workers' compensation was the first such insurance, and it spread rapidly as a social innovation in the period from 1910 to 1920.[60] Workers' compensation replaced an uncertain regime of tort liability for workplace accidents with a regime in which employers were made financially responsible for their employees' injuries and medical costs.[61] Crucially for my argument, workers compensation was, and often still is, justified as a moral obligation of one powerful and financially strong sector (employers) to help a less powerful and financially weak sector (workers) through the intermediate institution of insurance.[62] Workers' compensation set forth a model of social relations in which certain hazards of modernity were deemed to be beyond the control of individuals, while the activities in which these hazards occurred – in this case, factory work – were considered eminently beneficial to society. The solution was to establish a system of compulsory insurance by which the costs of losses could be spread among the larger society that benefited from the activities that produced the losses. At the same time, the people who suffered losses in the course of socially beneficial activities would be helped by the community they had served.[63]

This model of insurance as a system to underwrite the unavoidable costs of socially worthy activities and to share the losses had an enormous impact on American governance. Most notably, insurance came to be

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60. *See* John Fabian Witt, *The Transformation of Work and the Law of Workplace Accidents*, 107 YALE L.J. 1467, 1467 (1998) (citing Harry Weiss, *Employers' Liability and Workmen's Compensation*, in JOHN R. COMMONS ET AL., HISTORY OF LABOR IN THE UNITED STATES 564, 575-76 (1935)).

61. *See* Lawrence M. Friedman & Jack Ladinsky, *Social Change and the Law of Industrial Accidents*, 67 COLUM. L. REV. 50, 71 (1967).

62. *See supra* notes 51-55; *see also* LUBOVE, *supra* note 49, at ch. 3; MOSS, *supra* note 4, at ch. 4. Martha McCluskey argues that the traditional "story of origin" of workers' compensation, as well as current discourse, describes a seemingly morally neutral "bargain" between employers and workers, in which each side gives up something and both sides are better off. Thus, on the surface, moral obligation plays no part in the justification of workers' compensation. However, McCluskey shows that efficiency rhetoric masks deeper moral argument about distributional equity and deservingness. *See generally* Martha T. McCluskey, *The Illusion of Efficiency in Workers' Compensation 'Reform'*, 50 RUTGERS L. REV. 657 (1998).

63. *See* MOSS, *supra* note 4, at 59-76 (arguing that reformers understood social insurance as a vehicle for what economists today call "internalizing externalities").

regarded as an alternative to other forms of regulating hazardous activities.[64]

Insurance is a form of what Foucauldian scholars call discipline. That is, a system of inculcating norms, supervising behavior, and enforcing compliance with norms.[65] Those who view insurance through the lens of moral hazard do not see this disciplinary or regulatory power. Indeed, they see insurance as undermining individual self-restraint and even inciting people to destructive behavior. Thus, for example, in early debates about making liability insurance compulsory for automobile owners, opponents claimed that insurance stimulated irresponsible behavior.[66] It would be an inducement to fraudulent claims and malingering, and worse, it would insulate drivers from the costs of their carelessness and thus give them "licenses to do harm with impunity." Proponents of mandatory automobile liability insurance viewed the same situation through the lens of moral opportunity. Mandatory insurance, they believed, was a way of inculcating a sense of responsibility towards others, teaching the importance of careful driving, and compelling automobile owners to assume financial responsibility for the consequences of their driving.[67]

Even though the early proposal for mandatory automobile liability insurance failed on a national scale, most states now require car owners to carry liability insurance.[68] Every time a person buys a car and registers it, he or she has an encounter with a state agency that, by insisting on proof of insurance, teaches a moral lesson about mutual aid: you may not drive your car unless you participate in a system of helping people who might be injured by your car. At the same time, the car registrant absorbs another lesson: if you are injured by anyone else's automobile, you have a right to

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64. *See* Simon, *supra* note 41, at 563-67. My thinking on this whole point was stimulated by Simon's article.

65. *See, e.g.*, MICHEL FOUCAULT, DISCIPLINE AND PUNISH (Alan Sheridan trans., Vintage Books 2d ed. 1995) (1978) for the concept of discipline; *see* Jonathan Simon, *Ideological Effects of Actuarial Practices*, 22 LAW & SOCIETY REV. 771 (1998) (analyzing insurance as discipline).

66. *See* Simon, *supra* note 41, at 566.

67. *See id.* at 565-66, 584 (reviewing some of these arguments).

68. *See* Willy E. Rice, *Insurance Contracts and Judicial Discord Over Whether Liability Insurers Must Defend Insureds' Allegedly Intentional and Immoral Conduct: A Historical and Empirical Review of Federal and State Courts' Declaratory Judgments – 1900-1997*, 47 AM. U. L. REV. 1131, 1134, n.6 (listing the statutes of the twenty-eight states that required this coverage as of 1998).

expect help from that person through his or her insurance. These are potent lessons about interdependence and reciprocal obligation.

Because virtually every adult citizen participates in various forms of mandatory insurance, from automobile liability insurance to unemployment insurance, old-age pensions and disability insurance, everyone is exposed to two of the moral assumptions of these programs: collective responsibility for the well-being of individuals and individual responsibility for the well-being of others. Not everyone accepts these norms – many would opt out of some – mandatory insurance if they could, and many scholars and policymakers, believing that individuals should be responsible for themselves, think insurance should never be mandatory.[69] Nevertheless, insurance is deeply embedded in the social ordering of modern society, and citizens cannot escape its implicit moral lessons, no matter how much they chafe under mandatory participation.

III. INSURANCE CREATES NEW SOCIETAL STANDARDS OF WELL-BEING AND CHANGES THE SOCIAL MEANING OF AN ENTIRE PROBLEM.

Insurance often pays for services to alleviate harms, rather than paying cash to compensate for losses. By funding services, it stimulates the development of harm-alleviating technologies and occupations that then become part of the societal standard of care. Once these technologies and services are part of the societal standard of care, they also may come to be seen as legitimate, if not morally essential, collective aid. Lack of the services necessary to provide the standard of care then becomes, in effect, an adverse event against which people believe they are, or ought to be, insured.

This process is most evident in health insurance. Simply by paying for medical care, insurance stimulates the development of medicine, because it directs financial resources to that sector. Arguably, the modern hospital is

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69. *See generally* EPSTEIN, *supra* note 7 (arguing generally against collective responsibility for individual welfare and opposing many forms of health and liability insurance); *see also* MAX SKIDMORE, SOCIAL SECURITY AND ITS ENEMIES (1999) (analyzing viewpoints of opponents of social insurance).

a creature of health insurance.[70] But insurance also fosters medical innovation more directly: insofar as Medicare includes reimbursement for medical training and research as components of its payments for patients, it stimulates innovation.[71] And insofar as any health insurance pays for patients to receive treatment through clinical research trials, it pays for innovation.[72]

In-hospital births illustrate how insurance coverage creates a new standard of care which then becomes an object of political demand. Health insurance made in-hospital births possible for most women; without health insurance, births never would have moved to the hospital, because most families could not have afforded the cost of hospital births.[73] With the growth of maternity coverage, in-hospital births became standard medical practice, and indeed, home-births came to be treated as dangerous and sub-standard. This coverage led women (and their husbands and doctors) to expect a few nights in the hospital following childbirth. When, in the 1990s, managed care plans restricted payments for overnight stays and "kicked mothers out" (as the perception went),[74] there was a public outcry, so that many states, and eventually Congress, legislated mandatory coverage of at least forty-eight hours in the hospital for new mothers.[75]

Bone marrow transplants for women with breast cancer illustrate an even more complex set of political dynamics by which insurance can expand the public understanding and organizational practice surrounding a

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70. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF MODERN MEDICINE 290-334 (1982).

71. *See* RAND E. ROSENBLATT, SYLVIA A. LAW, & SARA ROSENBAUM, LAW AND THE AMERICAN HEALTH CARE SYSTEM 534-41 (1997) (explaining how Medicare's "indirect medical education costs" provisions finance medical education).

72. In general, most health insurance contracts exclude coverage for experimental treatments. *See id.* at 211-15. However, with the increasing politicization of this issue, as discussed *infra*, some insurers have begun financing the costs of participation in clinical trials for their policyholders. *See id.* at 253; *see also* Lawrence K. Altman, *Insurer to Finance Test of a Treatment for Breast Cancer*, N.Y. TIMES, Nov. 12, 1990, at A1.

73. *See generally* JUDITH WALZER LEAVITT, BROUGHT TO BED: CHILDBEARING IN AMERICA 1750-1950 (1986).

74. *See generally* Ming Tai-Seale, Marc Rodwin & Gerard Wedig, *Drive-Through Delivery: Where Are the "Savings?,"* 56 MED. CARE RESEARCH REV. 30 (March 1999).

75. *See* Newborns' and Mothers' Health Protection Act of 1996, 42 U.S.C. §300gg-4 (1999); *see also* Suzanne Seaman, Comment, *Putting the Brakes on Drive-Through Deliveries*, 13 J. CONTEMP. HEALTH L. AND POL'Y 497, 499 (1997); Milt Freudenheim, *HMO's Cope With a Backlash on Cost Cutting*, N.Y. TIMES, May 19, 1996, at A1.

standard of care.[76] We might hypothesize a social process something like this: physicians and clinical researchers develop a new treatment protocol and begin to use it. The new treatment is still experimental, not yet proven effective, but more and more doctors begin to offer it to their terminally ill patients, as it offers some hope. Some insurance companies and plans agree to cover the treatment for their policyholders, and others deny coverage. Through the positive coverage decisions of some insurers, the treatment becomes more common, stimulating more demand for it. Patients whose insurers deny coverage sue their insurers (or their families sue after they die). Through media coverage, the suits create public awareness of the treatment and the controversy, and adverse publicity for insurers. As more plaintiffs are successful, insurers become fearful of future litigation should they deny coverage for the treatment. They begin to cover the treatment for more and more patients. Gradually, the new treatment, still unproven in scientific studies, becomes standard practice.

A General Accounting Office (GAO) study of insurance coverage of bone marrow transplants for breast cancer suggests that a dynamic quite like the one just sketched does in fact operate.[77] The GAO interviewed medical directors or other officials responsible for coverage decisions in twelve large, national health insurance companies. All said that they did not normally cover experimental or unproven treatments, that they believed bone marrow transplants for breast cancer were still unproven, but that they nonetheless covered this treatment.[78] To explain this discrepancy, the insurers said the primary influence on their decisions to cover the treatment was the fact that the treatment was already widely used and there was suggestive evidence that it might also be beneficial to patients. The insurers also said the threat of litigation and the adverse publicity about their coverage policies were also very important factors in

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76. *See generally* ROSENBLATT, LAW & ROSENBAUM, *supra* note 71, at 211-82. Technically, this procedure is called "autologous bone marrow transplants," indicating that a patient receives her own, previously extracted, bone marrow cells instead of cells from another donor. I use the simpler phrase, bone marrow transplant, however, because that is the term used in public debate.

77. U.S. General Accounting Office, Health Insurance Coverage of Autologous Bone Marrow Transplantation for Breast Cancer (April 1996)(GAO/HEHS-96-83)(hereinafter "GAO Breast Cancer.").

78. *See id.* at 7.

their decisions to cover the treatment.[79] One highly publicized suit, *Fox v. Health Net of California*,[80] was particularly damaging and threatening to insurers, they said, because it focused on the insurer's economic self-interest as the reason for denial.[81] The case also received wide publicity because the jury awarded an $89 million verdict to the plaintiff.[82]

The political dynamic for expanding insurance coverage often does not stop even once major insurers begin to cover the treatment. The publicity about coverage denials, deaths, suits and plaintiffs' victories stirs public outrage and fuels activist mobilization. Popular culture can vastly amplify widespread media coverage of insurance coverage controversies.[83] As is frequent in health insurance, advocacy groups for a particular disease or treatment propose state legislation to require insurers to cover their disease or particular treatments. In the case of bone marrow transplants for breast cancer, by 1995 seven states had enacted such mandates.[84] Sometimes these state-level populist movements rise to the national level, where advocates seek federal legislation to universalize the benefits they have won in some states.[85] The expansion of state-level mandates for forty-eight hour maternity coverage to federal legislation exemplifies this phenomenon.[86]

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79. *See id.* at 7-10.

80. Case No. 219692 (Cal. Super. Ct., Dec. 28, 1993).

81. *See* GAO Breast Cancer, *supra* note 77, at 10. *See also* Christine Gorman, *Managed Care 1998: Playing the HMO Game*, TIME, July 13, 1998, at 22-28. This was a cover story, for which the text on the cover read "What Your HMO Won't Cover." Inside, a two-page spread showed color photos of six patients or their surviving relatives, and profiled their diseases and their insurers' negative coverage decisions. A banner headline running underneath all six profiles said, "They had a chance to be heroes or save money and they decided to save money," quoting the husband of a woman who was refused a bone-marrow transplant for aplastic anemia. *See id.* at 24-25.

82. *See* GAO Breast Cancer, *supra* note 77, at 10.

83. John Grisham's novel, *The Rainmaker*, and the movie of the same name based on the novel, is the story of a young lawyer who helps a family fight their health insurer to cover a bone-marrow transplant for their dying son. *See generally* JOHN GRISHAM, THE RAINMAKER (1995).

84. *See* GAO Breast Cancer, *supra* note 77, at 11.

85. *See* Karen Tumulty, *Let's Play Doctor*, TIME, July 13, 1998, at 28-32; James A. Morone, *Populists in a Global Market*,24 J. HEALTH POLITICS, POLICY & LAW 887 (1999); Richard Sorian and Judith Feder, *Why We Need a Patients' Bill of Rights*, 24 J. HEALTH POLITICS, POLICY & LAW 1137 (1999).

86. *See supra* note 75.

The expansionary dynamic has still another phase. Once insurance coverage for a new treatment becomes relatively standard, even though the treatment itself may still be unproven and may be highly aggressive and risky to the patient, the very existence of insurance coverage may "normalize" the treatment.[87] Insurance coverage, particularly state mandates requiring health insurers to cover a treatment, can subtly create a moral pressure on people who have a disease or problem for which a treatment is covered. They might be pressured by their doctors, families and friends to "try anything" as long as money is not an obstacle, to be "good patients," to use every available means to fight the disease, to stay in the battle until the end. Not accepting treatment that insurance would cover becomes defined as personal failure.[88]

Still another mechanism of enlarging the concept of insurable adverse events is far broader and more elusive than the re-definition of standards of care and well-being according to evolving technologies. Insurance and the remedial services it provides can change the cultural meaning of an entire social concept. For example, in thirty years of providing medical services for the elderly, a panel of the National Academy of Social Insurance wrote, "Medicare has helped to redefine the normal expectation of aging in America as a dignified, actively independent stage of life . . . rather than economically deprived dependency."[89] By financing medical care as well as health services in nursing homes and private homes, Medicare essentially did away with the poor houses of yore (though some might say many nursing homes are the modern-day equivalent).[90]

Home health services in particular have created an expectation that even people who need help with basic tasks of daily living, such as

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87. *See* ELIZABETH C. BRITT, CONCEIVING NORMALCY: LAW, RHETORIC, AND THE DOUBLE-BINDS OF INFERTILITY 58-78 (1999) (unpublished manuscript, on file with the author). Britt's research concerns the impact of state-mandated health insurance coverage of infertility treatment, but her findings are plausibly generalizable to other health insurance coverage of new and uncertain treatments.

88. *See id.* at 76 ("Insurance thus acts as an incentive for those who are accustomed to taking advantage of opportunities for success. For some individuals and couples, this incentive might be transformed into an obligation.").

89. NATIONAL ACADEMY OF SOCIAL INSURANCE, MEDICARE AND THE AMERICAN SOCIAL CONTRACT 43 (1999) (final report of a study panel on Medicare).

90. *See, e.g.*, MARY RICHARDS ROLLINS, PATIENTS, PAIN AND POLITICS: NURSING HOME INSPECTOR'S SHOCKING TRUE STORY AND EXPERT ADVICE FOR YOU AND YOUR FAMILY (1994); BRUCE C. VLADECK, UNLOVING CARE: THE NURSING HOME TRAGEDY (1980).

bathing, dressing, or eating, can aspire to remain in their own homes. Home health services were fostered by Medicare because they are cheaper than either nursing homes or hospitals.[91] But in promoting these services and in denying hospital coverage, Medicare touted the advantages of remaining independent and staying in one's own home and community. These are goals to which most elderly people aspire anyway – having to go into a nursing home is considered a nightmare and often the worst possible fate. So when Congress tries to cut back home health benefits, as it did in the 1997 Balanced Budget Act, there is new political resistance and a heightened sense that going to a nursing home is an adverse event against which Medicare should insure.[92]

To summarize, much of insurance, private and social, now provides services instead of or in addition to income to alleviate the consequences of adverse events. The perceived entitlements are to services, not cash, or to put it another way, the absence of services becomes perceived as the adverse advent against which people think they are insured. These services also become part of the general social expectation about what ought to be insured. Thus, insurance for services expands cultural perceptions of the basic standard of decency or the professional standard of care. These expanded standards effectively expand the definition of perceived adverse events.

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91. *See* Andrew Szasz, *The Labor Impacts of Policy Change in Health Care: How Federal Policy Transformed Home Health Organizations and their Labor Practices*, 15 J. HEALTH POL. POL'Y & L. 191, 194-97 (1990).

92. Local news stories about home health care troubles routinely describe "institutionalization" or "placement" in a nursing home as the terrible fate clients fear. *See, e.g.*, Brian McGrory, *A Tenuous Grip on Independence*, BOSTON GLOBE, June 29, 1999, at B1 (describing how a disabled working adult woman fears institutionalization if she cannot get personal care attendants at state's pay rate); *see also* Collins Connor, *Help Wanted In Home Health*, ST. PETERSBURG TIMES, July 27, 1999, at 1B (describing being sent to a nursing home as "a fate that awaits" people with severe disabilities if they cannot find home health aides); Mary Jo Layton, *Medicare Cuts Hitting Home for Seniors*, THE RECORD (Bergen County, N.J.), Feb. 22, 1999, at A01 (describing how woman says Medicare home visits enable her to keep her father out of a nursing home).

IV. INSURANCE IS USED BY INDIVIDUALS AND SOCIAL REFORMERS AS AN INSTRUMENT FOR ALLEVIATING PROBLEMS.

Because insurance is constructed by its advocates (including insurers themselves) as a source of help for people in trouble, people turn to it when they need help. Susan Daniels says that while she was Associate Commissioner of Disability, she was always asked why so many people come to the Social Security Administration's disability programs looking for disability benefits. "Because we have money and they don't," she always quipped.[93] That is the story of insurance. It is, or at least appears to be, pots of money waiting to be spent on people who need it.

Of course, people seeking help from insurance must prove that they and their specific troubles are covered. Insurers have a strong interest in minimizing their claims payments, and so every claim becomes something of a contest between the two sides.[94] Insurance policies are virtually the national metaphor for fine-print specificity and trick exclusions in contractual relationships. Yet even though the cards seem to be stacked in favor of insurers, the contests between claimants and their insurers are two-sided, and claimants often win.

Claimants' power comes in no small part from the leverage of ambiguity: insurance contracts are written in words, and words can never cover every possible situation. Like all legal contests, contests over coverage become contests of interpretation and persuasion. People who stand to benefit from an expanded interpretation use grievances, administrative channels, lawsuits and appeals, and legislative politics to get their situations read or written into a verbal formula. Ultimately, these contests are conducted like other political contests – people organize, form alliances, draw new groups into the contest and try to mobilize elite and popular support for their side.[95] They use existing rules and programs as an entering wedge, and try to expand their turf, their power, their resources incrementally.

Workers' compensation illustrates these mechanisms of expansion well. State workers' compensation programs were founded on the image

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93. Telephone Interview with Susan Daniels, Associate Commissioner for Disability (1993-97), in The Social Security Administration (March 15, 1995).

94. *See* Baker, *supra* note 20.

95. *See generally* E. E. SCHATTSCHNEIDER, THE SEMI-SOVEREIGN PEOPLE (1960).

of industrial accidents and injuries. The dominant image was physical injuries caused by one-time, sudden, discrete events in the workplace. From the beginning however, some advocates thought occupational diseases should be included, and eventually, the definition of a compensable injury was broadened to include more diffuse physiological and mental illnesses that might occur gradually over decades. Hence, workers' compensation came to include occupational diseases caused by toxic exposures, injuries caused by cumulative, repetitive motions, and mental diseases or stress disorders. Through a variety of political actions, including union-sponsored research and advocacy, individual and class-action suits, advocacy of the scientific community, and in some cases employer and insurer efforts to end tort liability for occupational disease, these new kinds of harms entered workers' compensation as legitimate adverse events for which workers deserved and would receive collective assistance.[96]

The evolution of workers' compensation presents a very different picture of insurance expansion than the moral hazard framework would suggest. In the moral hazard model, insurance growth is driven by individuals who are, in turn, induced by the possibility of material assistance to become needy (in the workers' compensation example, they get careless on the job) or to see themselves (illegitimately) as deserving help they do not really need.[97] In the moral opportunity model, insurance growth is driven by collective political action, and comes about through coalitions of beneficiaries and advocates who change the cultural understanding of a problem and use judicial and legislative channels to restructure the rules of insurance.

Claimants and potential claimants are not the only interests who stand to gain from insurance expansion, and not the only political actors who seek its expansion. "Career altruists," people whose jobs are centrally about helping other people (doctors, nurses, other health workers, many plaintiffs' lawyers, many scientists and social scientists, social activists), regard insurance plans and programs as potential tools for helping their clients. Many of these people devote some of their energies to helping make their clients eligible for the collective aid available in insurance pools. And they do so by using their professional skills to prove and

96. *See* McCluskey, *supra* note 29, at 767-87.
97. *See id.* at 742-44.

document that new problems fit within the old rubrics of insurance. Like people in trouble, people who whose careers are dedicated to helping people in trouble will turn to the best available source of help, and that is frequently insurance. Only in the narrowest sense could these helping professions be said to be acting in their own self-interest as they try to expand insurance coverage. Expanded coverage may help them get paid for the services they provide or the jobs they do, but the essence of their jobs is helping others.[98]

In sum, because insurance is culturally constructed as a helping institution, people who need help and people who are professional helpers look to insurance as a source of help. In asking for insurance to cover their losses, people in trouble are in essence asking a collectivity to make good on its promises. And in fighting for insurance coverage on behalf of clients or groups of citizens, advocates and reformers are seeking to enlarge the sphere of collective moral responsibility for the well-being of individual members of their community.

V. INSURANCE CREATES ORGANIZATIONS WITH VESTED INTERESTS IN PRESERVING AND EXPANDING INSURANCE COVERAGE

Insurance coverage for new services and technologies stimulates development of occupations and industries based on these technologies. These occupations and industries then acquire a vested interest in preserving and expanding insurance coverage for the services and products they provide. Again, health insurance provides a good example. Congress, when it decided to expand Medicare coverage for home health care after 1980, created a new demand for home care and essentially capitalized the industry.[99] Congress deliberately encouraged home care expansion as a way to stem Medicare's expenditures on hospital and nursing home care. In the 1980 Omnibus Budget Reconciliation Act

98. Scholars debate whether there is any such thing as altruism; that is, behavior motivated purely by the desire to help others. Many (if not most) psychologists and economists think that most behavior that appears to be altruistic in fact brings rewards to the "altruist" and indeed motivates him or her. For an excellent review of this literature and a well-reasoned and researched argument that there is a continuum of altruistic motivation, see KRISTIN RENWICK MONROE, THE HEART OF ALTRUISM (1996).

99. *See* Szasz, *supra* note 91, at 194.

("Act"),[100] two changes stimulated the home care industry. First, the Act liberalized eligibility requirements for home care services and expanded the number of visits Medicare would cover. These changes in effect boosted market demand for home care. Second, the Act changed agency certification requirements to make it easier for proprietary (for-profit) home care agencies to provide services for Medicare clientele. The number of Medicare-certified agencies almost doubled between 1980 and 1985, and predictably Medicare's home health expenditures more than tripled in the same period (from 662 million to 2,233 million).[101] By 1995, Medicare had become the source of payment for almost half of all home care services, and Medicaid for another quarter.[102]

By the mid-1990s, home health care had become the new "cost crisis" in health.[103] But when, in 1997, the federal government tried to cut back home health expenditures, two obstacles arose: (1) an industry of home health agencies with well-developed trade and lobbying organizations, and (2) a public expectation that on-going home health care for chronic problems is necessary to a decent standard of living. Both of these obstacles to retrenchment are creatures of the social insurance program itself.

The phenomenon of vested interests might seem to be a close cousin to moral hazard in the sense that occupation groups and industries come to rely on insurance, just as individuals are said to rely on their insurance coverage in deciding how careful to be. The two phenomena – moral hazard and vested interests – differ in important respects, however. In economic theory, moral hazard is a psychological construct that describes the way insurance affects individual thinking and behavior. Insurance is

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100. Pub. L. No. 96-499, 94 Stat. 2599 (1996).

101. *See* Szasz, *supra* note 91, at 196.

102. *See* National Association for Home Care, "Basic Statistics About Home Care," (Washington, D.C., November 1997), Table 6 at 4. Medicare accounted for 48.7 percent of all expenditures for home care; Medicaid for 24.2 percent; private insurance for 3.8 percent; out-of-pocket payments for 22.8 percent, and other sources for 0.5 percent. *Id.*

103. *See* Genevieve Kenney & Marilyn Moon, *Reigning in the Growth in Home Health Services Under Medicare* (Commonwealth Fund, New York, 1997); *see generally Medicare Home Health Care, Skilled Nursing Facility and Other Post-Acute Care Payment Policies*, Hearing Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives, 105th Cong., 1st Sess. (March 4, 1997); *Home Health Care*, Hearing Before the Subcommittee on Health, Committee on Ways and Means, House of Representatives, 105th Cong., 1st Sess. (March 4, 1997).

believed to encourage an insured person to behave in a way that creates a greater likelihood of loss and eventually, of the person making an insurance claim.[104] The pejorative moral overtones of moral hazard are clear: insurance (according to the theory) induces behavior that is less than virtuous; it brings out or encourages the weaker side of human character, notably a certain failure to act carefully.

By contrast, the mechanism by which insurance creates vested interests is a social phenomenon. It concerns the way insurance affects group behavior and character. The effect of insurance on occupations and industries is mediated through markets rather than through the individual psyche. By paying for policy-holders to receive goods and services, insurance effectively creates paying customers and economic demand. This demand in turn sustains growth of an occupation or industry; the industry's survival and people's jobs depend on the continued flow of insurance payments. There is nothing particularly moral or immoral about a firm's reliance on its customers or its sources of revenue. When an enterprise takes action to maintain its customers or to increase its sources of revenue, we do not think it is behaving "carelessly." On the contrary, it is acting carefully and judiciously.

Moreover, insofar as an industry's product or service is socially beneficial, the industry's political efforts to maintain or expand insurance coverage might well be seen as efforts to broaden the distribution of a socially valuable and worthwhile commodity. Of course, the moral assessment is ambiguous, here, since the providers of insured goods and services obviously benefit directly from third-party revenue sources. Nevertheless, the fact that they get paid to provide socially beneficial goods and services does not obviate the contribution they make to collective well-being. It is in this sense that the phenomenon of vested interests in insurance exemplifies moral opportunity.

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104. *See supra* note 1.

VI. IN A DEMOCRACY WHERE EQUALITY IS A FOUNDATION OF POLITICAL CULTURE AND CONSTITUTIONAL LAW, INSURANCE IS ONE VEHICLE FOR REMEDYING INEQUALITY AND INEQUALITY OF INSURANCE COVERAGE BECOMES AN ADVERSE EVENT.

Equality is one of the great rallying cries in American politics. It is perhaps the strongest and most effective way to cast political demands. Equality is not an objective criterion, but an interpretation of distributive justice that depends on particular definitions of what is being distributed and the identity of the relevant recipients.[105] Obviously, not all inequalities are remedied by insurance or by other political means. The inequalities that affect organized political constituencies are the most likely to be remedied, and likewise, constituencies are often organized by leaders who define and publicize some version of inequality, making it politically visible and intolerable.

Equality thus sometimes functions as a "meta value" that directs insurance programs to remedy certain inequalities in the distribution of the other things insurance covers. Insurance coverage of mental illness illustrates how the drive to equalize serves as an expansive force in insurance. Mental health advocates have successfully invoked equality to improve coverage of mental illness by calling for "parity" between mental and physical illness, and by using the language and symbolism of discrimination and disparate treatment to characterize insurance coverage of mental disease.[106] Advocates for parity are united under the umbrella of equality in the Coalition for Fairness in Mental Illness Coverage, which includes the National Alliance for the Mentally Ill (a patient organization) as well as several provider organizations such as the American Psychiatric Association and the National Association of Psychiatric Health Systems.[107] The coalition has won federal legislation that prohibits employer-sponsored plans from capping mental health benefits at lower levels than physical health benefits.[108]

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105. *See generally* DEBORAH A. STONE, POLICY PARADOX: THE ART OF POLITICAL DECISION MAKING (1997), at ch. 2.

106. *See* Maggie D. Gold, *Must Insurers Treat All Illnesses Equally? – Mental vs. Physical Illness*, 4 CONN. INS. L.J. 767, 771-82 (1997-98).

107. *See id.* at 775 n.32.

108. *See* The Mental Health Parity Act of 1996, 42 U.S.C. §300gg-5 (1999). Maggie Gold has analyzed the history and politics of this legislation, with particular emphasis on

Equality is the key symbolic resource in this movement. Like almost every current insurance movement, the coalition includes itself as part of the great civil rights movement by analogizing its demands to those of the black struggle against racial discrimination. The Coalition for Fairness in Mental Illness Coverage called mental illness "the last bastion of open discrimination in health insurance in this country."[109] At a White House Conference on Mental Illness in 1999, Tipper Gore implicitly joined mental illness to the civil rights movement when she declared mental illness "the last great stigma of the 20th century," and President Clinton tapped into the theme by exhorting, "It's high time our health plans treat all Americans equally."[110]

A very similar strategy is being pursued by women's health and reproductive rights advocates. They are calling for parity in insurance coverage of prescription contraceptives and publicizing the fact that most insurance plans that cover prescription drugs and devices do not cover contraceptives.[111] These groups have also seized on some recent insurer decisions to cover Viagra (the anti-impotence drug for men) to portray a differential treatment of men's and women's sexual and reproductive medical needs.[112] A state representative announcing a contraceptive parity bill in the Washington state legislature said, "Women pay for contraceptives and insurance companies pay for Viagra. What's wrong

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the remaining inadequacies in coverage of mental illness. *See generally* Gold, *supra* note 106, at 778-87.

109. Gold, *supra* note 106, at 775-76 (citing *CBO Analysis Doesn't Tell Full Story on Mental Health Parity, Coalition Says*, 4 BNA HEALTH CARE POL'Y REP., May 27, 1996, at 908).

110. Steven S. Scharfstein & Sally Satel, *'Parity' Isn't Charity*, WALL ST. J., June 11, 1999, at A18. Plaintiffs in suits over bone marrow transplants for breast cancer also used the discrimination argument, claiming that denial of coverage constitutes discrimination against women or discrimination against people with a particular disease (breast cancer), since insurers cover the treatment for other kinds of cancer. *See* GAO Breast Cancer, *supra* note 77, at 10. Advocates of a Minnesota law requiring insurers to cover bone marrow transplants for breast cancer pointed out that many insurers who refused to cover transplants for breast cancer *were* covering transplants for testicular cancer. *See* Alan Short, *Oversight Limits Access to Breast-Cancer Treatment*, MINN. STAR TRIB., July 2, 1995, at 1A.

111. *See* Peter T. Kilborn, *Pressure Growing to Cover the Cost of Birth Control*, N.Y. TIMES, Aug. 2, 1998, at A1.; *see generally* Carey Goldberg & Sylvia A. Law, *Sex Discrimination and Insurance Coverage for Contraception*, 73 WASH. L. REV. 363 (1998).

112. *See* Kilborn, *supra* note 111, at A1.

with this picture?"[113] Though federal legislation on this issue has stalled, many states are discussing legislation to require insurance plans to cover contraceptives if they cover other prescription drugs,[114] and eleven states have passed such laws.[115] "Parity" has become the insurance term-of-art for equality.

In addition to claiming equality in the coverage of similar kinds of losses, advocates might claim equal treatment of policyholders across different insurance plans. Advocates of broad federal regulation of managed care are using this strategy in the current congressional debates over what has come to be called a "Patient Bill of Rights."[116] These (mostly Democratic) advocates criticize the Republican proposals for not granting the same protections to members of private insurance plans that they grant to members of employer-sponsored plans.[117] Thus, inequality among plans is another rallying cry for regulations that will liberalize and expand health insurance coverage.[118]

Equality is the major force for reform in property and casualty insurance, as well. Under the banner of "redlining," homeowners' insurance, commercial insurance, and automobile insurance have all come under attack for their differential and disadvantageous treatment of low-income inner-city communities and ethnic and racial minorities.[119] The term comes from an obsolete industry practice of drawing red lines on maps around geographic areas where the companies would not sell or write

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113. Editorial, *Time for Parity on Contraceptives*, SEATTLE POST-INTELLIGENCER, June 22, 1999, at A1.

114. In 1999, thirty-three states considered laws requiring private insurers to cover prescription contraception in plans where they already covered prescription drugs. *See* ROSENBLATT, LAW & ROSENBLUM, *supra* note 71, 1999-2000 Supp. at 633.

115. *See* Center for Reproductive Law & Policy, *Contraceptive Equity Bills Gain Momentum in State Legislatures*, Fact Sheet, Sept. 30, 1999, at 2; Carey Goldberg, *Insurance for Viagra Spurs Coverage for Birth Control*, N.Y. TIMES, June 30, 1999, at A1.

116. *See* Alison Mitchell, *Senate Approves Republican Plan for Health Care*, N.Y. TIMES, July 16, 1999, at A1.

117. *See id.*

118. *See id.*

119. *See* Gregory Squires, ed., INSURANCE REDLINING: DISINVESTMENT, REINVESTMENT, AND THE EVOLVING ROLE OF FINANCIAL INSTITUTIONS (1997); Mark Feldstein, *Hitting the Poor Where They Live*, THE NATION, Apr. 4, 1994, at 450; Albert R. Karr, *Complaints That Some Insurers Are Redlining Minority Homeowners Get U.S., State Attention*, WALL ST. J., Apr. 19, 1994, at A22.

insurance. The term is now used metaphorically to mean any unfavorable treatment of applicants or policy holders on the basis of the economic, racial or ethnic make-up of their neighborhood, and even more broadly to mean unfair discrimination on the basis of stereotypes.[120] "Redlining" is now used as a pejorative epithet to describe insurer practices of charging higher rates to some policy holders than to others, refusing to insure some applicants altogether, or refusing to cover some kinds of losses.

As in health insurance politics, housing and community development advocates have used the imagery and legal tools of the civil rights movement to expand access to insurance. Coalitions for "fair housing" or "fair insurance" portray insurance classification decisions as "discriminatory," based on stereotypes rather than objective empirical data. They use disparate impact analysis from Title VII jurisprudence to litigate insurance claims under the Fair Housing Act.[121] In Massachusetts, the first state to pass a law prohibiting redlining in homeowners insurance, the insurance statute reads like a grand civil rights declaration, prohibiting discrimination against every imaginable social category:

> No insurer licensed to write and engaged in the writing of homeowners insurance in this commonwealth . . . shall take into consideration when deciding whether to provide, renew, or cancel homeowners insurance the race, color, religious creed, national origin, sex, age, ancestry, sexual orientation, children, marital status, veteran status, the receipt of public assistance or disability of the applicant or insured.[122]

Political demands for equality in insurance challenge the fundamental principle of actuarial fairness upon which most insurance operates.[123] The

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120. *See* William E. Murray, *Homeowners Insurance Redlining: The Inadequacy of Federal Remedies and the Future of the Property Insurance War*, 4 CONN. INS. L.J. 735, 736 (1997-98).

121. *See id.* at 743-56.

122. H.B. 5649, 1996 Reg. Sess. §3 (Mass. 1996), *cited in* Murray, *supra* note 120, at 761.

123. *See* Stone, *supra* note 4, at 290; *see also* Deborah A. Stone, *The Rhetoric of Insurance Law: The Debate Over AIDS Testing*, 15 L. & SOC. INQUIRY 385 (Spring 1990).

most basic principle of insurance is risk classification.[124] Insurers assess and classify risks in order to price coverage as closely as possible to the risk presented by an applicant – in other words, they seek to collect revenues from each policy holder that will cover the costs of that person's probable losses.[125] In political contests over insurance, insurers usually argue that their practices of charging differential rates or excluding certain categories of people and losses are simply reflections of economic reality.[126] The people who appear to be discriminated against are treated differently because they pose objectively greater risks of loss.[127]

If we were to interpret this broad expansionary movement in insurance through the lens of moral hazard, we might say that groups seeking coverage of their problems or seeking coverage on equal terms with other groups are pursuing their self-interest and exemplifying the problem of moral hazard. They would happily transfer their personal responsibilities to the collective society, and the very prospect of insurance induces them to shed personal responsibility and rely on outside help instead.

The lens of moral opportunity puts the contest in a very different light. Those seeking insurance expansion are making the quintessential democratic claim: they are asserting their membership in a community, their right to representation in its collective decisions, and their right to equal treatment vis-a-vis other citizens. The community of insureds is a group of people who share risks and who put some of their resources at the disposal of the community for the purpose of helping individual members who suffer losses. Groups and their advocates who make claims for inclusion are asking to have their problems recognized by one of the most important institutions for providing security. When they seek various kinds of mandates that require insurers to treat them and their problems in certain ways, they are in effect asking for a permanent seat at the table of

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124. *See generally* Herman T. Bailey, Theodore M. Hutchinson & Gregg R. Narber, *The Regulatory Challenge to Life Insurance Classification*, 25 DRAKE L. REV. 779 (1976).

125. *See id.*

126. *See, e.g.*, Joseph B. Treaster, *Writing Policies in Cities Once Written Off*, N.Y. TIMES, Oct. 30, 1996, at D1, D6. "While many companies acknowledge that city dwellers have often found it difficult to get coverage, they deny that they deliberately discriminated. It has been a question not of race or class, they say, but of economics."

127. *See also* Murray, *supra* note 120, at 738 ("discrimination based on risk is central to an insurer's decision to insure"); *see generally* Stone, *The Rhetoric of Insurance Law*, *supra* note 123 (regarding this argument as made by health and life insurers generally).

community governance. They are unwilling to let insurers decide who should be included in the collective mutual aid system that insurance represents. They use democratic political channels to open up insurance decisions to broader participation. In this view, security and its pursuit are matters of genuine civil rights.

CONCLUSION

Economics is the dominant paradigm for analyzing insurance. Within that paradigm, all social processes are understood to be the aggregate result of individuals' rational, self-interested, interest-maximizing behavior. Insurance is seen as an institution that modifies the incentives facing individuals, and offers them possibilities of gain (or loss alleviation) without their having to bear the full cost of their gains. This opportunity to gain without paying the full price is thought to create a temptation to immoral behavior, known as moral hazard. Moral hazard is, in this paradigm, an inescapable effect of insurance, and it means that insurance slowly, constantly, and inevitably creates more reliance on insurance and therefore ever more insurance.

Political science offers a very different interpretation of the steady long-term growth of insurance in modern industrial societies. Insurance is a social institution that helps define norms and values in political culture, and ultimately, shapes how citizens think about issues of membership, community, responsibility, and moral obligation. Insurance influences how individuals behave, not so much by dangling incentives in front of them one by one, but rather, by offering arenas for collective moral deliberation and political action. Insurance may also be regarded as a system of governance, and controversies over the design and operation of insurance plans as political struggles over the allocation of power and resources. Like any political authority, an insurance organization appears to citizens as an authority with the power and resources to improve or worsen their lives.

I have identified five broad political mechanisms by which insurance expands to cover more kinds of problems and more groups of people in more kinds of mutual aid arrangements. First, because it is a system of collective risk-sharing, insurance invites public discussion of the appropriate boundaries of individual and social responsibility. Wherever it operates, whether in the private or public sector, insurance perpetuates itself and ensures its survival in part by defending the legitimacy of mutual

aid. Second, insurance teaches citizens that they have an obligation to help others and the right to receive aid when they suffer certain kinds of losses. Third, insurance funds the development of helping technologies, services and occupations, which in turn create new, enlarged societal standards of well-being that alter public ideas about what adverse events ought to be insured and what standards of life quality ought to be provided through insurance remedies. Fourth, insurance policies and regulations offer ambiguity as a political resource to three sets of political actors who all have stakes in the expansion of insurance: claimants who want help with new kinds of problems, career altruists who see insurance as a tool for helping their clients, and service providers who depend on insurance reimbursement for their revenues. Finally, because equality is an overarching value in American political culture, claims of inequality and discrimination are powerful political tools for groups seeking inclusion of themselves and their problems in insurance plans. American political culture almost defines inequality as an adverse event itself, something that must be remedied as soon as it is revealed.

A political paradigm enables a different normative interpretation of insurance expansion. In the moral hazard model, insurance makes the individual engage in immoral behavior; in the moral opportunity model, insurance alters societal ideas about responsibility and obligation. If individuals come to believe that getting help for their problems is legitimate, they do so out of changed cultural perceptions about the causes and possible remedies for their problems, not out of a character weakness or an insufficient determination to be self-reliant. And when individuals who share common problems join together to seek help from private or public insurance plans, they are acting not as a band of brigands, raiding the common wealth for their narrow gains, but are acting the role of virtuous citizens, using democratic means to make their voices heard and their needs understood.

That we have insurance for more and more needs and that we expand the scope of public responsibility for many kinds of losses does not signal a moral decline in the citizenry, as opponents of insurance claim. Insurance growth is a social response to the Enlightenment faith that much of what happens to humans is not a matter of fate and that many of our problems are within our control.

THE RETURN OF THE CRAFTY GENIUS: AN OUTLINE OF A PHILOSOPHY OF PRECAUTION

*François Ewald**

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INTRODUCTION

Perhaps our societies, in terms of social obligations and the political philosophy of safety, are in the process of changing paradigms.

The 19th century witnessed the domination of the paradigm of *responsibility*. During the 20th century this has been fundamentally transformed: instead of the paradigm of responsibility we have that of *solidarity*. Perhaps, in this 20th century that is coming to its end, we are seeing the birth of a new paradigm, one which has not yet found its true name, but the arrival of which is presaged by certain signs.

In terms of safety, there is still the question of rights and duties, legal and moral obligations; these compromise without necessarily

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overlapping. The paradigm of *responsibility* designates a certain economy of rights and duties where the proportion of moral obligations towards oneself and others is far higher than the proportion of legal obligations. Arising from a liberal philosophy, it relies less on constraint than on freedom and individual intentions. The legal obligations with regard to others are summarized in the rule "do no harm to others." Virtue holds an important place here in the two-fold shape of *providence* (for oneself) and *charity* (for others).

The paradigm of *solidarity*, which corresponds to the welfare state, considerably extends the proportion of legal obligations. These legal obligations tend to overlap moral obligations. Solidarity is accompanied by the multiplication of social rights, and by the recognition of a sort of general right to compensation when faced with any mishap of living. It is contemporary with a scientific and technical utopia, where society would have the possibility of controlling itself, where knowledge would have an indeterminate control over power. In its philosophical foundations, it is inseparable from the imperative of *prevention*: prevention of illnesses (with Pasteur's discoveries), prevention of crimes (with the system of social defense), prevention of accidents (with the sciences of safety), prevention of poverty and social insecurity (with social insurances).

The new paradigm of *safety* reveals a new economy of rights and duties. While the notion of risk, together with the competencies given to scientific expertise, used to be sufficient to describe situations of insecurity, the new paradigm sees the reappearance of the notion of uncertainty. It bears witness to a deeply disturbed relationship to a science that is questioned less for the knowledge that it offers than for the doubts that it insinuates. Here, moral obligations take the shape of ethics, and the principle of responsibility is seen as a reflection of the new notion of *precaution*.

The paradigm of responsibility is a paradigm of insurance – one is situated in a logic of compensating for losses. The paradigm of solidarity is still a paradigm of insurance, of universal and indeterminate insurance, of social and compulsory insurance, and it is less concerned with voluntary and contractual forms than the institution of funds of any sort. The paradigm linked to the notion of precaution will undoubtedly remain a paradigm of insurance, but in a new shape that will need to integrate new cultural constraints.

I. RESPONSIBILITY

What is it that characterizes the arrangement for the attribution and compensation of damages that caused this to take, during the 18th and 19th centuries, the form and name of "responsibility?"

A. A Political Strategy

First of all, this arrangement needs a policy, an overall strategy of social control. Responsibility is based on the principle that "one person cannot transfer to another the burden of what happens to him." The principle of responsibility is in direct opposition to the principle of assistance. Adolphe Thiers, reasserting the liberal credo ceaselessly repeated for the previous fifty years, wrote in 1850 that:

> The fundamental principle of any society, is that each man is responsible for meeting his own needs and those of his family, by resources that are acquired or transmitted. Without this principle, all activity would come to a halt in a society, since, if man could rely on work other than his own to survive, he would gladly leave to others the tasks and difficulties of life.[1]

The formulation of this principle is linked to the advent of liberalism. It involved both making people provident, aware of the future, and preventing them from living solely in the present. The principle of responsibility goes through a human-nature relationship whereby everything that happens to a person must be considered a sanction, good or bad. Responsible for myself, I cannot attribute to someone else the reason for my failures. These failures, even if they are also the result of other circumstances, of a difficult situation, are basically down to me. It is I who was unable to take a particular element into account; it is I who did not understand the laws of nature or who was unable to use them. In any case, and always without exception, **it is my fault**. I am the only point of attribution for what happens to me. "To err is human," goes the saying. Accordingly, the principle of responsibility converts any mistake into a fault.

The principle of responsibility relies on a method of managing causality that makes it possible to devise self-regulation of conduct and

1. ADOLPHE THIERS, RAPPORT AU NOM DE LA COMMISSION DE L'ASSISTANCE ET DE LA PRÉVOYANCE PUBLIQUES 6 (1850).

activities. To the extent that one cannot attribute one's own failures and sufferings to someone else, failures and sufferings will be able to become the indeterminate principle of one's own self-improvement. The principle of responsibility, based on fault, thus serves as a universal converter of bad into good. But it is singularly demanding. Seen from this angle, security would not be a right, but merely a duty. For in this philosophy, there is no room for the notion of victim. In this world, suffering a wrong gives you no right to anything (unless it results from the fault of someone else). And victims, whatever feelings of compassion and pity they may inspire, are always assumed to be the sole creators of their own destiny.

The political principle of responsibility is at the basis of articles 1382 and subsequent of the Civil Code.[2] That principle is precisely what these articles are intended to enforce. One might as well say that they were not intended to extend the reach of damages by increasing the possible number of responsible parties, but rather to limit them to the situation in which the damage suffered was by the fault of another. The judge's responsibility is to ensure that he maintains the definition of faults within a limit that will conserve the meaning of the general principle of responsibility.

B. The Virtues Of Responsibility

The principle of responsibility and its legal sanction aim to make man provident and prudent: provident as to the effect of fortune, prudent as to himself and the consequences of his actions. Faults, in such a logic, are always faults of prudence; they sanction what one should have, or could have, foreseen. A prudent and provident man has no excuse. He will not only owe his safety to his prudence, but also to his capacity to associate with others to compensate for the effects of fate. If such a philosophy excludes any idea of insurance for responsibility, and even insurance for damages (long considered immoral as though encouraging crime and thus prohibited), it evokes, on the contrary, the idea of insurance of the person, on a strictly voluntary basis.

The notion of fault is a philosophical principle for attributing damages which should have the merit of combining harmoniously not only the three functions of sanction, prevention and compensation, but also ethics, law and politics. In this manner, the great legal commentator Jean-Etienne Labbé could still write at the end of the

2. *See* C. CIV. art. 1382 (Fred B. Rothman & Co. 1977) (Fr.).

19th century, at a time when the mechanism of responsibility was already deeply shaken, that "[r]esponsibility is the most perfect regulator of human actions."[3]

This model no longer corresponds to contemporary experience. And yet it is difficult, when it is evoked, not to feel its coherence and even its proximity. Its persistence as a model, or as a regulating principle, in the face of contrary social facts is nothing new. Since the time when it was first instituted, it has been contested by the developments of industrialization.

The form of *providence* supports the formulation of articles 1382-1386 of the Civil Code as they were interpreted until the end of the 19th century.[4] The legal notion of fault echoes that of providence: one can only reproach somebody for what he or she should have known. As seen in the jurisprudence of article 1382 of the Civil Code, the reference to the diligence of a "prudent head of family" or to certain standards of professional conduct indicates that one can only be held responsible to the extent of the available knowledge, which varies depending on the activity.[5] Doubt, uncertainty, or suspicion cannot make one responsible. Such emotions are more likely attributed either to chance, or to the prudence that each person owes to himself in the conduct of his life.

Providence is the great virtue of the 19th century. It is the foundation of responsibility in the conventional sense of the term, and it is the interdiction of blaming another for what happens to you (except in the case that it is due to the fault of another). Indeed, when the word was coined in the 19th century, responsibility did not, as it does today, designate a general principle of blaming another for unfortunate mishaps, but precisely the opposite. Responsibility as providence consisted of being aware of the risks to which one was subject because of the need to face up to them on one's own initiative. The world of providence is a world where one must perceive his or her weakness and fragility, subject to the incessant ups and downs of fate; it is a world of chance events. It is an unbalanced world where one knows oneself to be vulnerable and hardly thinks of being able to use science and engineering that are not readily available in order to rebalance one's relationship with nature. One must rather call on cunning, intelligence, and calculations of probabilities which teach that accidents do not happen without laws and that these laws are the

3. JEAN-ETIENNE LABBÉ, SIREY 25 (1885).
4. *See* C. CIV. art. 1382-86 (Fred B. Rothman & Co. 1977) (Fr.).
5. *See* C. CIV. art. 1382 (Fred B. Rothman & Co. 1977) (Fr.).

foundations of mutualities making it possible to face up to them rationally. This is how insurance promoted its merits throughout the 19th century as the institution of a rational providence. In the world of providence, one has no other resource than calculation and virtue. Faced with the accidents that one can hardly anticipate, the only resource available is to learn how to offset them. And insurance, which makes this possible, cannot itself be made compulsory, since the obligation would cancel out the exercise of the virtue of providence.

II. SOLIDARITY

The mechanism of responsibility was contested, reformed and replaced at the end of the 19th century with respect to the coverage of a certain number of events by an arrangement based on solidarity. The major issue in all industrial societies was that of accidents at work and pensions. The mechanism of solidarity is not based on fault but on risk; its main instrument is no longer the law but insurance.

A. Shift to Risk

The notion of risk, which makes its arrival in positive French law in 1898 with the "professional risk" of the law dated 9 April 1898 on accidents at work,[6] designates a way of envisaging the reparation which, without involving examination of the behavior of the worker or the boss, attributes them globally to the work and the company. "All work has its risks; accidents are the sad but inevitable consequence of work itself."[7] According to the principle of professional risk, the onus of accidents at work, whatever their cause, is attributed to the head of the company, whether they arise legally from a chance event or, better, from the fault of the worker. Thus, the outcome of the new law is that the head of a company is legally "responsible" not only for accidents resulting from personal imprudence or negligence, but also for those arising even when the company has taken all precautions to avoid them, and those for which the worker is the cause (with the exception of deliberate tortious intent).

The idea of professional risk thus undergoes a split between causality and attribution. The indifference of the latter in relation to

6. *See* EDOUARD THOULON, LA RESPONSABILITÉ DES ACCIDENTS DONT LES OUVRIERS SONT VICTIMES DANS LEUR TRAVAIL (1898).

7. *Id.*

the former is separated by the institution of a principle of attribution which no longer refers to the objective causality of damages. The rationality that is at the base of the notion of risk leads to a change in the manner of thinking through the problem of the legal allocation of damages. It is no longer in terms of "cause," but in terms of "distribution." Distribution within the company, and between profits and expenses, or more generally, as social distribution of expenses. Risk only exists socially. Whether professional risk or social risk, it institutes a social contract between individuals.

The invention of professional risk and social risk consists of thinking through a principle of allocation which, freed from the old dependence on nature, will find its reference in a social relationship. This accounts for both the richness of the category and the difficulty of thinking it through.

The idea of risk comes from a thought based on statistics and probabilities. Business risk, for example, characterizes a whole, the company, which conserves its identity despite the variations that may affect its different parts. The regularity of risk is independent from the conduct of individuals. The faults that they may commit are factors of risk that do not affect the company's statistical reality. This is one of the principal benefits of the notion of responsibility: enabling the law to base itself on reparation of the actual fact of the accident, of the damage suffered, whatever the cause. While a principle of responsibility founded on an idea of cause implies a selective distribution of the costs, business risk, to the contrary, provides "solidarity." Solidarity, on the one hand, of the boss and the worker in the context of the company, involves business risk that can put an end to the antagonism of capital and work that the law of responsibility fueled. Social solidarity, more generally, allocates risk by displacing the cost of accidents onto the company, thereby ensuring a new balance between rich and poor, producers and consumers.

B. A New Social Contract

The new solidaristic doctrine of spreading costs was to be repeated in eloquent terms by the reforming jurists of the end of the 19th century. Let's hear what they have to say. First, Raymond Saleilles:

> Modern life, more than ever, is a question of risks. Therefore, one takes action. An accident occurs, somebody must necessarily bear the consequences. This must be either the author or the victim. The issue is not of inflicting a penalty, but of knowing who must bear

> the damage, he who caused it or he who suffered it. The penal point of view is not at stake, only the social point of view is an issue. Properly speaking, it is no longer a question of responsibility but a question of risks: who must bear them? Obviously, in reason and in justice, it must be he who in taking action has taken responsibility for the consequences of his deeds and his activity....[8]

This text is a testimony of the intellectual conversion that gave birth to the mechanism of solidarity. "Modern life," says Saleilles, "is more than ever a question of risks."[9] This is the avowal that the real world is not one imagined by the drafters of the Civil Code. Whatever the diligence that each person can bring to his affairs, damages are not the exception but the rule. They are "normal" – which does not mean they are inevitable. Social life is not naturally harmonious, but conflictual, prejudicial. When the "good head of family," he who served as reference in defining the fault of conduct, takes action, exercises his business, does his work, he "naturally" causes, without wishing to do so, damage to other good heads of family. The outcome is necessarily that the damages must be objectified as "accidents" and, alongside this, they must no longer be considered faults. These are risks.

Another consequence: the problem of responsibility is no longer that of determining "who was at fault," but to whom the damage should be attributed, who should bear the loss caused by the damage.

> Between two individuals, one of whom, even without being at fault, has caused a personal accident or a loss of property to the other and of which this latter is the victim, who must bear the financial cost and, at the end of the day, on which asset-base must fall the final loss? Such is precisely the formula of the problem. The issue of fault has nothing to do with the question.[10]

Inherent in this consequence is a problem of fairness formulated in terms that are more economic than moral, causing the cost of damage to be borne by the victim or by another, in any case making one or the

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8. RAYMOND SALEILLES, LES ACCIDENTS DU TRAVAIL ET LA RESPONSABILITÉ CIVILE 4 (1897).

9. *Id.*

10. *Id.* at 75.

other "responsible." Spreading the risks means judging who must bear them, not in terms of the principles of a moral responsibility which is irrelevant here, but in terms of the rules of a "social fairness" to be determined. The source and foundation of responsibility are moved from the individual onto society: one is responsible not because one is free by nature and could therefore have acted differently, but because society judges it "fair" to make you responsible, that is to cause you to bear the financial cost of the damage, whether you be actor or victim.

Let us now hear the version of L. Josserand:

> The passer-by that I knocked down, the classmate that I injured did not for their part commit any fault and yet today's doctrine declares them responsible for the accident, since it makes them bear the consequences. For, and this is an idea which, despite its evidence, is not sufficiently visualized, it is impossible to subtract the owner of the thing from the responsibility of damage without causing this same responsibility to be borne by the victim: Since the cause of the accident is unknown, is what one sometimes hears, *nobody must be responsible*, since nobody is at fault. This reasoning is absolutely wrong: when an accident occurs, it is not possible for nobody to be responsible in the wide sense of the word, that is for nobody to bear the consequences of what happens: if the owner of the thing that caused the accident is not made to repair the damage, the victim must of necessity be the one to bear it; the victim will incur the full responsibility for the accident, responsibility which is seen in the loss of life or health, without compensation. Whatever the solution adopted, there is always responsibility: the only question is that of knowing who must assume it. In a nutshell: is there responsibility each time there is final endorsement of damage?[11]

Can we be clearer on the transformations undergone by the notion of responsibility? Earlier, and always in common opinion, responsibility designated a quality of human nature. Responsibility has changed its meaning; it is no longer the quality of a subject. Rather, it

11. L. JOSSERAND, RESPONSABILITÉ DU FAIT DES CHOSES INANIMÉES 107 (1897).

is the consequence of a social fact. Responsibility, in a way, has become a relationship without support.

There are no damages where loss is solely individual. All damage is social. A distinction must be made between the damage suffered by an individual – this is an affair of chance or mischance – and the loss linked to the damage for which the attribution is, for its part, always collective and social. In any case, society and its courts cause the cost of damage to be borne by someone, whether this is the victim or another: they spread the risks. The notion of spreading the risks implies that one conceives society not as an aggregation of individuals, who may be linked to each other by personal interest, but as a totality – the good and the bad of each individual dependent on everyone else. This is true whether one conceives it as a totality where any individual is no longer a third party in relation to others, or whether one conceives it in accordance with the principle of solidarity. One has moved from an individualistic to a holistic perspective.

If damages are individual, it behooves society to suitably spread the cost, and this necessarily opposes what nature or fate has decided, throwing a new light on the problem of justice. François Gény, another jurist from the end of the 19th century, prophesied the continuation of the transformations that he witnessed:

> One can imagine a social ideal which, without claiming to halt the blows of fate or defy the decrees of providence, would aim to discover in the nature of things, placed by God Himself at our disposal, the means of sharing amongst all, in the form of an intelligently organized mutuality, the risks which incessantly threaten each of us taken as an individual. However, and without speaking of the almost insurmountable difficulties, of the prodigious organization required by the realization of such an ideal, one easily glimpses the utopia and the danger of a system, which, firstly, in order to remain loyal to its aim, should, by means of compensations, although necessarily imperfect, straighten out all inequalities, take into consideration economic variations as well as material changes, share out the gains as well as the damages; which, secondly, however well-advised the application may be, will not fail to diminish the qualities of initiative, of diligence, of providence, which are

> among the conditions essential to the progress of humanity.[12]

Here we have the description of the program of social security which will exist throughout the 20th century not only with regard to the coverage of social risks (illness, old age, disability) but also for the compensation of an ever-increasing number of accidental risks. It is commonplace to recall that, during the 20th century law and responsibility were transformed, bit by bit, into a right to compensation, based on both risk and insurance. This is the case, on the one hand, for car accidents, but also for the compensation of natural disasters, for protection against attacks and the consequences of law breaking, and even of damages linked to the supply of defective products. Protection against sea pollution also obeys such mechanisms, certain of which should be extended to land pollution. By way of responsibility, the 20th century systematically thinks compensation, so much so that today the victim of damage, of any nature, seems to be able to claim compensation, and the media are tempted to denounce the scandal as soon as they see what seems to be an orphan situation, as is still the case in France with medical accidents.

C. Prevention First

The paradigm of solidarity is not only a paradigm of compensation; it is also a paradigm of prevention. One forgets the extent to which one needs to distinguish the three problems of reparation, sanction (in principle reserved for criminal law) and prevention. In fact, in the same way that compensation is no longer linked to a consideration of individual conduct in terms of prudence-imprudence, prevention is objectified as a specific function now resulting less from goodwill than from an independent function arising from scientific know-how. Man is no longer objectified as master of free conduct but rather as a link in a technical system where his faults are instead thought of as errors, which must themselves be considered less as individual errors, than as errors of organization. We know how systemic problems have become engulfed in such an opening.

Disassociated in their field of competence, compensation and prevention are nevertheless based on the same philosophical paradigm.

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12. François Gény, *Risque et responsabilité*, *in* REVUE TRIMESTRIELLE DE DROIT CIVIL 817 (1902).

The very word prevention took its present-day meaning, where it is no longer a question of an unwilling judgment, in the solidaristic environment as obligatory providence on the one hand, and as such conduct as will reduce the probability of something happening on the other. In fact, the notion of prevention, contained both in Pasteur's discoveries on infection and their public health consequences, as well as the association of engineers and their efforts to reduce the probability of machine accidents, presupposes and accompanies the promotion of the notion of risk and, which comes down to the same thing, of measurable risk. Prevention (the vocabulary of which has henceforth replaced that of providence) presupposes science, technical control, the idea of possible understanding and objective measurement of risks. Thus, the problem is no longer that of compensating for practically inescapable losses but more of reducing the probability of their occurrence.

The 19th century's dream of security becomes a utopia of a science ever more capable of controlling risks. While one cannot eliminate them (there is never zero risk), they will have been reduced sufficiently to be able to be dealt with collectively: accidents are the waste aspect, necessary although always more marginalized, of scientific and technical progress. These are special or abnormal risks, the responsibility for which should be spread over the community. Our concept of social security involves prevention, the dream of an ever more complete reduction of risk. It is not, in any case in this project, a mechanism intended to assume responsibility for all one's misfortunes.

Prevention is an attitude which, by principle, relies on trust in science and its know-how. It presupposes the appropriateness of knowledge and power, an ever-possible control of power by knowledge. Its utopia, a knowledge always capable of mastering techniques and practices that devolve from it, will also reveal its boundary. One cannot foresee what one does not know, even less what one cannot know.

III. SAFETY

This second paradigm is perhaps in the process of disintegrating before our eyes, around three major issues, which are also the three principal points of the problematization of contemporary problems of safety. These issues are medical accidents, particularly the aspect of serial risk revealed by transfusions, grafts and transplants; the environment, taking the dimension of global threats; and responsibility

of manufacturers in the event of a defective product, in terms of the problematic of the risk of development.

A. The Precautionary Principle

These three issues have two characteristics in common. First, they were imposed at virtually the same time: during the 1980s, and second, they were experienced as the test of a form of unexpected vulnerability, unsuspected by individuals in developed societies, lulled by the promises of an ever-safer world. We are seeing the return of disasters, the insistence on individual and collective damages of unequalled size, at least in peacetime. The 19th and 20th centuries were obsessed with the problem of accidents (work or car); we are now rediscovering the existence of disaster, but with the difference that disasters are no longer, as before, attributed to God and His providence, but to human responsibilities. It is in this deeply disrupted context that the notion of precaution now appears.

The category is now part of positive law: international, European community and domestic. First international: formulated at the time of agreements implemented, from the end of the 1980s, in order to combat the greenhouse effect and the hole in the ozone layer, in the context of the Brundtland Report on sustainable development,[13] the precautionary principle constitutes the tenth of the major principles retained by the Rio Summit in 1992.[14] Here, precaution designates the attitude that consists of preventing serious or irreversible deteriorations of the environment by a modification of the production, of the sale or of the use of products, of services or of types of business, and this in accordance with a scientific and technical approach. Next the European community: the Maastricht Treaty specifies in article 130 R that "community policy on the environment" is based on the precautionary principle and on the principles that preventative action should be taken, that environmental damage should as a priority be rectified at source and that the polluter should pay.[15] Finally, domestic

13. *See* Our Common Future: The World Commission on Environment and Development (Oxford Univ. Press, 1987) [hereinafter Brundtland Report].

14. *See* United Nations Conference on Environment and Development 1992: Rio de Janeiro, Brazil, The Rio Declaration on Environment and Development Principle 10 The Earth Summit, AGENDA 21, RIO DECLARATION, FOREST PRINCIPLES (New York, 1992) [hereinafter Rio Summit].

15. *See* Maastricht Treaty, Feb. 7, 1992, Title XVI – Environment, Article 130R(2) – Community Environmental Policy [Article 130 has been replaced by Article G(38) of the Union Treaty]; RICHARD CORBETT, THE TREATY OF MAASTRICHT: FROM

law: since French parliamentaries have given a definition of the precautionary principle in the first article of the law dated 2 February 1995 relating to the better protection of the environment: the precautionary principle, "in accordance with which the absence of certainties, having taken into account scientific and technical knowledge of the time, must not postpone the adoption of effective and proportionate measures intending to prevent a risk of serious and irreversible damage to the environment at an economically acceptable cost," [16] is specified as the first principle that should take precedence in policies for the protection of the environment.

From these different texts, it is immediately evident that the precautionary principle does not seem to have a universal meaning: its field of jurisdiction is limited in principle to the area of the environment. But, make no mistake, to the extent that this involves a principle aiming to impose a certain type of decision-making in a situation of uncertainty, its validity will not prevent it being exported outside its original territory. The Council of State has been seen to implement it in order to extend State responsibility in the blood transfusion crisis.[17]

Beyond this, it appears that the precautionary principle does not target all risk situations, but only those marked by two principal features: a context of scientific uncertainty on one side, the possibility

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CONCEPTION TO RATIFICATION: A COMPREHENSIVE REFERENCE (Harlow, Essex, U.K., 1993).

16. Law No. 95-101 of Feb. 2, 1995, J.O., Feb. 3, 1995, p. 1840 (Fr.); Legifrance, L'essentiel du droit français (visited 11/11/99) <http://www.legifrance.gouv.fr/citoyen/jofr>.

17. *Editor's footnote*: The French author of this piece assumes his readers' familiarity with France's tainted blood crisis. This situation received only cursory attention in the United States, and it is therefore helpful to include a brief explanation. In June 1985, Michel Garretta, then-director the of French National Blood Transfusion Center, ordered the normal distribution of non-heated blood products. Garretta decided that the widely accepted and American-pioneered heat treatment procedure that inactivated the AIDS virus in blood was unnecessary. This order was in direct conflict with the practices of other nations, including the United States and Canada. As a result of this order, French patients received untreated and untested blood for six months. In 1992, it was reported that about one-half of France's 4,000 hemophiliac population had contracted the virus and more than 250 had already succumbed to the virus. A battle of who was to blame ensued – scientists pointed the finger at the politicians and the politicians at the scientists. And there were also those who claimed they were blameless. Georgina Dufoix, then-Social Affairs Minister stated paradoxically that she was "responsible but not guilty." As one author noted, "[N]one individually were responsible; the system was assigned responsibility. And now they all claim that they were not at fault. The hemophiliacs are dead because they were not seen. As public technocracies spread, perhaps this is the sort of defendant we had better get used to." *Murder by Bureaucracy*, WALL ST. J., Aug. 5, 1992, at A14.

of serious and irreversible damage on the other. These two items are thoroughly problematic.

B. A New Balance

What should we understand by "serious and irreversible damage?" Does not any bodily injury, not to mention death, constitute, for the person suffering it, a serious and irreversible damage that no financial compensation could ever "repair?" In fact, the precautionary principle does not so much target individual damage that somebody may suffer in an accidental situation as collective damage, taking the aspect of disaster. As an example, however, it is difficult to refrain from, in the name of the above-mentioned principle, criticizing a doctor for lack of caution in her treatment of a patient. In addition, a distinction should be made between the seriousness of damage, in amplitude and nature, as well as the notion of irreversibility.

If irreversible damage is always serious damage, the reverse is not always true. The idea of irreversibility focuses on the fact of transforming the nature of nature, the balance between man and his environment, the introduction of a solution of continuity in the process of life on earth. The notion of irreversibility must no doubt be understood with regard to an "objective of sustainable development that aims to satisfy the needs for development of present generations without compromising the capacity of future generations to respond to theirs."[18] This involves preventing any event – the "revolutions" spoken of by Cuvier[19] – which might introduce a break in the natural course of history. It involves ensuring continuity for the future. The precautionary principle is counter-revolutionary: while it exists in a framework of uninterrupted progress, it also limits innovation.

But the precautionary principle does not proceed solely from a consideration concerning the nature and amplitude of damage that seems possible from our standpoint today. There is also a new relationship to damage. It is not only that damage is possible, it is also that it might be irreparable, irremediable, incompensable, unpardonable, and imprescriptible. The appearance of the precautionary principle enters into the context of victims who are no longer satisfied with having their damages compensated, no matter how high the compensation, and only find respite after having obtained

18. Law 95-101, art. 1, of Feb. 2, 1995.

19. *See generally* BARON GEORGES CUVIER, THE ANIMAL KINGDOM (Kraus Reprint 1969) (1863).

legal punishment of those responsible. Such persons are only satisfied if those responsible for the damage are held legally accountable.

This is certainly a modification of the solidaristic equation which implied that a risk was acceptable as long as it was reparable or repaired. This was the principle of the law on accidents at work of 1898,[20] and it was certainly at the foundation of the mechanisms of compensation on the basis of responsibility. One could take a risk on the condition that one paid the price. This attitude, which presupposed that everything – gains as well as losses – had a price, was the principle of cost-benefit analysis, in the name of which it became legitimate to undertake decisions. Was this not how it became justifiable to exercise objective responsibilities – for example, considering "externalities" in the price of a product's production? The problems of decision-making, business activities, compensation and responsibility henceforth became no more than economic problems. This involved ensuring that the cost of the risk remained compatible with the underlying need being addressed.

The appearance of the precautionary principle no doubt marks the limit of this equation and its underlying logic. With the irreversible, we rediscover that there is the irreparable. All is not, indefinitely, a question of economy. All is not assessable as a financial value. Thus there is no longer solely the compensating, but also the preventing, the forbidding, the sanctioning and the punishing. A logic of responsibility returns alongside the solidaristic problematic of compensation.

The same idea is expressed by the apparently contradictory term, "zero risk." This involves not so much defining an action without risk, as it involves asking oneself what merits running the risk. The notion of "zero risk" designates a risk that no longer has a value – that is, a risk to which we cannot assign a value. The recognition that there is the unpriceable represents a transformation in our systems of value. Here, it seems undeniable that the precautionary principle decenters certain postulates of an insurance-based society, which presupposes that one can assign a price to everything, even the very notion of risk, the function of which is to attribute an objective value and price to a threat. In a certain manner, the formula used by Portalis to condemn life insurance resurfaces: "Men's lives," he said, "have no price."[21] However, the precautionary principle takes this idea further in that this

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20. *See* THOULON, *supra* note 6.

21. JEAN-ETIENNE MARIE PORTALIS, NAISSANCE DU CODE CIVIL, AN X11 – 1800-1804 359 (1989).

formula concerns not only the lives of men, but also the lives of animals (via the protection of the diversity of species) and of nature.

Of course, this does not mean that, in a precautionary society, damage should suddenly become irreparable and that the logic of insurance and solidarity should disappear. First, it is important to note that precautionary logic is limited to serious and irreversible damage which, in principle, limits the scope of possible damage situations. Second, precautionary logic is, above all, a logic for reading a decision, aiming to define the conduct to use in a situation of uncertainty, such as when one desires the reparation of damage.

C. Science, Between Trust and Mistrust

The second element of the precautionary situation involves the "absence of certainties, having taken into account the scientific and technical knowledge of the time."[22] The formula defines the relationship between prevention and precaution: once there is a certainty of the consequences of an action, one remains with the logic of prevention, with all that this implies in conventional terms of responsibility. The notion of precaution concerns a situation where one can only formulate, between a cause and its effect, a relationship of possibility, eventuality, plausibility or probability without being able to provide the proof of its validity. The hypothesis does not concern exactly that of the unknown cause, but rather the probable, or even only feared, cause. This reference to scientific uncertainty is particularly disturbing.

Uncertainty does not solely concern the relationship of causality between an act and its consequences, but also the reality of the damage, and the measurement of the risk of such damage. The precautionary hypothesis puts us in the presence of a risk that is neither measurable nor assessable – that is, essentially a non-risk. While the logic of insurance and solidarity had reduced uncertainty to risk, in order to make the former something that was systematically assessable, the logic of precaution leads us once again to distinguish between risk and uncertainty. Precautionary logic does not cover risk (which is covered by prevention); it applies to what is uncertain – that is, to what one can apprehend without being able to assess. The changes we currently observe in weather patterns, do they constitute an irreversible interruption in the history of climates? Or are they only a vicissitude, the likes of which the earth has already seen on many occasions?

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22. *See* Law No. 95-101, *supra* note 16.

Should we continue to use blood transfusions when one already suspects that the blood contains the hepatitis virus – G, H or I – of which one is not even capable of assessing the potential danger?

The precautionary hypothesis focuses on the uncertainty of the relationship of causality between an action and its effects. This implies that, from now on, along with what one can learn from science, in a context that is always relative, it will also be necessary to take into account what one might only imagine, doubt, presume, or fear. The precautionary principle invites one to consider the worst hypothesis (defined as the "serious and irreversible" consequence) in any decision by a company. The precautionary principle requires an active use of doubt, in the same sense as codified by Descartes in his *Meditations on First Philosophy*.[23] Before any action, I not only ask myself what I need to know and what I need to master, but also what I do not know, what I dread or suspect. I must, by precaution, imagine the worst possible, the consequence that an infinitely deceptive evil spirit could have slipped into the folds of an apparently innocent enterprise.

From this point of view, the formulations that one gives of the precautionary principle, anticipating limits in the attitude of prudence to adopt, either in terms of scientific-technical criteria in accordance with the formula adopted at the Rio Summit which speaks of measures to be taken "in accordance with a scientific and technical approach,"[24] or in terms of more economic criteria if one follows the version of the French law dated 2 January 1995 which speaks of "effective and proportionate measures at an economically acceptable cost,"[25] do not, at least in appearance, avoid being contradictory. On the one hand, the decision-maker is invited to expect the worst, the possible catastrophe, the irreparable, while, on the other, one finds the measures to take if only in a "scientific and technical" context – while, by principle, their validity is placed in suspense – or at "an economically acceptable cost" – just when one must envisage the non-assessable of the irreversible. This is no doubt explained by the fact that one wants to maintain a principle of economic and industrial development – which prohibits the conclusion of abstention faced with the uncertain – at the same time as one seeks to limit as far as possible its harmful consequences. Hence the idea of "sustainable development."

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23. *See* RENE DESCARTES, MEDITATIONS ON FIRST PHILOSOPHY (George Heffernan ed. & trans., Univ. of Notre Dame Press 1992) (1641).

24. INT'L ENVTL. LAW AND POLICY SERIES, THE EARTH SUMMIT: THE UNITED NATIONS CONFERENCE ON ENV'T AND DEV. (Stanley P. Johnson ed., 1993).

25. *Cf. supra* note 16.

The precautionary hypothesis, finally, introduces uncertainty in both decisions and sanctions, *a priori* and *a posteriori*. *A priori*, to anticipate a danger or avoid damage is the cautious intention principally covered by the texts. Precaution designates, first and foremost, a logic of decision to act or not to act, to undertake or not to undertake. It complicates this by introducing the dimension of uncertainty, based on the worst hypothesis. It shall only be strictly meaningful before the decision is taken. And yet, to the extent that one will not fail to bring it into play, in the sanctioning of responsibilities, once damage should occur, it will find itself applied *a posteriori*. And one can see what this implies: that the sanction escapes the reference to available knowledge, a standard of determined knowledge, whether one is judged not only by what one should know, but also by what one should have or might have suspected. Here, precautionary logic, even if it extends the field of subjective responsibilities because it focuses on the act of decision, does not, strictly speaking, enter into the former logic of fault. The latter presupposes the existence of knowledge, absent here since one is in the uncertain.

To take its place, we have the verification of the observance of decision-making procedures which should be properly defined. Two situations should be taken into account: that where the damage takes place and the uncertainty of long-term causality. And one hardly sees how, in current law on responsibility, one could attribute to somebody the damage in question, except by employing new systems of causalities, vague logics and other systems of probable causalities, or by introducing a new law of proof, or by fixing responsibilities of principle to necessarily arbitrary foundations. The other situation is that where, with time, the causality of damage becomes known and therefore assignable. What was only suspected, now becomes progressively true. This is a formidable situation. Under the former approach to responsibility, uncertainty of knowledge was innocent. The application of the precautionary principle gives a very different result: the uncertainty of understanding is not an excuse, but rather motivation for a more cautious approach. The problem of responsibility therefore arises in a somewhat unusual fashion: while one cannot say that the risk was totally unknown since one might have or should have suspected it, sanctioning such "responsibility" can only lead to a considerable restriction of entrepreneurial spirit.

One of the new dimensions introduced in the problematics of safety by the precautionary hypothesis is the time factor: the uncertainty of precaution resides to a great extent in the time-span between the cause and the manifestation of the harmful effect; the delay before one or the other of these arises can be considerable. The

precautionary hypothesis exists alongside the awareness of a dilatation of time, of a new understanding of the duration in causality of human actions. This is in stark contrast to that of the "accident." Characterized precisely by the coincidence or the proximity of the cause and effect, the accident is conventionally defined by its "sudden" or instantaneous nature. Precautionary damage hardly has this nature; either time is needed for a damage to appear (cases of gradual pollution, climate changes), or it is only afterwards that we understand that an effect resulted from a cause, a relationship that was, until then, unsuspected. The precautionary principle invites one to take account of considerably extended temporalities, which leads to the question of duration in the law of responsibility, and of the very existence of limitations. The principle specifies that "efficacious and proportionate" measures must be taken "without delay," which presupposes that, in a certain manner, it is already too late. This most often concerns avoiding the aggravation of an already existing situation.

The precautionary principle presupposes a new relationship with science and with knowledge. We knew that scientific knowledge was relative to a certain state of knowledge, that its validity was limited, that it behooved science to continually progress, and thus ceaselessly reform itself. But this is not exactly the case here. Within its domain of validity, science produces, if not definitive certainties, at least an understanding of references, recognized by the scientific community. The precautionary principle invites one to anticipate what one does not yet know, to take into account doubtful hypotheses and simple suspicions. It invites one to take seriously the most far-fetched forecasts, predictions from prophets, whether true or false, without it being easy to tell them apart. We should remember the accusation made from Heidelberg by forty Nobel Prizes against their "colleagues" meeting in Rio, at the time of the World Summit.[26] The precautionary principle returns us to an epistemology of the relativity of scientific knowledge.

The ethics of precaution are both sophistic and skeptical. They are sophistic because they presuppose that any reason is opposed by an equal reason. To repeat the formula of Protagoras, man is the measure of all things of those which he knows as well as of those which he does

26. *See Twenty-Seven U.S. Nobel Prize Winners Join 237 World Scientists in an Appeal to Heads of States Attending World Summit on Environment*, BUSINESS WIRE, June 1, 1992, *available in* LEXIS, News Group File.

not know.[27] Skeptical because one is invited to suspend judgment faced with the assertions of science. For one must take all hypotheses into account, even and in particular the most dubious, wide open to speculation, to the craziest imagination. While the attitude of prevention presupposes a relationship with knowledge that guarantees the veracity of such knowledge, the precautionary hypothesis invites one to make the most deceptive evil genie into one's constant companion.

Marie-Angèle Hermitte has already pointed out that the precautionary hypothesis leads one to take into account opinions that are acknowledged to be marginal and dissident within a scientific paradigm.[28] Going into more depth, she refers to a disrupted relationship with science where one is less interested by the confidence this provides than by the suspicions and doubts that it can arouse both on what we know and on what we do not know.[29] With precaution, one uses science as a principle of defiance. Of a two-fold defiance: defiance against itself and defiance against the many proofs that everyday gestures are not the subject of permanent anxiety. Effectively, science today provides interest less by the new knowledge that it produces than by the doubts that this knowledge introduces. Without really paying much attention, certainty today is not procured so much by the conventional method of demonstration as, rather like the Cartesian credo, in accordance with a logic of double negation: it is excluded that it is not excluded.

D. Development Risk

The extreme form of the precautionary figure is provided by the hypothesis of the risk of development. It accentuates the paradoxes and the difficulties. Here, this no longer involves suspicion, but purely and simply ignorance. An impossibility not only to understand, but even to imagine. The question posed is this: can one permit a producer or a supplier, linked by an objective responsibility in relation to the consequences of the defects of a product that she may have put in circulation, to exonerate herself in the case that she could not have foreseen the existence of such a defect? Let us go further. The risk of development presupposes a product, affected by an undetectable and

27. *See* PLATO, PROTAGORAS (C.C.W. Taylor trans., 1991) (n.d.).

28. *See generally* MARIE-ANGÈLE HERMITTE, LE SANG ET LE DROIT: ESSAI SUR LA TRANSFUSION SANGUINE (1996).

29. *See id.*

unforeseeable defect, which only becomes known after a certain span of time, and where the attribution to the product or to the producer can only be made in a different level of science than that within which the product was put in circulation, used and consumed. The most recent feature of the risk of development is having to consider a transformation in knowledge, in awareness, in the perception that transforms reality.

The hypothesis of the risk of development is new, because it presupposes that we entertain a new relationship with science and engineering. Up until now, we lived in the illusion of a possible control of science by itself. No doubt prudence was needed, but any advance in knowledge reduced uncertainty. In the field of engineering, the engineer's sciences seemed to possess a certain kind of power of infinite self-control. As new dangers were introduced, new possibilities of controlling and reducing them were provided. We lived in the hypothesis of a continually possible balance between knowledge and power. The hypothesis of the risk of development is only formulated because we are now aware both of the dynamism of science and of the essential relativity of knowledge. It is thus that contemporary epistemologists teach us that science progresses less by the accumulation and extension of knowledge than by changes of "paradigms." And we also move from one paradigm to another by the play of controversies and necessary conflicts where it is less a question of substituting the error for truth than of taking the power in the discipline. From this relativity of knowledge it can be deduced that, while scientific development always permits the discovery of new substances or new processes, it cannot do so without risk, because no state of knowledge can continue to claim a guaranteed mastery of itself. Science increases our powers and our capacities without reducing the uncertainty that it generates. There is a necessary risk of the unforeseeable. In this distance, rediscovered between power and knowledge, understanding and awareness, science and morals, we find the possibility and the necessity of a science ethic as well as the emergence of those previously unseen problems of decision-making and responsibility that we try to take into account with the precautionary hypothesis.

In terms of responsibility, the novelty of the hypothesis of the risk of development will become evident in the fact that the risk of development reveals itself necessarily after the fact, *a posteriori*. It is not in the form of the objective development of the risk – when the risk has shown itself, one has already left the hypothesis – but rather that of becoming aware that what one had believed of a certain nature was, in fact, of a different nature, foreign, even opposite. This after-effect

gives a tragic or "dramatic" quality to situations, dramatic in the sense of the blood transfusion drama.

Now, precisely, the French legal tradition, at least since the Age of Enlightenment, is loath to sanction these situations of after-effect. The law of criminal responsibility is, since the Declaration of the Rights of Man and Citizen in 1789, founded on the principle of non-retroactivity of the law.[30] "Nobody can be punished except by virtue of a law established and promulgated prior to the offence and legally applied," specifies Article 8 of the Declaration.[31] The same principle is repeated in Article 2 of the Civil Code: "The Law only provides for the future; it cannot have a retroactive effect."[32] The conventional principle of civil liability, formulated by article 1382 of the Civil Code, which introduced fault, presupposed that one could only be responsible for what one knew about; one could not be found responsible without having been aware of doing wrong.[33] Until then, one was judged and sanctioned for what one was expected to know, for what one should have known, this being necessarily defined in the context of a certain level of science and knowledge.

The question which is posed by the hypothesis of the risk of development is new in the sense that it involves settling a sort of conflict of laws over time. Can one be fair in judging an act other than in accordance with the elements that accompanied awareness of it? Is it not unjust to judge an act in line with another state of awareness than that under which it was carried out? Is it fair, even for purposes of compensation, to appraise an act in accordance with suspicions and doubts that one is only capable of assessing after the event?

One can say that with the question of the risk of development we rediscover the face of destiny, but with one difference: in the Old World, destiny wore the face of the gods, while for us, it is now always and necessarily linked to a human face. Our face of tragedy belongs to the world of technology, to those situations where, because of transformations in awareness and in the nature of things, the consumer will discover, in a sort of retroactive revelation, the evil which is hitting him. There is his disappointment, his misplaced trust on the one hand, "it wasn't what I thought, what I expected, what I was told, promised," and on the other hand, the correlative awareness of the industrial pursued for something that not only he didn't want, couldn't

30. *See generally* GEORG JELLINEK, DECLARATION OF THE RIGHTS OF MAN AND CITIZEN IN 1789 (Henry Holt & Co.) (1901).

31. *Id.*

32. C. CIV. art. 2 (Fred B. Rothman & Co. 1977) (Fr.).

33. C. CIV. art. 1382 (Fred B. Rothman & Co. 1977) (Fr.).

want, but which he had done everything to avoid: "I didn't do that, I didn't want that, I couldn't want that." The question only arises alongside a new situation of the knowledge-power relationship and the problems of responsibility that it poses, that based on awareness that our societies are vulnerable to a new type of risk, in a new awareness of tragedy.

E. The Return of Responsibility

It is no doubt in the now famous book by Hans Jonas, *The Imperative of Responsibility*,[34] that one can find the philosophical bedrock of the precautionary principle. The importance of this book, written during the 1970s, is to highlight the philosophical framework that is found in the background of contemporary ecological awareness. For Hans Jonas, the history of humanity is marked by a firm division, distinguishing the ancient world from the modern world. Man's relationship with nature has reversed itself: while for a long time man was only a being *in* nature, he has now, thanks to science and technology, gained control of nature. The balance of powers has shifted to the benefit of man who now possesses the capacity to destroy himself and the nature which surrounds him. It is from this considerable increase in power that is born responsibility in the sense given to it by Hans Jonas. Man must be aware of his power as unlimited, sovereign, in the sense of an infinite capacity to produce effects that he could not anticipate with certainty and in the sense that he has no other master than himself. This is the first thesis from Hans Jonas: the world of ecology is a world of the most extreme responsibilities, a world where man no longer has nature as guide, a world of radical uncertainty, therefore also of necessary decision.

The powers of modern man confer upon him an infinite responsibility. His nature is revealed in fear, a feeling that makes man aware of the power of his new capacities. On one hand temporality, within which is situated his action, dilates to encompass the whole history of humanity, past and future, but it must be acknowledged that his powers are such that they threaten the existence of life itself. Contemporary man is becoming aware of himself in the feeling of anguish before the possibilities of annihilation that he bears in himself: for the first time, he is discovering in himself the power to commit suicide as a species. Faced with this possibility, and in order to

34. HANS JONAS, THE IMPERATIVE OF RESPONSIBILITY (Hans Jonas trans., in collaboration with David Herr, Univ. of Chicago Press) (1984).

overcome his anguish, modern man is on a quest to find the rules of a morality that will limit his powers: the ethics of responsibility. His enormous power needs holding.

The ethics of responsibility contain the risk and uncertainty to the extent that modern man must take account in his actions, both their long term consequences and their possibility of sweeping along with them, at least in certain cases, the worst, the catastrophe. Instead of the categorical Kantian imperative, there should be substituted an imperative adapted to the new type of human action: "Act so that the effects of your action are compatible with the permanence of an authentically humane life on earth."[35] For while we have the right to risk our own lives, we do not have the right to risk that of humanity. This imperative is the basis of the precautionary principle: it invites us to measure each of our actions against the principle of the worst scenario. Morality becomes a sort of negative morality: it is not so much turned towards the positive quest for the best as towards the avoidance of the worst. The uncertainty of long term prognostics confers the nature of a wager on human action, which leads to questions such as: do I have the right to endanger the interests of others in my wager?

Contrary to the supreme good and eternal timelessness, the aim of responsibility is the perishable, the vulnerable. The new obligation, born from threat, focuses on the ethics of conservation, of preservation, of impediment. For we are living in an apocalyptic situation that is in the imminence of a universal catastrophe due to the excessive powers of our scientific, technical and industrial civilization. It is necessary to "kiss goodbye to the utopian ideal" and to denounce the psychological danger of the promise of prosperity. After the warnings of the Rome Convention, Jonas is not afraid to affirm that "restriction, far less than growth, should become the watchword."[36]

The appearance of a new word is never without significance. The 19th century invented providence and made it into the highest of virtues. The 20th century replaced providence with prevention – providence made compulsory for reasons of social security. Now we have precaution. These are three attitudes before uncertainty. Providence is linked to the notions of fate, chance and misfortune, and hazard. It involves incorporating the future into the present, but on an individual scale and with the idea of a possible mastery of the event. Insurance has for a long time been presented as the science of

35. *Id.* at 5.
36. *Id.* at 190.

providence. The logic, essentially liberal, of individual providence was, at the end of the 19th century, a victim of the Pasteur-Léon Bourgeois association: Pasteur's discovery of infection showed that the well-being of each person did not depend solely on his own conduct but also on that of his neighbor. From that time it became possible, for reasons of public health, to impose, when faced with risks, certain behaviors that one can call by the name, new at the time with this meaning, of prevention. Prevention is a rational conduct faced with an evil that science can objectify and measure. Providence was contemporary with an ignorance of the hazards of existence; prevention develops from the certainties of science. It speaks the same language and beckons toward the reduction of risks and their probability. Prevention is a matter for experts who are confident in their knowledge. Precaution, such as we are seeing emerge today, focuses on another nature of uncertainty – the uncertainty of scientific knowledge itself.

Here, it is evident that the precautionary hypothesis echoes the ontological and epistemological conditions that are neither those that saw the emergence of providence, nor those which presuppose prevention. Precaution is not the result of an individualistic ontology such as providence. The threats that it involves are immediately collective. It implies motivations that are not only regional, but rather international. But it does not participate either in the contemporary preventive dream of solidarism.

The recent formulation of the precautionary principle is doubtless linked to several factors. First of all, there is the awareness of the utopian nature, relative and limited, of the attitude of prevention. We are, in fact, seeing the proof that our societies, and the individuals in our societies, are threatened by risks that can be disastrous, introduced within the very act that sought to reduce them. The issue of medical accidents at the age of what Jean Hamburger has called the therapeutic revolution exemplifies this problematic. When our societies discover themselves, in accordance with the now sacred term, to be "vulnerable," they experience a certain inseparability of good and evil, that, in accordance with the paradigm of prevention, was thought to have been indefinitely separated. We are also aware of the relativity of scientific knowledge and of the necessity for a science ethic, and finally of the excess of our powers over knowledge which is nevertheless at their foundations. Modern science no longer offers a knowledge that is always and necessarily uncertain, as seen, for example, in the birth and proliferation of ethics committees. It is seeking its own legislation. It never ceases doubting the effects of its own development. The building of nuclear power stations demanded

strict measures of prevention. This was the task of the engineers. The blood transfusion drama put a halt, if not to scientific knowledge itself, at least to certain terms of the relationship that we had with it. Regrettably, those responsible had been able to claim that they were only able to make decisions based on scientific certainties and had not adopted a precautionary attitude.

Precaution starts when the decision (necessary) must be made by reason of and in the context of a scientific uncertainty. Decisions are therefore made not in a context of certainty, nor even of available knowledge, but of doubt, suspicion, premonition, foreboding, defiance, mistrust, fear, and anxiety. There is to some extent a risk beyond risk, of which we do not have, nor cannot have, the knowledge or the measure. The hypothesis of the risk of development is found within the limit of this new figure of prudence. We have seen, in fact, that, once we are aware of the existence of the risk of development, we can no longer plead for the industry to put in circulation a product offering total quality, since, by hypothesis, the notion affirms that this is not possible. Precaution finds its condition of possibility in a sort of hiatus and time-shift between the requirements of action and the certainty of knowledge. It enters into a new modality of the relationship between knowledge and power. The age of precaution is an age which reformulates the Cartesian demand for the necessity of a methodical doubt. Precaution results from an ethic of the necessary decision in a context of uncertainty. The appearance of the precautionary principle is one of the signs of the profound philosophical and sociological transformations which characterize this end of century.

F. Precaution and the Risk Society

In the mid-1980s, Ulrich Beck published *Risk Society*,[37] a widely read book in which he demonstrated how contemporary societies revolve around the notion of risk. He could not have known then that his hypotheses would be borne out by the appearance and future developments of the precautionary principle.

In effect, the principle of precaution rounds out the agenda of the "risk society" in several ways. First of all, the principle of precaution appears as one of the primary instruments of "reflexive modernization" which, as Beck demonstrates, is characteristic of postmodernism. Through the notion of precaution, modern society thinks about its

37. *See* ULRICH BECK, RISK SOCIETY: TOWARDS A NEW MODERNITY (Mark Ritter trans., Sage Publications 1992).

problems and questions its basic assumptions. More than ever, modern society finds itself cut off from the natural world, removed as it were from the scientific and technological project on which it is based. Precaution appears when scientific expertise comes up against its own limitations and forces the politician to make sovereign decisions, alone and without recourse to others. It can perhaps be said that, with the principle of precaution, the analysis made by Beck within a specific national context has become an international preoccupation. Indeed, the true sphere in which the principle of precaution applies is international law – environmental law, trade law and government liability. Along with the principle of precaution, the notion of "reflexive modernization" has become a central preoccupation of the international community.

Through the notion of precaution, the experience of risk takes on three additional dimensions that build on the descriptions provided in *Risk Society*. First, the power dimension. The issues of liability and risk are linked to the phenomenal technological capabilities that we have achieved. The industrial "will to power" – to borrow Nietzsche's famous formulation[38] – is apparent in the proliferation of highly efficient technical systems. As this century comes to a close, industrial power is such that it no longer only causes accidents, but also catastrophes. We experience the industrial promise as fraught with the threat of disaster. When the multinational firms which manufacture GMOs (genetically modified organisms) state that, thanks to their efforts, world hunger will soon be eradicated and that environmental problems linked to intensive farming are already a thing of the past, the news sets off alarm bells. This is because such exploits are in fact tremendous displays of strength. Modern industrial power is a super-power of such might that the horizon of our accountability necessarily extends over the very long term. We are responsible for future generations. The Stoics, in an attempt to free man from worry, suggested that he draw a distinction between that which depends on us and that which does not, it being understood that we are only accountable for those things over which we have control. The problem with industrial power is that it appears that we no longer have control over anything. Hence the boundless nature of liability that is so worrisome. It leaves no room for innocence, as we can see from the rarefaction in law of the notions of the fortuitous event and *force majeure* (or act of God). However, this sense of boundlessness is

38. *See generally*, FRIEDRICH WILHELM NIETZSCHE, THE WILL TO POWER (Walter Kaufmann ed. & R.J. Hollingdale trans., Random House 1967).

merely the reflection of our awareness of contemporary industrial power.

But as Beck points out, risk is also a social relationship. The notion of precaution also raises the issue of power relationships in a global society in an era of globalization. Specifically, the power of the industrial society is exercised through relations of power, which are fundamentally asymmetrical. Modern technologies create dependencies, not equality. The more technologically developed societies become, the less they seem capable of being governed by the contractual model. The asymmetrical relationship between employer and employee is consecrated by the notion of the employment contract, which organizes the employee's subordination and the apportioning liability for professional risks. The relationship between producer and consumer is also asymmetrical, as is the relationship between the professional and the layman, underpinning the right to consume. Today, questions of liability turn essentially on these asymmetries. It is this asymmetrical dimension, and the feeling of dependency to which it gives rise, that lie at the heart of precaution. Risk is not only a danger, it is a social relationship. It is the relationship between those who have technological power and those who benefit or perhaps suffer from it.

Power in the relationship with nature, and power in relationships between human beings, leave the third dimension of the experience of precaution: that of harm suffered. In the industrial society, it is believed that activity and business are impossible without risk. Risk is considered normal; it is not contested in and of itself. The only question is how to organize the apportioning of risk. We can't even conceive of the idea that the acceptability of an activity or business could hinge on its posing no risk for others, provided that we do not hold liable only those who suffer harm due to the risk, and that those who put others at risk be held responsible.

With precaution, we are witnessing a remarkable change in this schema. The problem is no longer so much to multiply the responsibility for risk and to organize the solvency of those who are liable through insurance, but rather to prevent certain risks from being taken. Not only is prevention taking precedence over compensation – we are also trying to anticipate and prevent risks whose existence has not been proven. There are two major reasons for this: one is that the nature of damages has changed from mere individual accidents to catastrophes, and the other is that there has been a re-evaluation of the cost of risk. A perfect illustration of the new scale on which risk is measured: during the First World War, a general could send 300,000 soldiers to their death in waves of fifteen, as in the battle of the

Chemin des Dames. Today, the only acceptable war is the "zero risk" war. This is a peculiar transmutation of values. In the traditional cost benefit trade-off, it was enough that the advantages sufficiently outweigh the risks for us to feel justified in taking them and thereby accepting the residual portion of the risk taken. Today, we tend to measure the risk on the basis of this residual portion: what is worth sacrificing for this? Are those who are unlucky enough to be among the victims of so much less value than the others? This is the method of valuation that lies behind the zero risk problematic.

CONCLUSION

1. If it appears that precaution results from an appropriate epistemologico-legal system, that it is correct to distinguish between providence and prevention, and that precaution introduces a world which is neither that of responsibility nor of solidarity, it should be remembered that these three formations, far from being incompatible, are in fact complementary. It does not involve three worlds that succeed each other over time, each replacing another; it is rather three attitudes with regard to uncertainty, assessed and developed at three moments in time. They already existed before receiving the formalizations that have been seen over the last two centuries. It consists of three faces of prudence, to the extent that we interpret this notion in the sense that Aristotle gave it of behavior in the face of uncertainty. These three attitudes are not themselves the only possible attitudes of prudence. They each have their field of competence and areas of validity. For this reason, it is essential not to confuse them and to respect their spheres of influence and jurisdiction: while providence is always necessary, it is inadequate in order to affront these "global threats" which, themselves, relativize the attitude of prevention. Precaution condemns neither providence, nor prevention. It only introduces another level of preoccupation in the conduct of human in certain situations of uncertainty.

2. Precaution reintroduces, in the real meaning of the term, decision-making in policy, and in the practices of responsibility. The true decision is the sovereign decision. Conventional law on responsibility sanctions less a decision well or badly taken than the non-respect of available knowledge. The logics of fault and prevention presuppose that, in the spheres they govern that, it is always possible to explain a standard of conduct that everyone must observe. One incurs one's responsibility as soon as one does not respect the practical consequences of available knowledge, which itself makes possible the definition of the sanctioned obligation. Precaution, which re-situates us

in a context of uncertainty, reintroduces a logic of pure decision. And the rationality of the decision can no longer satisfy itself with the conventional cost-advantage balance, which is in principle unknown or at least dubious. It results from logics which risk economists explain as irreducible to the conventional functions of utility. This results in a two-fold consequence: the decision still belongs to the politician without being able to have access to expert knowledge, and it is the result more of an ethic, of the respect of certain procedures, than of a morality, linked to the application of a preexisting framework. This does not mean that scientific expertise is useless, but that it will not release the politician from the sovereignty of his or her decision.

3. Precaution, to a certain extent, brings us out of the age of insurance societies. It describes a world where, in principle, compensation no longer has a meaning, since the only rational attitude was to avoid the occurrence of a threat with irreversible consequences. Precaution is an attitude of protection rather than compensation. And it is true that, concurrent with the growth of the theme of precaution, one can observe a great prudence from insurers as to the possibility of covering the corresponding damages. This is understandable: one is in the order of the unlimited (from the point of view of amounts), not only of the indefinite, but also the undefinable (from the point of view of risk). But precaution does not itself disqualify the need for compensation once the threats at issue have consequences for individuals. From this point of view, precautionary logic accentuates the dissociation between responsibility and compensation which already characterized the face of solidarity. If the cause of damage is no longer the result, properly speaking, of a logic of risk, the same cannot be said of compensation. It does, however, impose the construction of new outlines: contractual definition of the risks covered either by a limitation of the duration of commitments, by fixing excesses and limits of coverage, or by changing the size of scopes of mutualization. In this respect, the mechanism implemented in France in 1982 for the coverage of natural disasters provides an interesting model: it makes prevention into a political function; it institutes a mechanism for solidary compensation, at two levels, anticipating if necessary cover from the State once it is necessary to face up to a super-disaster.[39]

Responsibility, in the strict sense of the word, corresponds to providence and solidarity to prevention. Categories that were

39. *See generally* Serge Magnan, *Catastrophe Insurance System in France*, 20 GENEVA PAPERS ON RISK AND INS. 474-80 (1995).

simultaneously moral, political and economic, responsibility and solidarity described a form of social contract, a method of distribution of rights and obligations in society. The word is missing that would correspond to them within the precautionary paradigm. Maybe one can, while waiting for better, speak of *safety*, inasmuch as the term describes, as in nuclear terms, a particularly strict safety requirement. And, in fact, in the long term, precaution demonstrates a sort of inflexion in our attitude with regard to risk. Fear, from which our societies had perhaps, in accordance with the progressive utopia of the 20th century, believed they could free themselves, returns in a new form. Solidarity had almost made us riskophiles; now we are almost riskophobes, individually and collectively. And for a period which, without doubt, will not limit itself to the situation at the end of this century.

The emergence of precaution accompanies the crisis of progress, a certain over-valuation of the past in relation to the future, the desire to limit the destructive effects of time, and perhaps also a new suspicion aroused on the human species and the rationality of its development. This occurs with the proviso that what is concerned is freedom, enterprise, innovation, their unwanted consequences, in the long term, on the scale of the species. Precaution is a way of raising, considerably, the price of innovation. The alert has been given by a succession of affairs in the sectors of the environment and public health. Damage, serious and irreversible, has been caused which it is now apparent, after the event, was possible to have been avoided by the observation of a precautionary attitude. They are behind the crisis of confidence that means that the spirit of enterprise, of creation, and of innovation, even in this period of unemployment, is no longer valued as before, with a certain privilege being given to abstention. In the age of precaution, the value of enterprise depends less on the well-being that it procures, than on the urgency and the degree of necessity for products that it makes available. We wondered, in a previous age, whether it was better to have a big enterprise or a small enterprise; now what counts is frugality. Paradoxically, at the dawn of the 21st century, value is no longer in abundance, but in scarcity. So be it, but if precaution is no doubt necessary, one can also fear the consequences of too great a precaution. Precaution demands regulation.

At the same time that we become aware that certain activities demand a precautionary attitude, and that precaution is being discovered as a principle of responsibility, we are seeing the formulation of precautionary legislation. In fact, precaution may be the worst or the best of principles. The saying goes: "When in doubt, do nothing." The risk of precaution results in inaction. As the

complementary saying goes "Too many cooks spoil the broth." The precautions to take in the context of a technologically developed society are no doubt necessary, but, as said in the principle, they must remain "reasonable" to prevent them from leading to an exhaustion of innovation and therefore to a revolutionary change in society with even more redoubtable consequences. This is the difficult knife's edge that we must tread in pursuit of the idea of sustainable development.

EVIDENTIARY SUFFICIENCY IN INSURANCE BAD FAITH SUITS

*William T. Barker**

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INTRODUCTION

Texas courts have recently struggled to define the standard for appellate review of the legal sufficiency of evidence in insurance bad faith cases. No consensus has been achieved, as demonstrated by the fractured

court in *Universe Life Insurance Co. v. Giles*.[1] Other jurisdictions have not perceived similar problems, but both the substantive standard for bad faith and appellate review standards are much the same elsewhere,[2] so they could now do so after reviewing the Texas debate.

Courts elsewhere have generally handled this issue correctly, if inarticulately.[3] But if forced to think about it, they might find themselves in the same predicament as the Texas courts unless they come to an explicit understanding of the more sophisticated analysis which supports the treatment they have adopted implicitly.[4] Moreover, examination of this issue illuminates fundamental issues about the very nature of the bad faith tort.[5]

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1. 950 S.W.2d 48 (Tex. 1997). Justice Spector wrote for a plurality of four justices. Justice Hecht wrote a concurring opinion for another group of four, taking a fundamentally different approach. Justice Enoch wrote a separate concurrence, disagreeing with both groups.

Giles is the subject of a casenote. *See* Justin L. Jeter, Note, *Is* Universe Life Insurance Co. v. Giles *a Reasonable Alternative to the "No Reasonable Basis" Standard of Bad Faith Liability?*, 51 BAYLOR L. REV. 175 (1999). It concludes, as I do, that *Giles* fails to provide the clarification of bad faith law necessary to solve the problem with which the court wrestled. *See id.* at 188. This article seeks to provide the necessary clarification.

2. To demonstrate the similarity of Texas bad faith standards to those elsewhere, the footnotes to this article extensively document the similarity of California law. In addition, secondary authorities and selected cases from additional jurisdictions are cited throughout this article.

3. The standard for appellate review of legal sufficiency is the same as that for summary judgment or directed verdict: whether there is evidence which would permit a fact finder to characterize the claim handling as inconsistent with good faith. A nationwide review of the law on this point can be found in William T. Barker & Paul E.B. Glad, *Use of Summary Judgment in Defense of Bad Faith Actions Involving First-Party Insurance*, 30 TORT & INS. L.J. 49 (1994). The decisions reviewed are "inarticulate" only in the sense that they fail to reconcile their (reasonably uniform) holdings with the requirement to respect the authority of the fact finder. *See also* Steven Alan Childress, *Judicial Review and Diversity Jurisdiction: Solving an Irrepressible Erie Mystery?*, 47 SMU L. REV. 271 (1994) (advocating a uniform rule for appellate review in federal diversity cases).

4. An analogy is the proverbial centipede who lost the ability to walk when asked to explain how he did it. Of course, it is not unusual for common law courts to develop sound rules which they cannot (or at least do not) adequately explain.

5. Florida and Montana have rejected fundamental tenets of bad faith law generally accepted elsewhere, most notably by holding that erroneous denial of a claim always creates a jury issue as to the reasonableness of the insurer's denial. State Farm Mut. Auto. Ins. Co. v. Laforet, 658 So. 2d 55, 62-63 (Fla. 1995); Dean v. Austin Mut. Ins. Co., 869 P.2d 256, 258 (Mont. 1994). Neither jurisdiction has clarified the nature of the inquiry it considers necessary to determine whether an erroneous denial is tortious. For reasons discussed *infra* Part IVB, pp. 97-98, and Part V, pp. 111-25, I think a tort not limited in the ways described

A solution is inherent in current Texas law and other legal authority. If the implications of existing law are properly appreciated, the problems that have vexed Texas courts can be resolved.

I. THE PROBLEM

Justice Spector stated the problem in *Giles*:

> A plaintiff in a bad-faith case must prove the *absence* of a reasonable basis to deny the claim, a negative proposition. Yet, under our no-evidence standard of review, an appellate court must resolve all conflicts in the evidence and draw all inferences in favor of a bad-faith finding. It has been argued, then, that if the reviewing court must give no weight to the insurer's evidence of a reasonable basis for the denial or delay in payment of a claim, no judgment can be reversed for want of evidence because there will never be any evidence of a reasonable basis.[6]

Yet judgments plainly can be reversed for legally insufficient evidence (also known as "no evidence"), as shown by *Lyons v. Millers Casualty Insurance Co. of Texas*,[7] *National Union Fire Insurance Co. v. Dominguez*,[8] and *United States Fire Insurance Co. v. Williams*.[9] No current member of the Texas court has suggested that these cases were wrongly

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in this note inappropriately increases the cost of insurance solely to confer windfalls on sympathetic plaintiffs.

6. 950 S.W.2d at 51 (Spector, J., announcing the judgment) (citations omitted) (footnote omitted). Justice Hecht echoed this statement of the issue:

> Bad faith liability ... depends in part on a determination that an insurer had no reasonable basis for denying or delaying payment of a claim. The reasonableness of the insurer's decision can be judged only by weighing the evidence for and against the claim. But no-evidence review of a jury finding forbids weighing of evidence by an appellate court .... Thus, by definition, no-evidence review of a jury finding of bad faith based on conflicting evidence is impossible.

Id. at 58 (Hecht, J., concurring).

7. 866 S.W.2d 597 (Tex. 1993).

8. 873 S.W.2d 373 (Tex. 1994).

9. 955 S.W.2d 267, 268 (Tex. 1997). *See* discussion *infra* notes 120-22.

decided, so the problem is to explain them in a way which allows other courts to decide whether the same analysis applies to a different record.[10] In fact, the problem thus defined is solved by a proper understanding of the substance of bad faith law and of the evidentiary burdens implicit in that substantive law, which can readily be integrated with the law stating the standard for "no evidence" review.

II. A PROPOSED SOLUTION

Both the purposes of the bad faith tort and the decisions of the Texas Supreme Court (like those in all but a few other jurisdictions) show that what the law of bad faith forbids is requiring the insured to litigate a claim which presents no question requiring litigation.

Insurers have the ability to exploit the needs of insureds who have suffered losses they cannot afford to bear. If limited to ordinary contractual remedies, such insureds might find it necessary to accept inadequate compromise settlements of claims, which are clearly due. The bad faith tort is recognized to prevent and remedy such abuses. But the bad faith tort must be confined, in order to protect the ability of insurers to prevent the inflated costs to insurance buyers that would result from paying unmeritorious claims. Consequently, an insurer is not liable in tort unless it lacked a "reasonable basis" to withhold payment, a basis which shows that there is a bona fide dispute as to the insured's right to payment. Such a dispute warrants "testing the claim in court" and precludes liability for requiring the insured to litigate.

The nature of the bad faith tort establishes that it is not analogous to professional malpractice, but instead to malicious prosecution. The "reasonable basis" which justifies an insurer's "testing the claim in court" is similar to the probable cause that justifies bringing a prosecution.

To establish a prima facie case of bad faith an insured must show that (1) the claim was payable under the contract and (2) enough information was available to the insurer to establish that right to payment. The insurer can defend by articulating one or more grounds on which it disputes that the claim is or was payable, and by producing evidence on which it relies to support that position. The insured must then present evidence, sufficient if

10. For a more recent example, although not one unanimously approved by the court's members, see Provident Am. Ins. Co. v. Castañeda, 988 S.W.2d 189 (Tex. 1998).

believed, to show that each of the grounds relied upon by the insurer failed to constitute a bona fide dispute.

In conducting "no evidence" review of a verdict for the insured in a bad faith case, the appellate court must first consider what the insurer relied upon, or could have relied upon, insofar as that is shown by undisputed evidence. It must then consider whether the evidence presented by the insured can support a finding that none of the grounds relied upon by the insurer warranted "testing the claim in court."

I now turn to the analysis that shows this solution to be correct, as a matter of policy, of current Texas law, and the law in almost all other jurisdictions recognizing the bad faith tort. While much of the problem relates to the substance of bad faith law, it arises in the context of the methodology for no-evidence review. Therefore, I begin by addressing that methodology in Part I. Part II expounds the substance of bad faith law, the burdens of proof implied by that substance, and the way in which those burdens solve the problems that troubled the court in *Giles*. Part III critiques an alternate view of bad faith law which I suspect underlies the confusion about appellate review. Part IV applies the analysis to insurer use of expert testimony on coverage to rebut allegations of bad faith, a problem addressed in *State Farm Lloyds v. Nicolau.*[11] Part V examines the use of circumstantial evidence, a problem presented, though not fully analyzed, in *State Farm Fire & Casualty Co. v. Simmons.*[12]

III. THE STANDARD FOR "NO EVIDENCE" REVIEW PROTECTS THE RIGHT OF THE FACT FINDER TO RESOLVE CONFLICTS IN THE EVIDENCE AND ITS INFERENCES, BUT IT NEITHER REQUIRES NOR PERMITS DISREGARDING UNCONTRADICTED EVIDENCE.

"No evidence" review must be sharply distinguished from review of the factual sufficiency of the evidence supporting a verdict. Review of

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11. 951 S.W.2d 444 (Tex. 1997). Much of the analysis in this article was developed for an amicus brief in support of a rehearing in *Nicolau* (filed by United Services Automobile Association, Allstate Insurance Company, Nationwide Insurance Companies, the American Insurance Association, the National Association of Independent Insurers ("NAII"), and the Alliance of American Insurers).

12. 963 S.W.2d 42 (Tex. 1998). Some of the analysis in this article was developed for use in an amicus brief on the merits in *Simmons* (filed by the National Association of Independent Insurers).

factual sufficiency allows the appellate court to weigh all the evidence and grant a new trial if the jury's verdict is "so against the great weight and preponderance of the evidence as to be manifestly unjust."[13] "No evidence" review, on the other hand, addresses the question of whether the evidence, together with the applicable burden of proof, requires a conclusion contrary to the verdict as a matter of law.[14] If this is so, the result is entry of judgment accordingly, not the mere grant of a new trial. Texas may be unique in allowing appellate review of the weight of the evidence. But "factual sufficiency" review is important here only as a contrast to "no evidence" review. The Texas "no evidence" review for "legal sufficiency" is essentially the same one other jurisdictions conduct under the name of "sufficiency" of the evidence to support a verdict.[15]

Fact finders are empowered to weigh conflicting evidence, to decide which view to accept, and to select among competing inferences that might be drawn from the evidence.[16] Factual sufficiency review considers

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13. *In re* King's Estate, 244 S.W.2d 660, 661 (Tex. 1951). *See, e.g,* Robert W. Calvert, *"No Evidence" and "Insufficient Evidence" Points of Error*, 38 TEX. L. Rev. 359, 366-68 (1960); W. Wendell Hall, *Revisiting Standards of Review in Civil Appeals*, 24 ST. MARY'S L.J. 1045, 1136-39 (1993); William Powers, Jr. & Jack Ratliff, *Another Look at "No Evidence" and "Insufficient Evidence,"* 69 TEX. L. REV. 515, 525-26 (1991).

14. *See In re* King's Estate, 244 S.W.2d at 661; Calvert, *supra* note 13, at 362-65; Hall, *supra* note 13, at 1115-16; Powers & Ratliff, *supra* note 13, at 519-25.

15. *See, e.g.*, Murray v. Laborers Union Local No. 324, 55 F.3d 1445, 1452 (9th Cir. 1995); *see also* Maynard v. City of San Jose, 37 F.3d 1396, 1404 (9th Cir. 1994); Bowers v. Bernards, 197 Cal. Rptr. 925, 926-27 (Cal. Ct. App. 1984) (holding that California courts must uphold a verdict supported by substantial evidence, even if the reviewing judges would have decided the matter differently or there is other substantial evidence that would have supported a contrary result); Bickel v. City of Piedmont, 68 Cal. Rptr. 758, 765 (Cal. 1997); Thompson v. Jacobs, 314 So. 2d 797, 799 (Fla. Dist. Ct. App. 1975) (finding that jury decides conflicts in evidence and inferences from the evidence); Vanzant v. Davies, 215 So. 2d 504, 505 (Fla. Dist. Ct. App. 1968); Birth Ctr. v. St. Paul Cos., 727 A.2d 1144, 1162 (Pa. Super. Ct. 1999) ("Courts should not interfere with the jury's determination unless the verdict is unsupported by the evidence or was the product of partiality, prejudice, mistake, corruption, or some other improper influence."); Tagliati v. Nationwide Ins. Co., 720 A.2d 1051, 1052-53 (Pa. Super. Ct. 1998).

16. This is especially so in jury trials, but a court's findings of fact in a non-jury matter are equally binding on Texas appellate courts, and those of some other states. *See* McGallard v. Kuhlmann, 722 S.W.2d 694, 696 (Tex. 1986); *accord* Alderson v. Alderson, 225 Cal. Rptr. 610, 618 (Cal. Ct. App. 1986); *Bowers*, 197 Cal. Rptr. at 926-27; *Tagliati*, 720 A.2d at 1052-53; Romano v. Nationwide Mut. Fire Ins. Co., 646 A.2d 1228, 1231 (Pa. Super. Ct. 1994). Federal courts and those in some other jurisdictions have a slightly greater ability to substitute their own view of non-jury findings that they deem "clearly erroneous." FED. R. CIV. P. 52(a); *see also* Adler v. Federal Republic of Nigeria, 107 F.3d 720, 729 (9th

whether the result of the process of weighing and selection is suspect. "No evidence" review, in contrast, defers completely to that weighing and selection: *a court reviewing a "no evidence" point may not reweigh the evidence.*[17] Rather, the finding must stand "if there is any evidence of probative force to support" it.[18] This limited review has two rationales. First, it acknowledges that the trial judge and jury are the only ones capable of evaluating the witnesses' demeanor. Second, it recognizes the division in the court system: trial courts are supposed to decide facts; appellate courts are supposed to decide legal issues.[19] In some jurisdictions, this distinction is considered jurisdictional.[20]

The rule against reweighing the evidence is frequently expressed in a shorthand form: the reviewing court is said to "consider only the evidence and inferences tending to support the jury verdict and disregard all evidence to the contrary" in deciding whether the evidence is sufficient to support the verdict.[21] But that is an oversimplification, for courts do not

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Cir. 1997) (reviewing trial court's findings of fact for clear error). Even if bench trials of bad faith cases were common, it is not necessary to resort to that power to conduct the sort of review discussed here.

17. *See* Havner v. E-Z Mart Stores, Inc., 825 S.W.2d 456, 461 (Tex. 1992); *see also* Woods v. United States, 724 F.2d 1444, 1451 (9th Cir. 1984) (holding that appellate courts should uphold reasonable inferences); Phelps Dodge Corp. v. Occupational Safety & Health Ass'n Comm'n, 725 F.2d 1237, 1239 (9th Cir. 1984); *Bowers*, 197 Cal. Rptr. at 927; Barber v. Rancho Mortgage & Inv. Corp., 32 Cal. Rptr. 2d 906, 911 (Cal. Ct. App. 1994).

18. *In re* King's Estate, 244 S.W.2d at 661; *accord* Kuhn v. Department of Gen. Servs., 29 Cal. Rptr. 2d 191, 194 (Cal. Ct. App. 1994); Toyota Motor Sales U.S.A., Inc. v. Superior Court, 269 Cal. Rptr. 647, 651 (Cal. Ct. App. 1990).

19. *See* Maslow v. Maslow, 255 P.2d 65 (Cal. 1953); Tupman v. Haberkern, 280 P. 970, 973 (Cal. 1929).

20. *See* TEX. CONST. art. V, §§ 2, 3 (providing that the Texas Supreme Court has no review of the factual sufficiency of the evidence as long as there is legally sufficient evidence); *see also* TEX. REV. CIV. STAT. ANN. art 1728 (West 1962) (same); Harmon v. Sohio Pipeline Co., 623 S.W.2d 314, 314-15 (Tex. 1981) (reasoning that the Texas Supreme Court cannot review the factual sufficiency of the evidence, but can review whether the appellate court applied the proper standard in its review [i.e. whether certain evidence is sufficient as a matter of law] because that is a question of law, not fact); *Tupman*, 280 P. at 973. *But see Kuhn*, 29 Cal. Rptr. 2d at 194 (reasoning that limited review of factual determinations is a matter of self-imposed policy, not jurisdiction).

21. Juliette Fowler Homes, Inc v. Welch Assoc., Inc., 793 S.W.2d 660, 666 (Tex. 1990); *see also* Allison v. Ticor Title Ins. Co., 979 F.2d 1187, 1193-96 (7th Cir. 1992) (applying Wisconsin standard of review); DeMaine v. Bank One, 904 F.2d 219, 220 (4th Cir. 1990) (applying North Carolina standard of review); LaRoche Indus., Inc. v. AIG Risk Mgmt., Inc., 959 F.2d 189, 193 (11th Cir. 1992) (applying Georgia standard of review); Truan v. Smith, 578 S.W.2d 73, 74 (Tenn. 1979).

disregard undisputed evidence.[22] When evidence concerning a vital fact is uncontradicted and proven conclusively, its effect is a question of law and there is no issue for the fact finder.[23] Thus, a precise statement of the complete rule calls for the consideration of all of the evidence supporting the verdict *and* all of the evidence contrary to the verdict which the fact finder is required to accept.[24]

Nor does a court consider inferences from the direct evidence that are so weak as to amount to a mere scintilla of evidence.[25] And, even if the evidence favorable to the verdict could, standing alone, support an inference favorable to the verdict, that inference could still be so undermined by other, undisputed evidence that it is reduced to a scintilla.[26] Thus, consideration of undisputed evidence can affect the inferences which are permissible.

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22. *See, e.g.*, Universe Life Ins. Co. v. Giles, 950 S.W.2d 48, 51 n.1 (Spector, J., announcing the judgment); *id.* at 74 (Hecht, J., concurring); Cecil v. Smith, 804 S.W.2d 509, 510 n.2 (Tex. 1991).

23. *See* Sullivan v. Barnett, 471 S.W.2d 39, 44 (Tex. 1971); *accord* Correll v. Elkins, 195 So. 2d 27 (Fla. Dist. Ct. App. 1967); Harris v. State, 104 So. 2d 739 (Fla. Dist. Ct. App. 1958); *see also* Tampa & Jacksonville Ry. Co. v. Crawford, 64 So. 437 (Fla. 1914). As an example of such evidence, the uncontradicted testimony of even an interested witness may conclusively establish a fact if that testimony is clear, direct and positive and there are no circumstances in evidence tending to impeach or discredit that testimony. *See* McGalliard v. Kuhlmann, 722 S.W.2d 694, 697 (Tex. 1986); *see also* Containerfreight Corp. v. United States, 752 F.2d 419, 422 (9th Cir. 1985); People v. Bassett, 70 Cal. Rptr. 193, 203 (Cal. 1968); *Kuhn*, 29 Cal. Rptr. 2d at 194.

24. *See* 9A CHARLES ALAN WRIGHT & ARTHUR R. MILLER, FEDERAL PRACTICE AND PROCEDURE § 2529 at 298-99 (1995) (stating standard under similar federal "substantial evidence" standard); Richardson v. Perales, 402 U.S. 389, 401 (1971); Alderman v. Securities & Exch. Comm'n, 104 F.3d 285, 288 (9th Cir. 1997); Container Stevedoring Co. v. Director, Office of Workers' Compensation Programs, 935 F.2d 1544, 1546 (9th Cir. 1991); Information Providers Coalition v. FCC, 928 F.2d 866, 870 (9th Cir. 1991); *accord* Tagliati v. Nationwide Ins. Co., 720 A.2d 1051, 1052-53 (Pa. Super. Ct. 1998); Alberici v. Safeguard Mut. Ins. Co., 664 A.2d 110, 113 (Pa. Super. Ct. 1995); People v. Johnson, 162 Cal. Rptr. 431, 444 (Cal. 1980).

25. *See* Continental Coffee Prods. Co. v. Cazarez, 937 S.W.2d 444, 450 (Tex. 1996). Similarly, in the federal courts, inferences drawn from facts that are "uncertain and speculative and which raise only a conjecture or possibility" do not provide a sufficient basis for upholding a verdict. Woods v. United States, 724 F.2d 1444, 1451 (9th Cir. 1984); Phelps Dodge v. Occupational Safety & Health Ass'n Comm'n, 725 F.2d 1237, 1239 (9th Cir. 1984).

26. *See Kuhn*, 29 Cal. Rptr. 2d at 194 ("The ultimate determination is whether a *reasonable* trier of fact could have found for the respondent based on the *whole* record.").

This explains the otherwise puzzling need for Texas courts to review all of the evidence in a case where gross negligence has been found.[27] Review of everything is necessary because consideration of undisputed facts that are favorable to the defendant, though insufficient to preclude liability for simple negligence, may preclude any finding that the defendant was consciously indifferent to the plaintiff's rights, welfare and safety, even though such a finding might be permissible if evidence of the defendant's neglect stood alone.[28]

While the customary shorthand method of ignoring the contrary evidence works adequately in many cases, it can be misleading. Better guidance in decision-making would be provided by adoption of the fuller description devised by the Fifth Circuit for the parallel federal standard governing motions for judgment as a matter of law.[29] This statement preserves the limited scope of "no evidence" review, because it prohibits weighing the evidence or rejection of reasonable inferences favorable to the verdict:

> the Court should consider all of the evidence – not just that evidence which supports the non-mover's case – but in the light and with all reasonable inferences most favorable to the party opposed to the motion. If the facts and inferences point so strongly and overwhelmingly in

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27. *See* Burk Royalty Co. v. Walls, 616 S.W.2d 911, 922 (Tex. 1981). "Gross negligence" is the Texas nomenclature for the minimum level of culpability permitting an award of punitive damages. It requires proof that the defendant exhibited "that entire want of care which would raise the belief that the act or omission complained of was the result of a conscious indifference to the right or welfare of the person or persons to be affected by it." *Id.* at 920. *See also* Transportation Ins. Co. v. Moriel, 879 S.W.2d 10, 19-24 (Tex. 1994) (explaining application of the "gross negligence" standard to insurance bad faith cases and analyzing the legal sufficiency of evidence to support an award of punitive damages).

Justice Enoch noted the seeming anomaly of the review applied to gross negligence findings, and the similarity of that problem to review of bad faith findings. *See* Universe Life Ins. Co. v. Giles, 950 S.W.2d at 75 (Hecht, J., concurring). But he did not explain the anomaly, and an understanding of this point helps in addressing bad faith review.

28. For example, in *Universal Services. Co. v. Ung*, 904 S.W.2d 638 (Tex. 1995), the evidence favorable to the plaintiff showed that the defendant had been aware of the serious risk which had produced the plaintiff's injuries. But undisputed evidence showed that the defendant had taken significant, though inadequate, precautions against that risk. Those precautions precluded any inference that the defendant was consciously indifferent to the plaintiff's rights, welfare, and safety. *See id.* at 642.

29. *See* Seven-Up Co. v. Coca-Cola Co., 86 F.3d 1379, 1387 (5th Cir. 1996).

> favor of one party that the Court believes that reasonable men could not arrive at a contrary verdict, granting of the motion is proper. In order to reach the jury on an issue, the plaintiff must be able to present more than a mere scintilla of evidence. There must be a conflict in substantial evidence to create a jury question. In determining whether there is substantial evidence to create a jury question, we are not free to weigh conflicting evidence and inferences, determine the credibility of witnesses, or substitute our judgment of facts for that of the jury. Nevertheless, where the jury . . . is asked to infer [a fact] based on circumstantial evidence, this Court must determine whether this is a *reasonable* inference to be drawn from the evidence presented.[30]

The statement of the standard is especially useful in bad faith cases, because it is frequently undisputed that the insurer had before it certain evidence on which it relied to deny the claim. The insurer's claim file normally shows what investigation took place, what information the insurer had, and when it was received.[31] Those facts are fundamental to bad faith analysis.

"Only after an appellate court has determined what potential basis an insurance company may have had for denying a claim can the court conduct a meaningful review of whether the insured has presented evidence that an insurer lacked a reasonable basis for denying or delaying the claim."[32] Even if the jury finds other evidence on point more persuasive than that relied upon by the insurer, that does not establish a basis to find bad faith.[33] Rather, an appellate court must consider the evidence presented in relation to "the tort issue of no reasonable basis for denial or delay in payment of a claim, not just to the contract issue of coverage."[34] If that

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30. *Id.* (citations omitted) (quotations omitted); *accord Kuhn*, 29 Cal. Rptr. 2d at 194; Bowers v. Bernards, 197 Cal. Rptr. 925, 927 (Cal. Ct. App. 1984).

31. Occasionally there is an issue as to the accuracy or completeness of the claim file, but that is rare.

32. National Union Fire Ins. Co. v. Dominguez, 873 S.W.2d 373, 376 (Tex. 1994).

33. *See id.* at 377.

34. Lyons v. Millers Cas. Ins. Co. of Tex., 866 S.W.2d 597, 600 (Tex. 1993).

evidence provides no basis on which to find the tort, the jury's finding of bad faith may be disregarded.[35]

For example, in *Lyons v. Millers Casualty Insurance Co. of Texas*,[36] the coverage issue was causation: was the loss the result of windstorm (covered) or settling (excluded). Each party offered evidence to support its theory, and the jury was entitled to prefer the evidence showing coverage. But that preference alone did not permit a finding of bad faith, so long as the evidence of excluded causation constituted a "reasonable basis" to deny the claim.[37] The evidence that the loss was caused by excluded settling took the form of expert testimony. "Lyons offered no evidence that the reports of Millers' experts were not objectively prepared, or that Millers' reliance on them was unreasonable, . . . or any other evidence from which a fact finder could infer that Millers acted without a reasonable basis."[38] Consequently, there was no evidence of bad faith.

How the significance of the evidence before the insurer is to be evaluated depends on what it means for an insurer to have a "reasonable basis" to delay or deny payment of a claim and how the absence of such a basis may be proven. As will now be shown, the Texas Supreme Court has ruled that an insurer has a "reasonable basis" whenever there is a bona fide dispute over any issue necessary to establish the insured's right to payment.

IV. THE ABUSE FORBIDDEN BY THE LAW OF FIRST-PARTY BAD FAITH IS FORCING THE INSURED TO LITIGATE TO COLLECT BENEFITS WHEN NO BONA FIDE QUESTION JUSTIFIES LITIGATION.

The purposes underlying the bad faith tort dictate the substantive standard of liability. That standard specifies what facts must be proven.

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35. *See id.* at 601.

36. 866 S.W.2d 597 (Tex. 1993).

37. *See id.* at 599-601.

38. *Id.* at 601; *see also* Provident Am. Ins. Co. v. Castañeda, 988 S.W.2d 189, 207 (Tex. 1998) ("when medical evidence is conflicting, . . . it cannot be said that the insurer had no reasonable basis for denying the claim unless the medical evidence on which the insurer based its denial is unreliable and the insurer knew or should have known that to be the case."); National Union Fire Ins. Co. v. Dominguez, 873 S.W.2d 373, 376-77 (Tex. 1994) (same); Rappaport v. State Farm Lloyds, No. 3-97-CV-2747-L, 1999 U.S. Dist. LEXIS 9992, at *13-14 (N.D. Tex. June 22, 1999) (expert's report established reasonable basis for denial of claim). *See* discussion *infra* Part VI.

Properly understood, it presents no unusual difficulties for "no evidence" review.

The law of bad faith represents a balance between two competing interests: "the right of an insurer to reject an invalid claim and the duty of the carrier to investigate and pay compensable claims."[39] The tort is recognized to protect the insured's right to payment. But the insurer's right to challenge validity limits the circumstances in which liability may be imposed for non-payment, even if the claim ultimately proves meritorious. Both interests must be considered in defining the substantive legal standard. The Texas Supreme Court (like courts in almost all other jurisdictions recognizing the bad faith tort) has prescribed a workable rule that accommodates both. That rule implies a particular allocation of evidentiary burdens between the parties, an allocation that largely resolves the issues at hand.

A. The Bad Faith Tort Seeks to Protect Insureds with Valid Claims against Abuse of the Insurer's Power To Force Them to Litigate.

An insurance contract is one where an insurer, in return for an agreed premium, assumes specified risks of financial loss which might otherwise befall the insured.[40] The insured usually has paid all premiums due before the insurer is ever asked to compensate a loss. Once a loss occurs, the insured can no longer seek to buy protection from competing insurers, which might have been willing to provide similar coverage. In this sense, "[a]n insurance company has exclusive control over the evaluation, processing and denial of claims."[41]

Of course, an insured can overcome an ill-founded denial by litigating with the insurer. But risks which are insured are normally ones which an insured cannot afford to bear without insurance, so the occurrence of such a loss exerts pressure on an insured to obtain a prompt settlement, even if

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39. Aranda v. Insurance Co. of N. Am., 748 S.W.2d 210, 213 (Tex. 1988). *See* Universe Life Ins. Co. v. Giles, 950 S.W.2d at 54 (Spector, J.). This view is generally accepted by jurisdictions recognizing the bad faith tort.

40. *See, e.g.*, Group Life & Health Ins. Co. v. Royal Drug Co., Inc., 440 U.S. 205, 211 (1979); LEE R. RUSS & THOMAS F. SEGALLA, COUCH ON INSURANCE 3D §§ 1.6, 1.9 (1997); CAL. INS. CODE §§ 22, 250 (West 1993).

41. Arnold v. National County Mut. Fire Ins. Co., 725 S.W.2d 165, 167 (Tex. 1987).

that may mean foregoing full compensation.[42] If the insured could borrow to finance the loss while suing, the usual right to prejudgment interest should cover the cost of the borrowing.[43] But the loss itself may render the insured unable to borrow or the insured may have purchased the insurance precisely because the insured lacks that ability, even without a loss.

The pressure created by an unaffordable loss is increased by the fact that any consequential losses that the insured might suffer while payment is delayed are ordinarily not recoverable in an action for breach of contract.[44] Not only does this limitation on recovery leave the insured uncompensated for some harms caused by an erroneous denial, but it also limits the incentive of the insurer to avoid such harms by prompt payment.[45] Moreover, litigation is expensive, although that expense would be recoverable should the insured prevail in any suit.[46] And, because of the expense and effort required to bring suit, even insureds whose claims are meritorious may not sue.

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42. *See, e.g.*, Fletcher v. Western Nat'l Life Ins. Co., 89 Cal. Rptr. 78, 95 (Cal. Ct. App. 1970) (under disability insurance policy, "[t]he very risks insured against presuppose that if and when a claim is made, the insured will be disabled and in strait financial circumstances and, therefore, particularly vulnerable to oppressive tactics on the part of an economically powerful entity").

43. *See, e.g.*, TEX. INS. CODE ANN. art. 21.55 (West 1999) (allowing a recovery of 18% per annum for wrongful and untimely denials of claims).

44. *See* Paulson v. State Farm Mut. Auto. Ins. Co., 867 F. Supp. 911, 917-18 (C.D. Cal. 1994) (emotional distress not compensable on contract claim). The propriety of this limitation on compensatory damages for ordinary breaches of insurance contracts is examined in William T. Barker, *Damages for Insurance Policy Breaches: A Reply to Ashley,* 13 BAD FAITH L. REP. 109 (1997).

45. *See Arnold*, 725 S.W.2d at 167 (in the absence of a tort cause of action, "insurers can arbitrarily deny coverage and delay payment of a claim with no more penalty than interest on the amount owed"). As Justice Cornyn has pointed out, this is an overstatement, because the insurer must pay the costs of its own defense no matter how the suit turns out, and must pay the insured's attorneys fees and a penalty interest rate if the insured prevails. *But see* Union Bankers Ins. Co. v. Shelton, 889 S.W.2d 278, 286-87 (Tex. 1994) (Cornyn, J., dissenting) (an insurer has more incentive to pay if it will be liable for any consequential damages in addition to interest and attorneys fees).

46. *See* TEX. INS. CODE ANN. arts. 21.21, 21.55 (West 1999); TEX. CIV. PRAC. & REM. CODE ANN. § 38.006(5) (Vernon 1999). Not all jurisdictions permit recovery of fees as a matter of course on wrongfully denied insurance claims. But allowing such recovery should be the first step in addressing any perceived abuses in insurer claim practices, and allowing bad faith recovery for consequential damages should be reserved for cases not adequately addressed by permitting routine fee awards. *See* William T. Barker & Michael A. Barnes, *The Standard for First-Party Bad Faith*, 10 BAD FAITH L. REP. 69, 71 (1994).

These concerns have led many courts to conclude that it is necessary to provide protection against the risk that "unscrupulous insurers [could] take advantage of their insureds' misfortunes in bargaining for settlement or resolution of claims."[47] Surely, it would be abusive for an insurer to deny a claim and force an insured to settle or litigate when it knows that the claim is payable.[48] And an insurer should not be permitted to avoid the obligation to pay by simply ignoring readily available information that would establish the insured's right to payment.[49] Starting from this core concept of unscrupulous and abusive conduct, bad faith law has somewhat eased the burden of proving abuse and regulated some less culpable misconduct which insurers have no legitimate reason to engage in.

So liability based on constructive knowledge is not limited to facts the insurer willfully avoided knowing. All courts recognizing any version of the bad faith tort extend the latter point by holding the insurer responsible for considering all information supporting the insured's claim that it would

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47. *Arnold*, 725 S.W.2d at 167. *See also* Universe Ins. Co. v. Giles, 950 S.W.2d 48, 52 (Tex. 1997) (Spector, J.) (relying on these same concerns to retain the bad faith tort); *id.* at 60-63 (Hecht, J., concurring); Lyons v. Millers Cas. Ins. Co. of Tex., 866 S.W.2d 597, 600 (Tex. 1993) (referring to insurer's "disproportionately favorable bargaining posture in the claims handling process"); Roger C. Henderson, *The Tort of Bad Faith in First-Party Insurance Transactions: Refining the Standard of Culpability and Reformulating the Remedies by Statute*, 26 U. MICH. J.L. REFORM 1, 9 (1993) (noting social importance of reliable performance of insurance contracts); *id.* at 13-15 (burdens on insureds created by coverage disputes and barriers to obtaining fair resolutions of such disputes).

48. *See, e.g.*, Neal v. Farmers Ins. Exch., 582 P.2d 980 (Cal. 1978) (finding it was bad faith to refuse any payment on $15,000 uninsured motorist claim when insurer knew that the only real issue was a possible $5000 offset for prior medical payments benefits, and insured offered to accept $10,000 and litigate about the offset); Gruenberg v. Aetna Ins. Co., 510 P.2d 1032 (Cal. 1973) (overruling demurrer to complaint alleging that the insurer deliberately sought to evade payment of a claim it knew was valid by making unfounded accusations of arson and then exploiting the insured's unwillingness to submit to an examination under oath until the criminal charges were dismissed); Richardson v. Employers Liab. Assur. Corp., 102 Cal. Rptr. 547 (Cal. Ct. App. 1972) (finding it was bad faith for insurer to withhold payment it knew was due, force an arbitration hearing despite that knowledge, and then demand a compromise settlement after an award in the insured's favor); *see also* Fletcher v. Western Nat'l Life Ins. Co., 89 Cal. Rptr. 78 (Cal. Ct. App. 1970) (insurer was liable for intentional infliction of emotional distress where it withheld payment on a disability insurance claim it knew was valid, trumped up charge of application misrepresentations for which it had no probable cause, and sought to exploit insured's need for funds to coerce surrender of policy in settlement of the nonexistent dispute).

49. *See* Mariscal v. Old Republic Life Ins. Co., 50 Cal. Rptr. 2d 224, 227 (Cal. Ct. App. 1996).

have obtained by a reasonable investigation.[50] This creates an incentive to investigate properly and provides compensation for harms resulting from failure to do so.

And no jurisdiction recognizing the bad faith tort limits it to cases where the insurer actually knew the claim was payable. Most extend it to cases where the insurer recklessly disregarded its lack of any reasonable basis for withholding payment.[51] A few extend it to cases where the insurer was only negligent in failing to know that a reasonable basis was lacking.[52]

Texas law follows that broader standard of liability: an insurer breaches the duty of good faith if it delays or denies payment when (1) it has no reasonable basis for doing so and (2) it knows or should know that it has no such basis.[53] However, liability cannot be based simply on an erroneous

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50. *See, e.g.*, Egan v. Mutual of Omaha Ins. Co., 620 P.2d 141 (Cal. 1979) ("[A]n insurer cannot reasonably and in good faith deny payments to its insured without thoroughly investigating the foundation for its denial."); McCormick v. Sentinel Life Ins. Co., 200 Cal. Rptr. 732, 737-43 (Cal. Ct. App. 1984) (failure of insurer to seek information missing from statement submitted by doctor precluded it from relying on the omission to deny the claim); *see also* STEPHEN S. ASHLEY, BAD FAITH ACTIONS: LIABILITY & DAMAGES, § 5:08 (2d ed. 1997).

51. *See* ASHLEY, *supra* note 50, at 5-9 & nn. 7-9; *Giles*, 950 S.W.2d at 71-73 (Hecht, J., concurring) (advocating similar standard requiring that insurer have "reason to know" that it had no reasonable basis to withhold payment).

52. *See Gruenberg*, 510 P.2d at 1037; *see also Neal*, 582 P.2d at 985-86 & n.5; *McCormick*, 200 Cal. Rptr. at 741 ("We note at the outset an insurer may breach the duty of good faith without acting maliciously or immorally. Such a breach may occur merely by *unreasonably* denying a claim for benefits."); ASHLEY, *supra* note 50, at 5-4 & nn. 4-6.

53. *See* Republic Ins. Co. v. Stoker, 903 S.W.2d 338, 340 (Tex. 1995); Aranda v. Insurance Co. of N. Am., 748 S.W.2d 210, 213 (Tex. 1988). *Giles* restated the first part of the standard in terms of whether coverage had become "reasonably clear," rather than whether the insurer had "no reasonable basis." But this change in terminology did not affect the substance of the standard. *See* Universe Life Ins. Co. v. Giles, 950 S.W.2d at 80 (Enoch, J., concurring) ("this semantic recasting of the elements of bad faith in no way alters the character of the proof necessary for a plaintiff to prevail . . . . Liability is 'reasonably clear' only when there is no reasonable basis for an insurer to deny coverage."); *see also id.* at 59 (Hecht, J., concurring, joined by Phillips, C.J., and Gonzalez & Owen, JJ.) ("[t]he change in terminology is purely semantic, nothing more"); Provident Am. Ins. Co. v. Castañeda, 988 S.W.2d 189, 207 (Tex. 1998) (using standards interchangeably); Alvarado v. Old Republic Ins. Co., 951 S.W.2d 254, 258 (Tex. Ct. App. 1997). Review of the post-*Giles* cases to date shows little impact on any appellate result from the reformulation. The analysis presented here is more readily stated by using the older vocabulary, so this article will continue to use it.

denial of a claim,[54] even though every such denial forces an insured to litigate in order to collect a meritorious claim. So merely forcing an insured to litigate is not considered an abuse justifying tort remedies.

B. Because Paying Unmeritorious Claims Would Inflate Insurance Costs, Insurers Must Be Given Wide Latitude To Challenge Claims Without Fear of Tort Liability.

There is a powerful reason why insurers cannot properly be held liable for mere erroneous denial of a claim. The *obligation* to pay meritorious claims is accompanied by the *right* to deny those without merit.

This right is more than an ordinary contractual right: it serves an important public interest. Insurance rates are based on insurers' predictions of the claims they will be required to pay. If erroneous denial of a claim can result in expensive tort remedies, insurers may feel compelled to pay questionable claims rather than risk such liability. This is a particular concern with possibly fraudulent claims, where any impropriety of the claim will have been assiduously concealed and may only be detectable by expensive investigation and resort to circumstantial evidence.[55] Such payments, or the expectation of having to make them, would tend to inflate costs for those wishing only coverage for the risks specified in the contract.

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54. *See Castañeda*, 988 S.W.2d at 196 (no evidence to support finding of bad faith, even though coverage was unchallenged on appeal); *see also* U. S. Fire Ins. Co. v. Williams, 955 S.W.2d 267, 268 (Tex. 1997) (no evidence to support finding of bad faith even though finding of coverage affirmed on appeal); Transportation Ins. Co. v. Moriel, 879 S.W.2d 10, 17 (Tex. 1994) ("[e]vidence that merely shows a bona fide dispute about the insurer's liability on the contract does not rise to the level of bad faith"); National Union Fire Ins. Co. v. Dominguez, 873 S.W.2d 373, 376 (Tex. 1994) (existence of conflicting medical opinions on key issue showed absence of bad faith); Lyons v. Millers Cas. Ins. Co. of Tex., 866 S.W.2d 597, 600 (Tex. 1993) (no evidence of bad faith, despite affirmance of verdict finding coverage). Other jurisdictions agree. *See, e.g.*, Dalrymple v. United Servs. Auto. Ass'n, 46 Cal. Rptr. 2d 845, 857 (Cal. Ct. App. 1995); Tomaselli v. Transamerica Ins. Co., 31 Cal. Rptr. 2d 433, 440 (Cal. Ct. App. 1994); Opsal v. United Servs. Auto. Assn., 10 Cal. Rptr. 2d 352, 356-57 (Cal. Ct. App. 1991).

55. Detection and prevention of fraud is an interest strongly shared by all honest purchasers of insurance, who would object to paying higher premiums merely to enrich the perpetrators of fraud. *See* Alan O. Sykes, *"Bad Faith" Breach of Contract by First-Party Insurers*, 25 J. LEGAL STUD. 405, 425-29 (1996). Anything which inhibits insurers from challenging potentially fraudulent claims will not only permit the success of frauds which go undetected as a result, but will also tend to encourage additional fraudulent claims.

These concerns were given great weight by the two cases on which the Texas Supreme Court relied in *Aranda* to formulate the standard for bad faith liability. In *Anderson v. Continental Insurance Co.*,[56] the court recognized the undesirability of inflating insurance rates by "scaring insurers into paying questionable claims because of the threat of a bad faith suit and its excessive damages."[57] The *Anderson* court was confident it had prevented this by adopting a standard that protects any insurer which "makes an investigation of the facts and law and concludes on a reasonable basis that the claim is at least debatable."[58] Similarly, in *Travelers Insurance Co. v. Savio*,[59] the court emphasized the need to accord an insurer "wide latitude in its ability to investigate claims and to resist false or unfounded efforts to obtain funds not available under the contract of insurance."[60]

Aranda recognized the legitimacy of these concerns and shaped the standard to assure that insurers would "maintain the right to deny invalid or questionable claims and will not be subject to liability for an erroneous denial of a claim."[61]

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56. 271 N.W.2d 368 (Wis. 1978) (quoting John W. Thornton & Milton S. Blacot, *Bad Faith and Insurers: Compensatory and Punitive Damages*, 12 FORUM 699, 719 (1977)).

57. *Id.* at 377. *See also* Paulson v. State Farm Mut. Auto. Ins. Co., 867 F. Supp. 911, 913-14 (C.D. Cal. 1994) (insurance rates are based on estimates of the costs of performance and breach, but tort liabilities are too vague to be accounted for in advance, so scope of tort must be narrowly and precisely defined, lest "[t]he ability of an insured to create a tort lawsuit out of a good faith denial of insurance coverage create[] settlement value . . . out of proportion to the merits of the underlying contract dispute[s].") (second alteration in original).

58. 271 N.W.2d. at 377.

59. 706 P.2d 1258 (Colo. 1985) (en banc).

60. *Id.* at 1274. *See also* ROBERT E. KEETON & ALLAN I. WIDISS, INSURANCE LAW § 7.10(a), at 918 (1988) ("Policyholders and insureds clearly have an interest . . . in not discouraging insurers from contesting claims when there are reasonable questions about whether the insured's claim is within the scope of the coverage"); Blue Cross & Blue Shield v. Campbell, 466 So. 2d 833, 841 (Miss. 1984) (court recognizes "an obligation to support any insurance company fulfilling its lawful responsibility of investigating any claim which is dubious").

61. Aranda v. Insurance Co. of N. Am., 748 S.W.2d 210, 213 (Tex. 1998).

C. *Bad Faith Law Balances These Competing Interests by Creating Extracontractual Liability for Denial or Delay in Payment, but Only Where There Is No Bona Fide Dispute as to the Insured's Right to Payment.*

Texas law provides insurers with the necessary "latitude . . . to investigate claims and to resist false or unfounded efforts to obtain funds not available under the contract of insurance" by imposing two prerequisites to bad faith liability. To incur liability, the insurer (1) must have lacked any "reasonable basis" to delay or deny payment and (2) at least should have known that it lacked such a basis.[62]

The latter requirement is significant primarily when the insurer failed (or may have failed) to discover some information favorable to the insured. After all, to reach the second prong of the test, the jury must have found that the denial of the claim was unreasonable in light of all the evidence presented at trial. That conclusion alone would permit an inference that the insurer knew or should have known that its action was unreasonable, *unless* the insurer had failed to discover some of the information favorable to the insured. In the latter situation, there would be a question whether the insurer's failure to discover that evidence was caused by failure to conduct a reasonable investigation.[63]

Once one determines what evidence was available to the insurer, the question is whether that evidence provided (or at least left open) a "reasonable basis" for refusal to pay. To answer that question, one must know what constitutes a "reasonable basis." *Aranda* suggested that the inquiry called for an "objective determination of whether a reasonable insurer under similar circumstances would have delayed or denied the claimant's benefits."[64] But it did not explain how one could determine the answer to that question.[65]

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62. *See id.*; *see also* Republic Ins. Co. v. Stoker, 903 S.W.2d 338, 340 (Tex. 1995). All states that recognize the bad faith tort require some sort of denial without reasonable basis, though some impose liability on that basis alone, without any additional requirement of subjective culpability. *See, e.g.*, Neal v. Farmers Ins. Exch., 582 P.2d 980, 985-86 & n.5 (Cal. 1978); Gruenberg v. Aetna Ins. Co., 510 P.2d 1032, 1037 (Cal. 1973).

63. For a general discussion of the proper treatment of cases in which it is claimed that an insurer would have discovered additional facts had it conducted a reasonable investigation, see Barker & Glad, *supra* note 3, at 77-82.

64. *Aranda*, 748 S.W.2d at 213.

65. Differences on that issue, rather than on the technicalities of "no evidence" review, are at the heart of the dispute between State Farm Fire & Cas. Co. v. Simmons, 857 S.W.2d

The definitive standard was laid down in *Transportation Insurance Co. v. Moriel*,[66] where Justice Cornyn wrote for the Court that "[e]vidence that merely shows a bona fide dispute about the insurer's liability on the contract does not rise to the level of bad faith."[67] This rule recognizes that "the parties to an insurance contract will sometimes have a good faith disagreement about coverage. Under such circumstances, the parties may require a court to interpret the policy language for them, or a jury to resolve factual disputes."[68] Stated otherwise, a "reasonable basis" for denying a claim is one that warrants testing the claim in court.[69]

While the bona fide dispute test had not yet been articulated, its essence is implicit in *Lyons* and *Dominguez*. The Texas Supreme Court reaffirmed and applied it in *Williams*,[70] *Simmons*,[71] and *Provident American Insurance Co. v. Castañeda*.[72] It is the settled law of Texas.

This test appears to be equivalent to the widely followed rule that an insurer may deny a claim without risking bad faith liability so long as the insured's right to payment is "fairly debatable."[73] Justice Spector's opinion

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126 (Tex Ct. App. 1993), *aff'd without addressing this point*, 936 S.W.2d 42 (Tex. 1998), and State Farm Lloyds, Inc. v. Polasek, 847 S.W.2d 279 (Tex. Ct. App. 1992). The *Polasek* court believed that the fact finder is not permitted to second-guess an insurer's weighing of the evidence if the evidence against coverage created a bona fide dispute over the right to payment. *See* 847 S.W.2d at 287. The *Simmons* court, on the other hand, believed that a jury could find bad faith if it concluded that the insurer should have accepted the evidence supporting coverage even though there was enough contrary evidence to create a bona fide dispute. *See* 857 S.W.2d at 134-35. In particular, the *Simmons* court apparently thought that the jury could rely on supposed inadequacies in investigation or other aspects of the claim handling to show that the insurer was subjectively unfair. *See id.*

Of course, neither *Simmons* nor *Polasek* had the benefit of the subsequent decisions discussed in text. And even the court of appeals that decided *Simmons* views the rule announced there as having very narrow application to only "those cases where an insurer wholly disregards its obligation to its insured in pursuit of the insurer's self-serving interest." Connolly v. Service Lloyds Ins. Co., 910 S.W.2d 557, 562 (Tex. Ct. App. 1995) (affirming summary judgment against insured).

66. 879 S.W.2d 10 (Tex. 1994).

67. *Id.* at 17.

68. *Id.* at 18 n.8.

69. Union Bankers Ins. Co. v. Shelton, 889 S.W.2d 278, 287 (Tex. 1994) (Cornyn, J., dissenting).

70. United States Fire & Ins. Co. v. Williams 955 S.W.2d 267 (Tex. 1997).

71. 963 S.W.2d at 11.

72. 988 S.W.2d at 194.

73. *See* Barker & Glad, *supra* note 3, at 52; DENNIS J. WALL, LITIGATION AND PREVENTION OF INSURER BAD FAITH §§ 11.04, at 499 & n.34, 11.17 (2d ed. 1994 & Supp.

in *Giles* declined to adopt the latter standard, because it failed to solve the problem the court perceived in applying the "no evidence" standard of review.[74] But the court failed to explain how one could distinguish that standard from the "bona fide dispute" standard that it adopted. What makes a dispute bona fide is the existence of a fair argument on either side. Because the standard of review problem is solved without changing the "no reasonable basis" requirement,[75] there ought to be no hesitation in recognizing that Texas follows a rule similar to that elsewhere.[76]

Because the bad faith inquiry is whether there is a basis to withhold payment which warrants "testing the claim in court," the requirement that the insured prove that there was no bona fide dispute finds a close analogy in the law of malicious prosecution. Under the latter, a plaintiff must prove that the defendant lacked probable cause to initiate the prior unsuccessful proceeding. Just as it is not bad faith for an insurer to deny a claim which is actually payable, malicious prosecution cannot be shown by proving the innocence of the party prosecuted: "[t]he question of probable cause does not depend upon the guilt or innocence of the defendant [in the prosecution] but on whether the prosecutor had reasonable grounds, from the facts known to [the prosecutor] at the time, to believe that the accused was guilty."[77] "Reasonable grounds" to prosecute are analogous to a "reasonable basis" to deny a claim, and, conversely, existence of "probable cause" is similar to existence of a "bona fide dispute."[78]

1997) (collecting cases); Universe Life Ins. Co. v. Giles, 950 S.W.2d at 54-55 (Spector, J.) (same).

74. *See Giles*, 950 S.W.2d at 54-55. Justice Hecht's opinion endorsed the "fairly debatable" standard. *See id.* at 67-68 (Hecht, J., concurring) (collecting cases). Justice Enoch has not commented on it. Justice Hankinson (who recently replaced Justice Cornyn), Justice O'Neill (who replaced Justice Spector), and Justice Gonzales (who replaced Justice Gonzalez), have had no occasion to address it.

75. *See infra* Part IVD, pp. 102-11.

76. The "when liability has become reasonably clear" formulation of that standard, adopted by a majority in *Giles*, will be critiqued *infra* at Part V, pp. 111-13.

77. Parker v. Dallas Hunting & Fishing Club, 463 S.W.2d 496, 500 (Tex. Ct. App. 1971).

78. *See* Dalrymple v. United Servs. Auto. Ass'n, 46 Cal. Rptr. 2d at 857-58 (using analogy to analyze bad faith claim). *Dalrymple* and the analogy are discussed *infra* at pp. 119-25.

The two causes of action differ in many other respects. For example, malicious prosecution is a disfavored cause of action, subject to heightened proof requirements. *See* Brookshire Groc. Co. v. Richey, 899 S.W.2d 331, 333 (Tex. Ct. App. 1995), *aff'd*, 952 S.W.2d 515 (Tex. 1997); Montgomery Ward & Co. v. Kirkland, 225 S.W.2d 906, 909 (Tex. Ct. App. 1949). No such requirements apply to bad faith claims. Moreover, the party

This understanding of the substantive requirements of the law of bad faith dictates the proper allocation of evidentiary burdens in bad faith cases, an allocation which simplifies the process of "no evidence" review.

D. Once an Insured Has Produced Prima Facie Evidence That the Claim Was Payable and That the Insurer Had Notice of the Claim and Access to Evidence Sufficient To Support the Claim, the Insurer Must Articulate One or More Bases for Challenging the Validity of the Claim, After Which the Insured Has the Burden of Establishing that None of Those Bases Constituted Fair Ground for "Testing the Claim in Court."

Justice Hecht attributes some of the difficulties with the law of bad faith and the proper application of "no evidence" review to a burden of proof which, if actually imposed, would be impossible to meet: "[i]f . . . a judgment for bad faith must be supported by evidence negating the existence of any reasonable basis, then no judgment can survive review. No plaintiff can disprove every reasonable basis *conceivable* for denying or delaying a claim."[79] If that were indeed the burden, it would create the problems described. But that is not the real burden.

The burden Justice Hecht describes is imposed only on one group of litigants: those mounting equal protection (or similar constitutional) attacks on statutes.[80] Under that extraordinary procedural regime, a court may uphold a statute if the court can conceive of a basis that the challenger has failed to negate, *even if that purpose was never advanced either in the legislature or at trial.*[81] But that framework is designed to afford maximum protection to the broad power of the legislature against possible encroachment by the courts.[82] Private litigants like insurers are entitled to no such protection.

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initiating a prosecution is not obliged to look for exculpatory evidence or give the party to be prosecuted an opportunity to explain the suspicious circumstances providing probable cause for the prosecution. *See Brookshire Groc.*, 899 S.W.2d at 333. In contrast, an insurer does have a duty to investigate for evidence which might support coverage.

79. Universe Life Ins. Co. v. Giles, 950 S.W.2d at 74 (Hecht, J., concurring) (emphasis added).

80. *See, e.g.*, Madden v. Kentucky, 309 U.S. 83, 88 (1940).

81. *See* William T. Barker & Robert E. Wagner, *State Insurance Tax Differentials and Regulatory Objectives: A Constitutional Analysis*, 7 J. INS. REG. 128, 143-48 (1987) (describing structure of rational basis equal protection analysis).

82. *See id.* at 136-39.

An insurer can be required, through discovery, to specify *every* allegedly reasonable basis for withholding payment on which it relies to defeat the bad faith claim.[83] An insured then seeks to show that none of the bases so identified provided a sufficient ground to withhold payment.[84] If successful in this, the insured has made out a case, unless there is a question about what the insurer knew or should have known.[85]

Even without reliance on the availability of discovery, a manageable framework can be established by proper allocation of evidentiary burdens. Of course, the burden of proof is ultimately on the insured who asserts the bad faith claim. But that does not mean that the insurer has no evidentiary burden once coverage has been established. Instead, the insurer's burden has escaped notice, because the practicalities of defending a bad faith claim induce insurers to shoulder that burden without any court ever saying that it exists.[86] Making the burden explicit helps clarify both the law of bad faith and the application of "no evidence" review to bad faith claims.[87]

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83. *See, e.g.*, TEX. R. CIV. P. 197; FED. R. CIV. P. 34.

84. In the contract phase of the suit, the insured has the initial burden to prove he has a covered claim. The insurer then has the burden to prove any exclusions that apply, or other reasons that the policy does not provide coverage. Once that is accomplished, the burden then switches back to the insured to prove any exceptions to the exclusions that apply. *See generally* Wallis v. United Services Auto. Ass'n, No. 04-97-00803-CV, 1999 Tex. App. LEXIS 812 (Tex. Ct. App. Feb. 10, 1999); Telepak v. United Servs. Auto. Ass'n, 887 S.W.2d 506, 507-08 (Tex. Ct. App. 1994).

85. *See* Michael Sean Quinn, *Insurer Bad Faith – Sic et Non – Texas Style*, 19 INS. LITIG. RPTR. 485, 494-95 (1997). This could also be implemented by a pleading requirement, like Rule 94 of the Texas Rules of Civil Procedure. But discovery is a more flexible and appropriate mechanism.

86. The practicalities of defending malicious prosecution litigation have had a similar effect.

87. The burdens described here are analogous to those utilized in employment discrimination law, pursuant to *McDonnell Douglas Corp. v. Green*, 411 U.S. 792 (1973); *Furnco Constr. Corp. v. Waters*, 438 U.S. 567 (1978); and *Texas Dept. of Community Affairs v. Burdine*, 450 U.S. 248 (1981). The insurer's burden is one of producing evidence in response to a prima facie case, not of persuasion. But the evidence produced by the insurer frames the issues for the insured's proof.

Arguably the initial *McDonnell Douglas* burdens do little or no work, because they are easy to satisfy and have little or no role in structuring the inquiry at the final stage. *See* George Rutherglen, *Reconsidering Burdens of Proof: Ideology, Evidence, and Intent in Individual Claims of Employment Discrimination*, 1 VA. J. SOC. POL'Y & L. 43, 56-60 (1993). In contrast, the burdens at the first two stages of the bad faith proof structure articulated here have real substance and the third stage is structured by what is produced in the second.

In general, every bad faith claim depends on the existence of a valid claim for insurance benefits.[88] The insured bears the burden of proving the existence of coverage.[89] In considering a claim presented by an insured, an insurer is entitled (after conducting a reasonable investigation) to insist that this burden be met.

Absence of enough evidence to establish coverage would be a reasonable basis to withhold benefits, at least until the missing evidence were found (or would have been found with a reasonable investigation).[90] So an insured cannot make out a prima facie case of bad faith without presenting evidence sufficient, if believed, to establish two things: (1) existence of coverage and (2) withholding of payment even after enough information to show coverage was available to the insurer. For this purpose, evidence is "available" if the insurer either actually knew of it or would have known of it had it conducted a reasonable investigation. Thus, an insured establishes a prima facie case of bad faith by proving entitlement to coverage and presenting evidence that all of the facts necessary to do so were or should have been known to the insurer.

Once the insured has done this, the insurer then has a burden of articulating one or more grounds for withholding payment. The insurer may do this, for example, by offering a legal argument that the evidence

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88. *See* Republic Ins. Co. v. Stoker, 903 S.W.2d 338, 341 (Tex. 1995). *Stoker* reserved the possibility that bad faith liability might be possible even without coverage in some extraordinary circumstance. *See id.* For an analysis of this issue nationwide, see William T. Barker & Paul E. B. Glad, *Bad Faith in the Absence of Coverage: The Insurer's Perspective, in* DAVID R. LEITNER (ED.), RECURRING ISSUES IN INSURANCE DISPUTES: A GUIDE FOR INSURERS AND INSUREDS (ABA 1996); Paul E.B. Glad, William T. Barker & Michael J. Hassen, *Bad Faith Liability in the Absence of Coverage?*, 7 BAD FAITH L. REP. 1 (1991); William T. Barker & Paul E.B. Glad, *Bad Faith Liability in the Absence of Coverage: A Reply*, 7 BAD FAITH L. REP. 83 (1991); William T. Barker & Paul E.B. Glad, *Bad Faith Liability in the Absence of Coverage? Arizona Speaks Up*, 7 BAD FAITH L. REP. 131 (1991).

Many post-*Giles* bad faith opinions turn simply on the absence of any contractual breach. *See, e.g.*, Fuller v. State Farm Mut. Auto Ins. Co., 971 F. Supp. 1098 (N.D. Tex. 1997); Betco Scaffolds Co. v. Houston United Cas. Ins. Co., No. 14-98-00179-CV, 1999 Tex. App. LEXIS 6016 (Tex. Ct. App. Aug. 12, 1999); Withrow v. State Farm Lloyds, 990 S.W.2d 432 (Tex. Ct. App. 1999); Lane v. State Farm Mut. Aut. Ins. Co., 992 S.W.2d 545 (Tex. Ct. App. 1999); Evry v. United Servs. Auto. Ass'n, 979 S.W.2d 818 (Tex. Ct. App. 1998).

89. *See* Employers Cas. Co. v. Block, 744 S.W.2d 940, 944-45 (Tex. 1988).

90. *See, e.g.*, Mock v. Michigan Millers Mut. Ins. Co., 5 Cal. Rptr. 2d 594, 606 (Cal. Ct. App. 1992) (holding insurer was entitled to time necessary to obtain and evaluate geological evidence bearing on claim).

presented by the insured does not establish coverage because the policy, a governing statute, or a rule means something different from what the insured now asserts, or that it did at the time payment was withheld.[91] The insurer may do this by explaining that it contends that some of the evidence necessary to support coverage is of doubtful credibility or arguably supports different inferences than those drawn by the insured. And the insurer may do this by producing evidence of its own, which, if believed, contradicts essential evidence offered by the insured or avoids its effect.[92] A common method of avoiding the effect of evidence showing coverage is presentation of evidence supporting application of an exclusion, such as the one for arson.

In the ordinary case, the insurer can, and usually does, satisfy any production burden by introducing its claim file (or key parts of that file) if the insured has not already done so. The claim file ordinarily constitutes undisputed evidence of what investigation occurred, what the insurer knew, and when it knew it. If the insurer can point to portions of the file supporting its decision to "test the claim in court," that satisfies its burden. Of course, the insurer is free to supplement the claim file with additional evidence that its action was proper, even though it did not have that evidence in its possession when it denied the claim.[93]

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91. *See* United States Fire Ins. Co. v. Williams, 955 S.W.2d at 268-69; Lunsford v. Am. Guar. & Liab. Ins. Co., 18 F.3d 653, 656 (9th Cir. 1994) (insurer's construction of policy, while erroneous, was supported by a reasonable argument); Dalrymple v. United Services Auto. Assn'n, 46 Cal. Rptr. 2d 845, 857-59 (Cal. Ct. App. 1995) (describing existence of legally tenable basis to regard injuries inflicted by insured as intentional precluded bad faith in refusing to indemnify against liability for those injuries). Of course, the legal argument offered must be one which is tenable in light of existing authority. *See also* Barker & Glad, *supra* note 3, at 86-89. *Williams* and *Dalrymple* are discussed *infra* at pp. 116-25.

92. But production of evidence avails an insurer nothing if the evidence it adduces provides no basis for a finding against the insured, even if the evidence itself is accepted. *See, e.g.*, Arnold v. National County Mut. Fire Ins. Co., 725 S.W.2d 165 (Tex. 1987) (insurer relied on (1) facts which led it to suspect possible speeding or intoxication but did not support either conclusion and (2) the belief that jurors would be unfairly prejudiced against motorcyclists).

93. *See* Provident Am. Ins. Co. v. Castañeda, 988 S.W.2d 189, 197-98 (Tex. 1998); Republic Ins. Co. v. Stoker, 903 S.W.2d 338, 341 (Tex. 1995) (explaining that even if claim denied for inadequate reason, bad faith is not shown if a good reason was available because a reasonable insurer would have denied the claim for lack of coverage and thus the insured is not harmed by the erroneous denial); Barker & Glad, *supra* note 3, at 74-77.

The insured then has the burden of showing that none of the grounds asserted by the insurer gives rise to a bona fide dispute that warranted "testing the claim in court."[94] This *cannot* be done merely by presenting evidence contradicting the insurer's evidence, for conflicts in the evidence are precisely the reason why it is proper to "test the claim in court."[95]

Absence of a bona fide dispute *can* be proven, as it was in *Giles*, by showing that the insurer relied on an interpretation of the evidence which the source of that evidence had disclaimed and that the insurer knew or should have known of the disclaimer.[96] As *Giles* also shows, it can be proven by showing that some of the evidence relied upon by the insurer was erroneous, and that the insurer knew of the error.[97] And showing that the information on which the insurer relies "was known or should have

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94. Justice Enoch, at least, seems to agree that the burdens are as suggested here. *See* Universe Life Ins. Co. v. Giles, 950 S.W.2d 48, 81 (Tex. 1997) (Enoch, J., concurring). He notes that the insurer will normally "put forth some purportedly reasonable basis for denial or delay in payment" and considers what the insured must do to respond to such assertions. *Id.* He concludes that the insured would have the

> burden . . . to put before the factfinder some evidence that no reasonable insurer would have relied on the information before the insurer to deny or delay payment, or that the insurer's proffered reasons were a pretext or a sham or that the information before the insurer at the time it denied coverage was known or should have been known to be unreliable.

Id.

95. *See id.* ("the plaintiff may not parse through the information before the insurer and pull out only the information showing coverage to prove bad faith"); Lyons v. Millers Cas. Ins. Co. of Tex., 866 S.W.2d 597, 601 (Tex. 1993); Blake v. Aetna Life Ins. Co., 160 Cal. Rptr. 528, 542 (Cal. Ct. App. 1979) (failure of evidence provided to or discovered by insurer to rule out suicide created reasonable ground to withhold accidental death benefit); Anderson v. Continental Ins. Co., 271 N.W.2d 368, 376 (Wis. 1978) ("when a claim is 'fairly debatable,' the insurer is entitled to debate it, whether the debate concerns a matter of fact or law"); Barker & Glad, *supra* note 3, at 53-82 (collecting cases).

96. *See Giles*, 950 S.W.2d at 56-57 (Spector, J., announcing the judgment) (explaining that insured's supposed "positive history of heart disease" was only a family history, not a personal history); *id.* at 82 (Enoch, J., concurring) (same); *id.* at 79 (Hecht, J., concurring) (agreeing with other justices on lack of basis for denying claim).

97. *See id.* at 57 (Spector, J., announcing the judgment) (noting that correction of transcription error removed alternate basis for claiming pre-existing personal history of heart disease). *See also id.* at 81 (Enoch, J., concurring) (insured may prove that "the insurer's proffered reasons were a pretext or a sham").

been known to be unreliable can prove it."[98] For example, if the testimony of a witness on whom the insurer relies is a pure fabrication and the insurer knows that (or is deemed to know that because the lying witness is an insurer employee), that testimony cannot create a bona fide dispute.[99]

But the term "unreliable" in the foregoing statement must be understood in the narrow sense of something unworthy of reliance, something that does not warrant "testing the claim in court." It is not enough for the insured to show that the insurer's evidence (or the inference it seeks to draw from the evidence) is subject to question and impeachment if, despite that, a fact finder might reasonably find it worthy of sufficient credence to defeat the insured's claim.[100] (After all, the insured's claim may itself rest upon questionable evidence). Evidence which might reasonably be found sufficient to defeat the claim warrants "testing the claim in court," and reliance on such evidence is not improper, even if the evidence is subject to impeachment or an argument for a different inference than the insurer seeks.

In light of this allocation of evidentiary burdens, "no evidence" review of a bad faith finding would proceed as follows. First, the appellate court

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98. *Id.*; *see also* Provident Am. Ins. Co. v. Castañeda, 988 S.W.2d 189, 194 (Tex. 1998). *See* Barker & Glad, *supra* note 3, at 62-63.

99. *See, e.g.*, Jones v. Alabama Farm Bureau Mut. Cas. Co., 507 So. 2d 396, 401 (Ala. 1986). *See* Barker & Glad, *supra* note 3, at 68-70 (and cases cited therein).

100. Justice Enoch apparently sees fact finders as having some discretion to find the opinions of insurer-selected experts "unreliable" even if such opinions could have permitted a finding in the insurer's favor on the subject of those opinions. *See* State Farm Lloyds v. Nicolau, 951 S.W.2d 444, 453 (Tex. 1997) (Enoch, J., concurring) (evidence challenging the "reliability" of the evidence used by insurer could support finding of bad faith where the only evidence so challenged was expert's opinion). *Nicolau* is extensively discussed *infra* at pp. 128-135.

This is the only point I can find where Justice Enoch appears to part company with the views expressed here, though he has not articulated his analysis well enough to be sure there are no other divergences. Justice Hecht criticizes Justice Enoch for treating bad faith as essentially a form of negligence, a view which Justice Hecht and I agree would be unsound. *See* discussion *infra* at notes 112-73. As Justice Hecht stated, "I do not agree with [Justice Enoch] . . . that bad faith liability is based on failure to act as a reasonable insurer would. That is a negligence test which [does] not and should not apply in the context of bad faith." State Farm Fire & Cas. Co. v. Simmons, 963 S.W.2d 42, 50 (Tex. 1998). While some of the language in Justice Enoch's *Nicolau* opinion might support the characterization that the insured must prove that "no reasonable insurer *would* have" denied or delayed payment, *see Nicolau*, 951 S.W.2d at 81 (emphasis added), his *Simmons* opinion suggests otherwise by stating the required showing as one that "a reasonable insurer could not have denied the . . . claim." 963 S.W.2d at 51.

would determine what information should be deemed available to the insurer.[101] Any question as to what the insurer knew or would have learned from reasonable investigation is a fact issue, subject to jury determination if there is any probative evidence to support a finding for the insured.[102] So, for purposes of appellate review, one would assume the view most favorable to the verdict *and also* consistent with whatever evidence is undisputed.

Then the court would examine the evidence with respect to each of the grounds for withholding payment articulated by the insurer (unless the ground is an argument of law, not requiring evidentiary support). *Existence* (as opposed to correctness) of whatever evidence allegedly supports the insurer's position will often be undisputed, but if the existence of that evidence is in question, that too is an issue of fact, on which the jury's verdict would be binding if supported by any probative evidence. As to each ground for which it is undisputed that some evidence supporting the insurer exists, the insured must have offered evidence sufficient to support a finding that there was no bona fide dispute as to the insured's right to payment.

In a point of considerable significance here, *any inquiry into the adequacy of the insurer's investigation has only limited relevance on "no evidence" review.*[103] Adequacy of the investigation is relevant only to the extent that it bears on whether the insurer should be charged with knowledge of facts it did not actually discover. After all, one does not investigate for the sake of investigating. One investigates to find useful information. If further investigation would not have revealed anything useful, it makes no difference that such investigation was not done.[104]

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101. *See* Universe Life Ins. Co. v. Giles, 950 S.W.2d at 82 (Enoch, J., concurring).

102. *See, e.g.*, Duzich v. Marine Office of Am. Corp., 980 S.W.2d 857, 867 (Tex. Ct. App. 1998) (finding summary judgment improper because there was disputed fact question as to what evidence insurer had before it).

103. Inadequacies in investigation would have greater relevance in jurisdictions, unlike Texas, that require a showing of subjective culpability (at least recklessness) for a finding of bad faith. *See* ASHLEY, *supra* note 50, § 5:02, at 5-5 to 5–11 and note 11. Obvious deficiencies in investigation might support an inference of conscious indifference to the rights of the insured. But under Texas law, the subjective culpability of the insurer is relevant only to punitive damages. And even in other jurisdictions, inadequate investigation will have limited relevance to the issue of whether there was a reasonable basis to deny the claim.

104. *See* Republic Ins. Co. v. Stoker, 903 S.W.2d 338, 341 (Tex. 1995) (error in insurer's handling of the claim not was not basis for bad faith liability if correct handling would have produced same result); Lyons v. Millers Cas. Ins. Co. of Tex., 866 S.W.2d 597,

Once the court determines what the insurer knew (actually or constructively), it must determine whether those facts created a "bona fide dispute" as to coverage. Even one bona fide dispute as to the right to payment justifies "testing the claim in court." So, unless the insured has presented probative evidence of the absence of a bona fide dispute on *every* ground relied upon by the insurer, there is "no evidence" to support the verdict. But deciding whether there is a bona fide dispute, even on a factual point, does not require weighing the evidence: the issue is simply whether a reasonable person, in possession of the information available to the insurer, would have been justified in "testing the claim in court."[105]

I suggest that this analysis should be supplemented by drawing once more on the analogy to malicious prosecution to define the roles of court and jury. If there is no conflict in the evidence regarding probable cause, then the question of whether the information available to the prosecutor constituted probable cause is a question of law to be decided by the court.[106]

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601 n.3 (Tex. 1993) (evidence missed by omitted investigation would merely have been cumulative of evidence already known to insurer, so omission could not support bad faith liability); Barker & Glad, *supra* note 3, at 74-82. *But see* State Farm Fire & Cas. Co. v. Simmons, 963 S.W.2d 42 (Tex. 1998) (decrying failures to investigate without suggesting what evidence they would – or even might – have revealed to refute the hypothesis that the insureds had committed arson). *Simmons* is discussed *infra* Part VII, pp. 140-46.

105. On this point, I respectfully disagree with Justice Hecht's statement that "the reasonableness of an insurer's decision can be judged only by weighing the evidence for and against the claim." *Giles*, 950 S.W.2d at 58 (Hecht, J., concurring). Justice Enoch, at least, agrees that Justice Hecht is wrong on this point. *See id.* at 80-81 (Enoch, J., concurring).

Simmons says that "whether an insurer has breached its duty of good faith and fair dealing is a fact issue." 963 S.W.2d at 44. Clearly, this is sometimes true. But *Lyons* and *Dominguez* show that it is not always true. *Simmons* does not explain how to decide whether it is true in a particular case.

106. *See* Richey v. Brookshire Grocery Co., 952 S.W.2d 515, 518 (Tex. 1997). In *Richey*, the members of the court disagreed as to what facts constitute probable cause for an accusation of shoplifting. They did not disagree about what the jury might have found, but on whether certain factually supportable findings had a bearing on existence of probable cause. *See id.* at 520-23. Similar disagreements may arise about what constitutes a bona fide dispute.

The requirements for probable cause may, sometimes or always, be more stringent than for a bona fide dispute. Criminal prosecutions demand proof of guilt beyond a reasonable doubt, while defeating an insurance claim requires no more than a preponderance of the evidence. Prosecutions commonly require proof of a criminal intent, often difficult to find, while intent is usually not critical to an insurance claim. The evidence necessary to justify litigating a particular matter presumably bears some relation to the difficulty of prevailing in any such litigation, suggesting that a criminal prosecution ought to be instituted more

The same should be true of the existence of a bona fide dispute.[107] If there is a conflict in the evidence, the existence or lack of a bona fide dispute, like the existence or want of probable cause, should be treated as a mixed question of law and fact. But there would be a jury question only if the view of the facts most favorable to the insured would show the absence of any reason to "test the claim in court."[108]

As the example of malicious prosecution indicates, it is not always true that "reasonableness is . . . a question of fact."[109] Reasonableness is a fact question in its most common context, namely negligence law. There the issue is whether the defendant acted unreasonably in not taking greater precautions, given the safety risks of his conduct. That sort of fact-bound balancing is inextricably intertwined with judgments about what further precautions would have prevented the harm to the plaintiff, how burdensome it would have been to take them, and how much risk was created by failure to take them. Rather than require detailed findings on subordinate facts where achieving unanimity would be difficult, the jury is permitted to treat the entire complex of judgments as a single question, requiring agreement on only the bottom line.

But bad faith law does not call for balancing of that sort. The insurer's right to "test the claim in court" does not vary with the harm that the insured may suffer if the claim is denied or with the size of the amount claimed by the insured. The issue is whether a qualitative threshold requirement is satisfied. If there is a bona fide dispute, then the insurer may challenge the claim; if not, it must pay without requiring the insured to sue.[110]

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cautiously than a challenge to an insurance claim. But the fact that the *substantive* requirements differ somewhat does not destroy the *procedural* analogy.

107. *See* Dalrymple v. United Servs. Auto. Ass'n, 46 Cal. Rptr. 2d 845, 857-58 (Cal. Ct. App. 1995). That appears to be the rule implicitly applied in *Lyons, Dominguez,* and *Williams*. *See* United States Fire Ins. Co. v. Williams, 955 S.W.2d 267, 268-69 (Tex. 1997); National Union Fire Ins. Co. v. Dominguez, 873 S.W.2d 373, 376-77 (Tex. 1994); Lyons Millers Cas. Ins. Co. of Tex., 866 S.W.2d 597, 600-01 (Tex. 1993). It is explicitly advocated by Justice Hecht. *See* Universe Life Ins. Co. v. Giles, 950 S.W.2d 48, 67-68 (Tex. 1997) (Hecht, J., concurring). And it is widely followed elsewhere. *See* Barker & Glad, *supra* note 3, at 53-58. *Dalrymple* and the analogy to malicious prosecution are discussed *infra* at pp. 119-24.

108. *Cf.* Akin v. Dahl, 661 S.W.2d 917, 920-21 (Tex. 1983) ("no evidence" review of finding of no probable cause).

109. *Giles*, 950 S.W.2d at 56 n.6.

110. If existing Texas bad faith law is understood in the way I have argued it should be, then I would share the view attributed to Justice Enoch by Justice Hecht that "bad faith

Whether a reasonable prosecutor (or a reasonable juror) could take a particular view on the basis of specified evidence is a question of law, and it is so treated in the law of malicious prosecution. The question of whether specified evidence created a bona fide dispute warranting "testing the claim in court" is analogous. So for purposes of "no evidence" review in bad faith cases, a reviewing court is ordinarily required to defer to jury factfinding *only* on the question of what the insurer knew (actually or constructively) when it decided to deny the claim.[111]

V. THERE IS NO PROPER PLACE IN BAD FAITH LAW FOR FACT FINDERS TO MAKE VALUE JUDGMENTS ABOUT WHETHER PARTICULAR CLAIMS OUGHT TO HAVE BEEN PAID.

While Justice Hecht and those joining his opinion in *Giles* would limit bad faith liability more extensively than the law analyzed above, they come to much the same conclusion as I do on the scope of the factfinding function.[112] Those asserting that bad faith includes a greater role for the

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law is fine as it is and no change is needed." *Giles*, 950 S.W.2d at 59 (Hecht, J., concurring). *Giles, Nicolau,* and *Simmons* are the only Texas Supreme Court cases even hinting at a different view, and they have not yet articulated a different view or otherwise altered pre-existing law. *See Nicolau* and *Simmons* discussed *supra* at notes 11 and 12, respectively. The possible alternate view which might be implied by the new formulation of the bad faith standard, which was adopted in *Giles,* is critiqued *infra* at pp. 111-15.

Justice Hecht argues that scholars have characterized bad faith law as inadequately defined. *See Giles*, 950 S.W.2d at 65-66. Such complaints frequently reflect the extent to which various jurisdictions define the tort differently and the difficulty of predicting which view a previously uncommitted jurisdiction might take; some of the complaints are directed more to what the commentators deem undue expansion of the tort. *See* Roger C. Henderson, *supra* note 47, at 3-4. I believe that, after *Lyons* and *Dominguez*, Texas *law* had become reasonably clear on the major issues, though *application* has been uneven because many trial courts and some courts of appeals had failed to fully understand that law. *Cf.* Kenneth S. Abraham, *The Natural History of the Insurer's Liability for Bad Faith*, 72 TEX. L. REV. 1295, 1296 (1994) (commenting on the "current stability of bad faith law" nationally).

111. In theory, there could be another factual issue. If the jury could have found that the insurer missed significant information favorable to the insured, it might be arguable that finding that information would have persuaded the insurer to pay, even though a legitimate question about coverage might remain. *See* Barker & Glad, *supra* note 3, at 74-82. But I do not believe there is any case, anywhere in the country, where such a contention has been made by the insured. So the possibility remains a theoretical curiosity.

112. *See* Universe Life Ins. Co. v. Giles, 950 S.W.2d 48, 70-71 (Tex. 1997) (Hecht, J., concurring) (proposing similar scope for factfinding); *see also id.* at 71-74 (advocating more stringent requirement that insurer had been reckless with regard to lack of reasonable basis

fact finder have not explained why they believe this or what that role should be. I suspect that they believe that the fact finder is entitled to make some sort of individualized value judgment, analogous to that in negligence cases, about whether it was reasonable to withhold payment, even if there was a fairly debatable question about the right to payment.[113] If so, I submit that they are mistaken; bad faith law neither does nor should allow such value judgments.

To explain why I think this is so, I begin by pointing out problems created by the new formulation of the bad faith standard adopted in *Giles*. I think that formulation encourages juries to believe that they are entitled to make the sort of value judgments that I oppose. Thus, far from clarifying the standard, that formulation confuses it. A majority of the Court holds that the substance of the standard is unchanged, yet the above analysis shows that the old standard did not authorize juries to make such value judgments.[114] This formulation is likely to have practical consequences that illustrate the theoretical undesirability of allowing such value judgments under any formulation.

I agree with Michael Sean Quinn that "[a]lthough the court intends its tinkering to be merely semantic, its intention is likely to be frustrated by the realities of pre-trial and trial practice."[115] Unless very clearly instructed to the contrary, jurors are likely to feel that liability can be "reasonably clear" even though there remains a bona fide dispute. In particular, "a juror who believes insurers should err on the side of paying a claim will think the

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to deny claim). The major difference between our views on the power of fact finders is that Justice Hecht believes that the proposed division of authority between fact finder and law determiner entails a change in Texas law, while I argue that it is already implicit in existing law. *See id.* at 70, 73-79. (This article takes no position on which standard of culpability is proper.) Cases in most other jurisdictions recognizing the bad faith tort implicitly take the view of factfinding that Justice Hecht and I advocate, but they do not explain their reasons for doing so. *See* Barker & Glad, *supra* note 3, *passim.*

113. That was the explicit position of the court of appeals in *State Farm Fire & Cas. Co. v. Simmons*, 857 S.W.2d 126 (Tex. Ct. App. 1993), *aff'd without addressing this point,* 963 S.W.2d 42 (Tex. 1998). It is also the position taken in Phil Hardberger, *Juries Under Siege*, 30 ST. MARY'S L.J. 1, 39-44 (1998). It is unclear, however, how the jury is supposed to make such a judgment or why a judgment is either necessary or appropriate.

114. *See Giles*, 950 S.W.2d at 48 (Tex. 1997), discussed *supra* at note 1. In contrast to the suggestion that courts must defer to some jury determinations about the reasonableness of an insurer's assessment of the evidence on factual issues, it seems quite clear that courts are to make their own independent evaluation of whether an insurer's legal arguments could be reasonably supported. *See* United States Fire Ins. Co. v. Williams, 955 S.W.2d 267, 268 (Tex. 1997).

115. Quinn, *supra* note 85, at 496.

failure to do so unreasonable."[116] That will force insurers to pay some claims that they might have been defeated if permitted to "test the claim in court." Consequently, it will deny insurers the latitude necessary to question doubtful claims, latitude which decisions recognizing and defining the bad faith tort have always sought to preserve. In turn, that would necessarily inflate insurance costs.[117]

Nor is this the only flaw of the reformulated standard. The statute whose language the court has grafted onto the bad faith tort proscribes failure "to attempt in good faith to effectuate a prompt, fair and equitable settlement of a claim with respect to which liability has become reasonably clear."[118] If "reasonably clear" means that there is no reasonable basis to withhold payment, then this will presumably require insurers to do no more than promptly pay claims which are due. That would mirror the requirements of pre-*Giles* bad faith law.[119] But a requirement to "attempt to effectuate a . . . settlement" might lead jurors to believe that insurers are obliged to offer to compromise doubtful claims, and that the jury is authorized to decide how "fair" the insurer has been in any settlement negotiations.

Bad faith liability for denying claims that are not subject to bona fide dispute is a manageable risk. Exposing insurers to second-guessing of their handling of *questionable* claims would be disastrous. Even if the claim were defeated, an insured might argue that it had enough merit that the insurer should have offered a compromise. If the claim succeeds, the existence of a bona fide dispute would not preclude the contention that a

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116. *Giles*, 950 S.W.2d at 59 (Hecht, J. concurring).

117. Of that possibility, it has been said, "[i]f it is right, then the liability-has-become-reasonably-clear standard spells 'trouble with a capital T' and should not have been adopted." Quinn, *supra* note 85, at 496. "[T]he locution *reasonably clear* brings the tort closer to the law of negligence," and "we can expect counsel to seek a jury charge assimilating insurer bad faith to negligence and, more significantly, to argue the case to the jury as though insurer bad faith is a form of negligence, whatever instruction the court gives." *Id.* at 496-97.

118. TEX. INS. CODE ANN., art. 21.21 (West 1997). *See Giles*, 950 S.W.2d at 55 (quoting statute and proposing to adopt it as the standard for common law bad faith).

119. Justice Hecht's opinion construes the statutory language that way. *See* Universe Ins. Co. v. Giles, 950 S.W.2d 48, 69-70 (Tex. 1997). Justice Enoch must agree in order to conclude that the change in the common law formulation leaves the substantive standard unaltered. *See id.* at 80 (Enoch, J., concurring).

generous compromise should have been offered, so as to save the insured the expense, delay, and anxiety of litigating the claim.[120]

The latter hazard could be avoided by using a formulation that does not suggest an obligation to compromise. But the problem of forcing insurers to pay claims that are subject to legitimate question is inherent in any standard allowing fact finders to make individualized judgments. No judgment is necessary if the claim is beyond question. Any judgment would have to be based on some balancing of the burden to the insured of having to sue for payment against the benefit to the insurer of requiring a suit. Because the typical insured may be seriously impacted by an insured loss, while the insurer is able to pay any individual claim, fact finders are likely to require insurers to call even substantial doubts in favor of insureds.

Fact finders are also likely to create inequalities between insureds whose claims are subject to similar doubts. If some form of balancing of benefits and burdens is allowed, doubts will be called more strongly in favor of more vulnerable insureds. Either the poor must be charged more for similar risks or the rich will be forced to pay an equal amount for what,

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120. Even the technical problems in application of any standard requiring compromise are daunting:

> [H]ow much of an attempt must a carrier make to effectuate a settlement in order for it to be a good faith attempt? In what spirit must the carrier act? Is a letter whereby the carrier offers to pay what it thinks it owes sufficient to avoid liability? What if the carrier is right that it owes some money but wrong about how much it owes? Since a carrier has the right to be wrong, if it makes a good faith error as to the amount it owes, then there should be no liability. Further an almost universally employed negotiation style is to offer less than you think you owe and to demand more than you think you can get. Is an insurance company barred from utilizing this negotiation style, once its liability for some amount has become reasonably clear? . . . . What is the difference between *fair* and *equitable* when it is said that an insurance company must 'effectuate a prompt, fair and equitable settlement of a claim'? What is the force of the word 'settlement'? That term connotes the possibility of free-wheeling negotiation. But the whole thrust of bad faith law is to induce insurance companies to pay what they owe, as opposed to trying to negotiate themselves better deals than they deserve.

Quinn, *supra* note 85, at 496.

in practice, will be lesser coverage.[121] Neither of these effects has any relevance to the purposes justifying the bad faith tort.

To say that insurers should be *legally* free to deny all questionable claims is not to say they will *actually* do so. They must also take account of business issues. An insurer can build valuable goodwill by giving insureds the benefit of the doubt in cases where any dispute is marginal. Also, litigating a claim is frequently more expensive than paying it, even if the insurer expects to win. That is even more true if the insurer expects to lose, as losing will require it to pay, not only the claim, but also possibly the legal fees on both sides and penalty interest.

But there are some claims that the insurer may find should be resisted regardless of expense and risk of loss. This would be especially likely for possibly fraudulent claims.[122] It might also be true of a claim that the insurer sees as part of a pattern that it regards as dubious claims (especially large ones, like those for foundation damage). The insurer might well conclude failure to put such claims to the test whenever possible will only inflate costs by encouraging even more dubious variants.

Forcing insurers to call legitimate doubts in favor of insureds would limit the ability of insurers to resist such claims, if they also realize that a jury might well accept those claims. By definition, fraudulent claims have their infirmities concealed, and the concealment may fool the fact finder (who may call doubts in favor of the insured in determining contract liability). Insureds generally have a strong interest in not funding payment of fraudulent claims, and anything that weakens the ability to challenge such claims is likely to increase their frequency. If there is a bona fide dispute as to the insured's right to payment, the insurer should be entitled to "test the claim in court" even if it is pessimistic about its prospects before a jury. I fear that jurors will not permit this if they are allowed to decide that the insurer ought to have disregarded a genuine question about the bona fides of a claim.

We have grown accustomed to juries making individualized judgments in negligence cases, where they are unavoidable. But nothing inherent in the right to jury trial requires that the legal standard for other causes of action, like malicious prosecution and insurance bad faith, be defined to

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121. *See* Barker, *supra* note 44, at 112-13.

122. *See* Sykes, *supra* note 55, at 425-29 (arguing that forcing insureds to sue when the insurer develops reasonable suspicions of fraud may be the most efficient way to sort out valid claims which generate such suspicions from those in which the suspicions are justified).

require or permit such judgments. For the reasons previously stated, I believe the law of bad faith has been defined in a way that does not require or permit them. Defining the legal standard that way was correct, because (as just explained) broader fact finder discretion would impair the proper operation of the insurance mechanism.

Most of this article focuses on issues raised by *Giles, Nicolau,* and *Simmons.* Like many bad faith cases, they turned on whether the insurer had taken a reasonable view of the available evidence (or had failed to develop evidence) on a coverage-determinative factual issue (respectively, was the insured's treatment the result of a preexisting condition, was the foundation problem caused by a plumbing leak, and was the fire caused by arson). For the reasons discussed above, the question should simply be whether a bona fide dispute warranted testing that issue in court.[123] Before continuing the examination of *Giles, Nicolau,* and *Simmons*, it is necessary to comment on a recent California case raising an even broader issue of jury function.

While the *Giles* plurality and *Nicolau* seem to suggest that juries are, at least sometimes, entitled to exercise some discretion in determining whether the insurer's development and analysis of the evidence was reasonable, that discretion apparently does not extend to analysis of the insurer's legal arguments. This limitation is evident from one of the companion cases to *Giles*, *United States Fire Insurance Co. v. Williams.*[124] *Williams* differs from the others because the denial of coverage was based on a disputed (and incorrect) interpretation of an administrative rule, rather than a contested view on some factual issue. The interpretation, though incorrect, was reasonable, as illustrated by the fact that some of the administrative reviewing officers agreed with it.[125] The court unanimously so held, with none of its members even suggesting any reason for deference to the contrary jury finding. In that respect, the Texas court appears in accord with the general rule that an insurer can conclusively establish proper cause for denying a claim by advancing a tenable legal argument for that result.[126]

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123. *See* Barker & Glad, *supra* note 3, at 53-82 (authorities cited therein).

124. 955 S.W.2d 267, 268 (Tex. 1997).

125. *See id.* at 269.

126. *See* Barker & Glad, *supra* note 3, at 82-91 (authorities cited therein). Texas appellate decisions since *Williams* involving denials based on legal, as opposed to factual, positions accord with this view. *See, e.g.*, Douglas v. State Farm Lloyds, 37 F. Supp. 2d 532, 540-41 (S.D. Tex. 1999) (holding summary judgment of no bad faith based on division

Another example of this doctrine is the recent coverage question in Texas affecting hundreds of cases involving damage to a home's foundation allegedly caused by plumbing leaks. The standard all risk homeowner's policy in Texas had been changed and a question arose as to whether this damage was covered or excluded under the new policy. Once cases went to litigation, insurers began raising this legal question as a defense and litigating the issue. A federal district court and the Fifth Circuit agreed with the insurer's position that this type of damage was excluded under the unambiguous language of the policy, and that there was no applicable exception to the exclusion for damage to the dwelling.[127] Subsequently, however, the Texas Supreme Court disagreed and found coverage for the loss.[128] The courts wisely recognized in subsequent decisions that although the Supreme Court ultimately ruled there was coverage, at the time the issue was litigated, the law was unclear, and the insurer's position was a reasonable one to take, especially considering that the Fifth Circuit agreed.[129]

The recent California appellate decision in *Filippo Industries, Inc. v. Sun Insurance Co.*[130] rejected that rule and allowed jury imposition of tort liability where the jury deemed the insurer's position unreasonable, even though the insurer's position had initially been accepted by the trial court. Such an extension of jury discretion is even less supportable than what is suggested by the recent Texas cases.

Filippo contrasts with the *Williams* court's holding that the acceptance of the insurer's coverage position by some administrative hearing officers demonstrated the reasonableness of the insurer's position. This was so despite the subsequent judicial rejection of that position. The latter holding accords with a long line of cases elsewhere dealing with cases where the

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of authority on key legal issue, even though issue later resolved favorably to insured); Ruch v. State Farm Fire & Cas. Co., No. 3:96-CV-2040-D, 1998 U.S. Dist. LEXIS 19853, at *7-8 (N.D. Tex. Dec. 14, 1998).

127. *See* Sharp v. State Farm, 938 F. Supp. 395 (W.D. Tex. 1995), *aff'd*, 115 F.3d 1258 (5th Cir. 1997).

128. *See* Balandran v. Safeco Ins. Co., 972 S.W.2d 738 (Tex. 1998).

129. *See id.* at 741-42; *see also* Oram v. State Farm Lloyds, 977 S.W.2d 163, 167 (Tex. Ct. App. 1998).

130. 88 Cal. Rptr. 2d 881 (Cal. Ct. App. 1999). As this article goes to press, this decision is still subject to a petition for rehearing. Should that fail, it is likely that the California Supreme Court will be asked to review the case or to order that the opinion not be published in the official reports. Should either of these requests be granted, the case would be deprived of precedential significance. *See* CAL. R. CT. 977.

coverage determining issue is legal, rather than factual. Indeed, a colleague and I have previously written:

> Perhaps the most reliable method of establishing that the insurer's legal position is reasonable is to show that some judge of the relevant jurisdiction has accepted it as correct. The favorable decision need not have been available to the insurer at the time it acted on the claim. After all, if an impartial judicial officer informed by adversarial presentation has agreed with the insurer's position, it is hard to argue that the insurer could not reasonably have thought that position viable.[131]

Examples of this point abound. When a trial court has rendered judgment for the insurer on coverage, an appellate reversal on coverage is commonly accompanied by a ruling that the legal position is fairly debatable and, as a result, precludes any bad faith claim on remand.[132] Similarly, a showing of division among judges considering the question (in other cases or in the same case in another court) ordinarily precludes bad faith exposure.[133] Even acceptance of the question for review by the state

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131. Barker & Glad, *supra* note 3, at 81.

132. *See, e.g.*, St. Paul Fire & Marine Ins. Co. v. Tinney, 920 F.2d 861 (11th Cir. 1991) (Alabama law); Starkville Mun. Separate Sch. Dist. v. Continental Cas. Co., 772 F.2d 168, 170 (5th Cir. 1985) (Mississippi law) (relying on district court's acceptance of insurer's position to show its reasonableness); Safeco Ins. Co. v. Guyton, 692 F.2d 551, 557 (9th Cir. 1982) (California law); Badners v. Prudential Life Ins. Co., 567 So. 2d 1242, 1244 (Ala. 1990); Greene v. Truck Ins. Exch., 753 P.2d 274, 278-79 (Idaho Ct. App. 1988), *review denied*, 776 P.2d 829 (Idaho 1989); Soniat v. Travelers Ins. Co., 538 So. 2d 210, 216 (La. 1989); Carney v. American Fire & Indem. Co., 371 So. 2d 815, 819 (La. 1979); Moore v. Central Am. Life Ins. Co., 535 So. 2d 773, 779 (La. Ct. App. 1988); Kreighbaum v. Automobile Club Ins. Ass'n, 428 N.W.2d 718 (Mich. Ct. App. 1988).

A rare decision subjecting an insurer to bad faith liability despite a trial court decision favoring it on coverage is LaHaye v. Allstate Ins. Co., 570 So. 2d 460, 469 (La. Ct. App. 1990), *writ denied*, 575 So. 2d 391 (La. 1991). The significance on the bad faith question of the trial court's decision favoring the insurer does not appear to have been called to the court's attention.

133. *See* Hillman v. Nationwide Mut. Fire Ins. Co., 855 P.2d 1320, 1325-26 (Alaska 1993); *see also* First Fin. Ins. Co. v. Rainey, 401 S.E.2d 490, 491-92 (Ga. 1991); International Indem. Co. v. Collins, 367 S.E.2d 786, 788 (Ga. 1988); Cotton States Mut. Ins. Co. v. McFather, 309 S.E.2d 799, 802-03 (Ga. 1983); Jefferson Pilot Fire & Cas. Co. v.

supreme court will show that the position was tenable and that there is sufficient doubt to justify continued assertion of the position despite prior rejection by lower courts.[134] Strong, though less conclusive, arguments can be made from judicial acceptance of the argument in other jurisdictions or from the absence of clear authority, such that the insurer's argument was an open question.[135]

A California appellate court in *Dalrymple v. United Services Automobile Association*[136] adopted essentially that logic. Dalrymple, a military officer, had resisted efforts to hospitalize her for mental illness by barricading herself in her quarters and shooting at all who attempted to enter.[137] Before she surrendered, she shot a police officer in the leg.[138] A court martial determined that she was not criminally responsible for the incident because she was unable to appreciate the nature and quality or wrongfulness of her conduct.[139]

The policeman sued for his injuries and Dalrymple demanded a defense from USAA, her homeowner's insurer.[140] While disputing coverage on the basis that the shooting was not an "occurrence" (i.e. accident), USAA defended under a reservation of rights.[141] USAA also brought an action seeking a declaration that there was no coverage. The trial court found

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Prickett, 345 S.E.2d 629, 630 (Ga. Ct. App. 1986); International Indem. Co. v. Woods, 333 S.E.2d 640, 641 (Ga. Ct. App. 1985); Southern Guar. Ins. Co. v. Rowland, 313 S.E.2d 753, 755 (Ga. Ct. App. 1984); Opsal v. United Servs. Auto. Ass'n, 10 Cal. Rptr. 2d 352, 357 (Ct. App. 1992).

134. *See* First Fin. Ins. Co. v. Rainey, 401 S.E.2d 490, 491-92 (Ga. 1991); *see also* International Indem. Co. v. Collins, 367 S.E.2d 786, 788 (Ga. 1988); Downer v. Georgia Farm Bureau Mut. Ins. Co., 337 S.E.2d 422, 424-25 (Ga. Ct. App. 1985); Rago v. State Farm Mut. Auto. Ins. Co., 513 A.2d 391, 395 (Pa. Super. Ct. 1986); Larr v. Minnesota Mut. Life Ins. Co., 924 F.2d 65, 67 (5th Cir. 1991) (law sufficiently doubtful that Fifth Circuit had resorted to certifying question to state court). The Rago court indicated that the reasonabless of the insurer's position also was supported by a supreme court decision on another issue that had raised doubts about an earlier lower appellate court decision adverse to the insurer's position. *See* 513 A.2d at 397.

135. *See* Barker & Glad, *supra* note 3, at 85-87.

136. 46 Cal. Rptr. 2d 845, 857 (Cal. Ct. App. 1995). As this article goes to press, this decision is still subject to a petition for review by the California Supreme Court, which is also being asked (by amici) to order that the opinion not be published in the official reports.

137. *See id.* at 849.

138. *See id.*

139. *See id.* at 849-50.

140. *See* Dalrymple v. United States Auto. Ass'n, 46 Cal. Rptr. 2d 845, 849-50 (Cal. Ct. App. 1995).

141. *See id.*

coverage and USAA then indemnified Dalrymple against the subsequent tort judgment for the policeman.[142]

Dalrymple initially was awarded attorneys fees incurred in the coverage action, but the court of appeal found that she could not recover such fees without establishing bad faith.[143] That issue was tried to a jury, with expert testimony on whether USAA had acted reasonably.[144] The jury found bad faith, but the court of appeal reversed.

The court reasoned that establishing lack of proper cause for contesting coverage was similar to showing lack of probable cause in a malicious prosecution action.[145] Any dispute as to the facts the insurer had before it, like disputes about the facts known to the instigator of a prosecution, would create a jury issue.[146] But where the facts known to the insurer were undisputed, the bad faith issue, like the issue in a malicious prosecution case, was whether a legally tenable basis for litigation existed.[147] That issue "is clearly not a matter within the scope of experience of a lay jury. Rather, the trial court is best equipped to assess whether the insurer had proper cause to seek a ruling on coverage under the particular circumstances."[148]

In *Dalrymple,* there was no dispute about the evidence available to the insurer.[149] While the claim was pending, the insurance law was evolving and uncertain on the relevance of an insured's mental impairment to negate the effect of an intent to injure.[150] Given that state of the law, "there was a genuine issue as to coverage under this policy and USAA had proper cause at each stage of the proceedings to pursue a coverage determination."[151]

The analogy between malicious prosecution and bad faith supports the *Dalrymple* court's treatment of the two standards as equivalent. The essence of malicious prosecution is forcing defense of litigation that should

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142. *See id.* at 850-51, 853.

143. *See id.* at 850.

144. *See id.* at 851.

145. *See* Dalrymple v. United States Auto. Ass'n, 46 Cal. Rptr. 2d 845, 854-55 (Cal. Ct. App. 1995).

146. *See id.* at 855.

147. *See id.*

148. *Id.* While *Dalrymple* itself involved a coverage dispute turning on a purely legal issue, the court's analysis was not limited to disputes of that sort. It applies equally to questions of whether the particular information available to an insurer creates a legally tenable basis to dispute coverage.

149. *See id.* at 856-57.

150. *See* Dalrymple v. United States Auto. Ass'n, 46 Cal. Rptr. 2d 845, 858-59 (Cal. Ct. App. 1995).

151. *Id.* at 860.

never have been brought. The essence of bad faith is forcing the insured to bring litigation that never should have been required.[152] Liability for malicious prosecution has been circumscribed "so that litigants with potentially valid claims will not be deterred from bringing their claims to court."[153] Bad faith law has a similar concern that insurers not be deterred from raising potentially valid challenges to claims for benefits.[154]

Probable cause to bring a prosecution exists if, as an objective matter, the action was "legally tenable."[155] As applied to civil proceedings, it "requires no more than a 'reasonable belief that there is a chance that [a] claim may be held valid on adjudication.'"[156] The applicability of this standard to bad faith cases is shown by the widely followed rule that a genuine issue of fact on coverage, sufficient to preclude summary judgment for the insured on coverage, precludes any liability for bad faith.[157] That is so because any such issue creates a bona fide dispute as to coverage. A legal argument that an insurer could reasonably think might succeed also creates such a dispute.

While *Dalrymple* comports with this analysis, *Filippo Industries* does not. Filippo Industries, a distributor of women's clothing, had purchased inventory (some imported and some domestic), which it stored in a warehouse, pending resale to retailers.[158] Filippo purchased a $650,000 open marine cargo policy from Sun Insurance in 1990, increasing the limit to $1.5 million in the spring of 1992.[159] A fire occurred on May 14, 1992, destroying over $1.7 million worth of clothing, almost half of it domestic goods.[160] Filippo had been in the habit of submitting required inventory reports late and the last report before the fire was for December, declaring goods worth $647,000.[161] In December 1992, Filippo filed a report showing

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152. *See* discussion *supra* Parts IV A-C.

153. Sheldon Appel Co. v. Albert & Oliker, 254 Cal. Rptr. 336, 340 (Cal. 1989).

154. *See* discussion *supra* Parts IV B & C.

155. *Sheldon Appel Co.*, 254 Cal. Rptr. at 337.

156. Professional Real Estate Investors, Inc. v. Columbia Pictures Indus., Inc, 508 U.S. 49, 62-63 (1992) (using same standard to determine when litigation conduct is immune from antitrust liability, even if brought for an anti-competitive purpose).

157. *See* Barker & Glad, *supra* note 3, at 53-67 and authorities collected therein.

158. *See* Filippo Indus., Inc. v. Sun Ins. Co., 88 Cal. Rptr. 2d 881, 882-83 (Cal. Ct. App. 1999).

159. *See id.* at 883.

160. *See id.*

161. *See id.*

an inventory for May exceeding $1.5 million.[162] While investigating the loss, Sun made advances totaling $650,000 by September 1992.[163] On January 28, 1993, Sun declined to make any further payments, taking the position that domestic goods were not covered and that the maximum amount payable was the $647,000 shown by the last pre-fire inventory report.[164] Since Sun had already paid $650,000, it said nothing more was due.

Filippo sued, but Sun obtained summary judgment that the last pre-fire inventory report fixed the maximum amount due.[165] The court of appeals reversed, finding that the late inventory reports affected only collection of the appropriate premium, not the amount payable.[166] Sun then paid an additional $225,876 for the imported goods not covered by its advances, but continued to dispute coverage for the domestic goods.[167] A jury found that the entire policy limit, including $624,124 for domestic goods, was due by January 1, 1993, and that failure to pay the full amount had been in bad faith.[168] It awarded $4,125,000 in consequential damages for the failure of Filippo's business and $750,000 in punitive damages.[169]

Among Filippo's arguments on appeal from the resulting judgment was the claim that its initial victory on summary judgment established that its reliance on the inventory report had not constituted bad faith. Most of the opinion is unreported, but one reported portion rejects that argument.[170] *Dalrymple* was distinguished on the ground that it addressed the propriety of filing a declaratory judgment action, while no such action had been filed in *Fillipo Industries*.[171] Moreover, *Dalrymple* had involved evolving and uncertain law, while *Fillipo Industries* turned only on interpretation of what the court had already held to be unambiguous policy language.[172]

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162. *See id.* at 884.

163. *See id.*

164. *See* Filippo Indus., Inc. v. Sun Ins. Co., 88 Cal. Rptr. 2d 881, 884 (Cal. Ct. App. 1999).

165. *See id.*

166. *See* Filippo Indus., Inc. v. Sun Ins. Co., 42 Cal. Rptr. 2d 182, 185 (Cal. Ct. App. 1995) (*"Filippo I"*).

167. *See Filippo Indus.*, 88 Cal. Rptr. 2d at 885.

168. *See id.*

169. *See id.* The jury also awarded $1.5 million in punitive damages against McGee, Sun's managing agent in the United States, but the court of appeal reversed that award. *See id.*

170. *See id.* at 886-87.

171. *See id.*

172. *See id.*

In this context, the court rejected any analogy to malicious prosecution, finding the contrasts greater than the similarities:

> Malicious prosecution is a disfavored remedy, is a second law suit arising from the same facts, follows a prior resolution in the party's favor, is potentially susceptible of other forms of redress, and necessarily involves legal knowledge in the evaluation of the defendant's act (the filing of the underlying suit). Nothing disfavors a finding in favor of insurance coverage; it has not been preceded by litigation arising on the same facts; the insured has gained nothing from prior litigation; the insured has no other potential redress; legal knowledge is not necessarily required to evaluate the reasonableness of an insurer's actions in denying coverage.[173]

The court also drew an analogy to the rule governing a liability insurer's duty to defend, which it may not refuse to do merely because it believes (even correctly) that the facts are such that no indemnity coverage is due.[174] Just as an insurer may not rely on hindsight to defeat the duty to defend, the court thought it could not do so to defeat bad faith.

Finally, the court reasoned that allowing the trial court's coverage decision to shield the insurer from bad faith claims would effectively deny the insured its right to appeal that decision. It felt this especially inappropriate "in the insurance coverage context, where legal knowledge is not a prerequisite."[175] The court expressed "great faith in the sagacity and reasonableness of trial judges, but we decline to impute infallibility to any court . . . . Mistakes happen, but . . . a mistake should [not] automatically result in depriving an insured of its right to appeal the dismissal of its claim of bad faith."[176]

The *Filippo Industries* court's reasoning fails to distinguish between (1) an insurer's contractual obligation to provide the benefits promised by

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173. Filippo Indus., Inc. v. Sun Ins. Co., 88 Cal. Rptr. 2d 881, 887 (Cal. Ct. App. 1999).

174. *See id.* at 888.

175. *Id.* at 889.

176. *Id.*

its policy, and (2) its tort obligation of good faith and fair dealing in determining whether payment is due. It is true that a finding of coverage is not disfavored. But deterring an insurer from challenging a questionable claim *is* disfavored. Procedurally, bad faith litigation is part of the same suit as the coverage determination, but the two are distinct issues with the same relation as between an underlying suit and a malicious prosecution action. (Indeed, coverage is often bifurcated and determined before any bad faith trial proceeds.[177]) Moreover, treating the trial court's coverage ruling as dispositive of the bad faith claim does not deny the insured the right to appeal the coverage denial or to obtain full redress for any breach of contract.

The issue is whether, in addition to recovering full contractual remedies under the insurance policy, the insured is also entitled to the extraordinary tort remedy granted to protect against insurer abuse in claim handling. Strong reasons of public policy, parallel to those operative in defining the malicious prosecution tort, require protection of an insurer's right to challenge questionable claims. After adversarial presentation, a trial court's conclusion that the claim lacks merit is, at a minimum, powerful evidence that the insurer had reasonable grounds to think that a court might so conclude.[178] It is important to remember that the issue in *Filippo Industries* was whether Sun's legal position on the proper interpretation of the contract was tenable. The jury would not have been permitted to pass on whether Sun's construction was correct, and there is no reason to allow it to sit in judgment (based on conflicting expert testimony) on the reasonableness of the trial court's prior decision.

The supposed analogy to the duty to defend ignores differences between the two issues. A duty to defend is triggered by a mere potential

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177. *See* ASHLEY, *supra* note 50, § 10:41.

178. *Filippo Industries* is particularly troubling because the jury was not permitted to learn that the trial court had ruled in Sun's favor. *See* Filippo Indus., Inc. v. Sun Ins. Co., 88 Cal. Rptr. 2d 881 (Cal. Ct. App. 1999); Appellant's Opening Brief, 14, 45-49; (asserting this as error); Respondent's Brief, 45-48 (arguing that offer of this evidence was not properly renewed and that its exclusion was proper); Appellant's Reply Brief, 40-43 (quoting in limine ruling excluding this evidence and replying to arguments that exclusion was proper). The court of appeal ruled that even an evidentiary presumption based on that ruling would unduly burden the insured. *See Filippo Indus.*, 88 Cal. Rptr. 2d at 889. The court of appeal was also troubled by the possibility that the trial court's decision might not have been fully considered. *See id.* But the remedy for oversights of the sort suggested is the litigant's right to point out those oversights on a motion for reconsideration. There is neither need nor reason to substitute later tort litigation for that remedy.

for indemnity coverage, and the existence (at the time a defense was required) of such a potential is not defeated by the fact that no need for actual indemnification develops. And the test is not, as it would be in a bad faith case, whether it was *reasonable* to believe that indemnity coverage *might not* be required. Rather, the test is whether there was *any possibility* that indemnity coverage *might* be required. Because the substantive standards are almost opposite, no procedural analogy is proper.

Apart from its failure to distinguish properly between the insurer's contractual duties and its tort duties, the *Filippo Industries* court erred in failing to understand the balance struck by bad faith law between assuring payment of claims that are clearly due and assuring that questionable claims may be challenged. Other courts ought not to follow that decision.

VI. WHERE AN INSURER RELIES ON A DISPUTED EXPERT OPINION, EVIDENCE THAT MAY JUSTIFY THE FACT FINDER IN REJECTING THAT OPINION DOES NOT SUPPORT AN INFERENCE OF BAD FAITH UNLESS IT PROVIDES A BASIS TO FIND THAT THE INSURER AT LEAST SHOULD HAVE KNOWN THAT THE OPINION WAS UNWORTHY OF RELIANCE.

The Supreme Court wrestled with the significance of insurer reliance on expert testimony in *State Farm Lloyds v. Nicolau.*[179] Of particular concern there were facts said to permit a jury to find that the insurer had deliberately used a "biased" expert. This section will offer a way of analyzing such problems, and will then apply that to the facts in *Nicolau.*

A. The Role of Experts In Claim Adjustment

As just explained, every claim potentially requires an insurer to make both a legal judgment (is there a bona fide dispute permitting this claim to be challenged) and a business judgment (is it worthwhile economically to challenge this claim even if there is a bona fide dispute). If the claim involves complex or technical matters, the insurer may find it desirable to seek the advice of an expert. Such advice may be useful in making both of these decisions. The insurer will also wish to be able to use the expert to testify, if the opinion results in denial of the claim.

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179. 951 S.W.2d 444, 448-50 (Tex. 1997). The subject has since been touched upon in *Provident Am. Ins. Co. v. Castañeda,* 988 S.W.2d 189, 194 (Tex. 1998).

In selecting an expert for these purposes, an insurer will be aware that there is a range of opinions on most subjects in a complex body of expertise. The more knowledgeable and experienced the expert, the more likely it will be that the expert will have developed opinions about the expert's discipline which would suggest one or another answer to a particular question. To be an expert at all, one must have some beliefs about how the world works, even if other experts in the field accept other beliefs. If the expertise is scientific in nature, these beliefs can be described as a "scientific bias" in favor of particular theories, and the expert will naturally approach specific problems in light of those beliefs.

If the expert's beliefs are outside the bounds of legitimate opinion in the expert's discipline, they are unlikely to be admissible evidence.[180] If they are within those bounds, then they form a proper basis on which to analyze evidence relating to the particular claim. A fact finder could reasonably be asked to accept an opinion based on those views of "how the world works."

An insurer faced with a doubtful claim involving a scientific problem will normally seek the assistance of an expert whose "scientific bias," while within the range of legitimate opinion, is relatively skeptical of the technical positions necessary to support the claim. After all, if the claim is litigated, the insured will undoubtedly select an expert whose bias, scientific or otherwise, is as receptive to those technical positions as possible. If there are no legitimate differences of expert opinion, selection of the expert will not matter. If there are legitimate differences, that very fact would warrant "testing the claim in court," unless the claim would be payable under all of the diverse views. And if the claim is tested, the contest will be unequal if the insurer is not permitted to use the experts whose views of "how the world works" are most hostile to the claim while the insured is permitted to use those whose views are most supportive of the claim.[181]

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180. *See* TEX. R. CIV. EVID. 702; E.I. duPont deNemours & Co. v. Robinson, 923 S.W.2d 549, 553-56 (Tex. 1995); Kelly v. State, 824 S.W.2d 568, 572 (Tex. Crim. App. 1992). *See also* Merrell Dow Pharm., Inc. v. Havner, 953 S.W.2d 706, 711-13 (Tex. 1997) (discussing legal sufficiency of expert testimony to support a verdict).

181. If an expert's general views are treated as a type of "predisposition" rendering an insurer relying on those views liable for bad faith, reliance on an expert can never be safe. Rather the jury will be permitted to subject the insurer to tort liability merely because it is sufficiently persuaded of the views of the insured's expert, who was almost certainly just as "predisposed."

It is even more obviously appropriate for an insurer to select an expert skeptical of the insured's technical position to investigate the claim where, as in *Nicolau*, the insured had already obtained an expert report before the insurer selected its own expert. In such a case, the insured's own expert can be relied upon to call to the attention of the insurer's expert those facts and technical propositions most supportive of the insured's position. Similarly, if the insurer's expert omits any necessary investigative step, the insured's expert can point out the omission and request that it be corrected.

While entitled to do so, an insurer will not usually choose an expert with the most extreme views, even if they are within the bounds of what the discipline regards as legitimate. If the claim is later litigated, an expert usually will be more credible if he or she is closer to the mainstream of opinion in the discipline than to the fringe. And the insurer will normally want the most objective evaluation possible of any competing views which other experts might offer. Such an evaluation would be important in making the business decision whether to challenge the claim, even if it is subject to a bona fide dispute. These factors, however, are matters of good business practice, not issues of good faith.

To rise to the level of bad faith, the insurer must choose an expert whose opinion is unworthy of reliance. This could be an expert whom it knows or should know is unqualified or holds views outside the bounds of those regarded as legitimate in the expert's discipline. This could be an expert whose opinions it knows or should know are formed without adequate investigation. This could also be an expert whom it knows or should know will dishonestly render an "opinion" favorable to the retaining party even when the expert's actual opinion is to the contrary. But the mere fact that the expert selected has a "scientific bias" against claims of the sort at issue does not constitute bad faith. "All experts presumably have certain general views and expertise, and an insurer's mere awareness of such views is not necessarily an indication of bad faith."[182]

Even having retained a properly qualified expert, an insurer may not blindly rely on the opinion rendered. If the opinion is facially incomplete or fails to take account of obviously relevant information, then even a non-expert may be in a position to recognize that it is unworthy of reliance.[183]

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182. State Farm Lloyds v. Nicolau, 951 S.W.2d 444, 449 (Tex. 1997).

183. *See, e.g.*, St. Paul Ins. Co. v. Rakkar, 838 S.W.2d 622, 626-27 (Tex. 1992); Fehring v. Republic Ins. Co., 347 N.W.2d 595, 601-02 (Wis. 1984) (discussed in Barker & Glad, *supra* note 3, at 62-63). *See* Pena v. State Farm Lloyds, 980 S.W.2d 949 (Tex. Ct. App. 1998) (appearing to have been decided on this basis). *See also* Merrell Dow Pharm.,

Absent such glaring defects, however, a non-expert claim handler cannot be expected to second guess an expert on what is necessary to form a proper opinion.

B. State Farm v. Nicolau

While all of this seems entirely clear to me, it is hard to reconcile this analysis with the result in *Nicolau,* at least when review is confined to the facts stated in the various opinions and in the briefs of the parties.[184] On its face, this appears to be an example of unwarranted appellate deference to a value judgment by a jury that the insurer ought not to have contested so vigorously a claim that unquestionably appears to have involved a bona fide dispute.

In rough outline, the facts in *Nicolau* were that the Nicolaus had suffered problems with the slab foundation of their home. Investigation of those problems revealed a plumbing leak. If that leak was the cause of the foundation problems, they were covered. If the foundation problems had some other cause, such as natural groundwater, there was no coverage. The Nicolaus retained experts, who opined that the plumbing leak was the cause. The Nicolaus then filed a claim. State Farm retained Haag Engineering, which opined that the leak was not the cause. After hearing these and other experts, a jury found both coverage and a bad faith denial.

It was undisputed that Haag and the two engineers Haag used to investigate the Nicolau claim for State Farm were highly qualified.[185] It was undisputed that a report by the University of Texas at Arlington had concluded, on the basis of substantial investigation and testing, that leaks of the sort suffered by the Nicolaus rarely cause damage noticeable by a homeowner.[186] It was undisputed that this report was a proper basis for Haag to form a view of "how the world works" which is generally skeptical of claims that damage of the sort here results from the type of leak found

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Inc. v. Havner, 953 S.W.2d 706, 714 (Tex. 1997) (a flaw in expert's reasoning or assumptions may render expert's opinion so unreliable as to be no evidence of its conclusion).

184. I have not examined the record, so it is always possible that there are facts that were not mentioned by either the opinions or the briefs provide the necessary reconciliation.

185. *See Nicolau,* 951 S.W.2d at 458-59 (Hecht, J., dissenting). I treat facts as undisputed if asserted by an opinion or brief in support of State Farm's position and not challenged by or inconsistent with the factual accounts in the Nicolaus' briefs or any of the opinions supporting their position.

186. *See id.* at 458-59.

here.[187] There was no evidence that such a view is beyond the range of legitimate engineering opinion. To the contrary, the Nicolaus' own expert, Hayden, admitted that it would be proper for an engineer to rely on that report.[188]

It is undisputed that Haag considered all of the facts developed by the Nicolaus' engineers and all of the opinions they offered to support the conclusion that the foundation damage resulted from the plumbing leak.[189] It is also undisputed that Haag made extensive investigations of its own, including construction of an elaborate model designed to test the hypothesis that the damage resulted from the leak.[190] Lastly, it is undisputed that Haag presented a plausible explanation relating its opinion to the evidence and explaining its rejection of the contrary opinions of the Nicolaus' experts.[191] Other competent and reputable experts who testified for State Farm at trial also supported Haag's opinion.[192] An expert hired by the Nicolaus, though called by State Farm, testified that the differences among the experts were legitimate variations in expert opinion.[193]

Despite all of this, the Court says that "the Nicolaus presented evidence from which a fact finder could logically infer that Haag's reports were not objectively prepared, that State Farm was aware of Haag's lack of objectivity, and that State Farm's reliance on the reports was merely pretextual."[194] While the evidence described was sufficient to allow the jury to believe the conclusions of the Nicolaus' experts in preference to those of Haag, it does not provide any basis for determining that Haag's reports were so unworthy of reliance that State Farm was not entitled to "test the claim in court."

The evidence indicated that Haag does much of its work for insurers and that it knew that a conclusion that the leak had caused the damage

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187. *See id.* at 459, 461.

188. *See id.* at 461.

189. *See id.* at 459-61.

190. *See id.* at 460.

191. Indeed, the briefs indicate that Haag identified a construction defect – improper placement of the post-tension cables – as a cause, unrelated to the plumbing leak, of many of the problems with the foundation.

192. *See Nicolau,* 951 S.W.2d at 461.

193. *See id.* at 461-62.

194. *Id.* at 448 (opinion of the court). Justice Enoch specifically based his vote to affirm on the conclusion that "[t]he Nicolaus presented evidence . . . that challenged the reliability of the information used by State Farm to deny their claim." *Id.* at 453 (concurring opinion).

would require State Farm to pay the claim.[195] It would support an inference that State Farm selected Haag in part because of Haag's skepticism about the ability of plumbing leaks to cause significant foundation problems.[196] It would support an inference that Haag rarely found that such leaks had caused such problems.[197]

But none of that indicates that Haag was so unworthy of belief as not to warrant "testing the claim in court." The supposed near uniformity of Haag's findings is amply explained by its well-supported views of "how the world works." Nor was there any indication that even one of the other findings referred to have been incorrect. There was simply nothing to support an inference of dishonesty, and that is the only inference that could render unworthy of reliance an expert opinion so clearly supportable within the expert's discipline. Yet dishonesty is precisely what is charged when the court says the jury could have found reliance on Haag's report "pretextual."[198]

The Nicolaus' experts also criticized Haag's investigation in various ways. Perhaps Haag erred in simply accepting the facts found by the Nicolaus' experts about soil conditions, without independent verification and supplementation.[199] (But there was no showing that the sorts of additional investigation suggested would have revealed any further support for the Nicolaus' claim.) Perhaps Haag erred in the evaluation of the reports supplied by the Nicolaus' experts.[200] Perhaps these assessments of

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195. *See id.* at 448.

196. *See id.*

197. *See id.* at 449. As the court points out, there was testimony that the individuals responsible for Haag's findings of such causation (in the only instances known to the Nicolaus' experts) never again (so far as the Nicolaus' experts knew) worked on another case involving a slab foundation. Presumably, this was intended to lead the jury to believe that they had been fired or transferred to some other type of assignment on account of those findings, but there was no showing that the Nicolaus' experts had sufficient familiarity with Haag's reports after the ones in question that they would be expected to have encountered these individuals were they still doing similar work. Consequently, the evidence was considered mere innuendo, which may raise a suspicion but cannot support an inference of the sort of corruption suggested.

198. *Id.* at 449. Even if State Farm set out, dishonestly, to deny the claim no matter what, that dishonesty could hardly be the cause of any wrong to the Nicolaus when the investigation so commenced revealed strong reasons to dispute their claim.

199. *See id.*

200. *See id.*

the significance of the soil moisture observations in the latter reports were unreasonable, as other experts testified.[201]

But neither alone nor together do these points indicate anything more than a bona fide dispute among experts. In particular, the last point does not appear to be critical to Haag's ultimate opinions. An isolated unreasonable evaluation of one piece of evidence is hardly enough to render the entire report unworthy of reliance, unless the jury could have found that the point was critical. The court does not suggest that the jury could have decided, and even if the point was critical, there is no evidence which would support an inference that State Farm knew or should have known either that Haag was being unreasonable on even this point or that the point was indeed critical, if it was.

The court says that the jury could find that State Farm and/or Haag did not handle this claim "objectively."[202] But what does that mean and why does it matter? Neither State Farm nor Haag was required to approach this claim without preconceived ideas about "how the world works" or without a belief that claims of this type are usually ill founded. What State Farm was required to do was (1) to consider all of the facts supporting the claim which a reasonable investigation would reveal, and (2) to pay the claim if those facts showed, beyond bona fide dispute, that the world does not work that way or that this was the exceptional situation where the claim was well-founded even if the world does work that way.

The Nicolaus pointed to no evidence supporting their claim that State Farm failed to discover and consider. A plausible and seemingly well-supported opinion from Haag provided ample ground for State Farm to conclude that there was a bona fide dispute as to the causation of the foundation damage. Nothing in the evidence described by the court or in the Nicolaus' briefs provides any basis to conclude that State Farm was unwarranted in "testing the claim in court."

Michael Sean Quinn has suggested an alternate basis for finding bad faith on this record:

> Haag began with a hypothesis that the plumbing leaks did not cause the foundation to move. A fair-minded person should be willing to abandon (or, at the very least doubt) an initial hypothesis if he is

201. *See id.* at 450.
202. *Id.* at 448.

> faced with clear and intractable counter-evidence, which cannot otherwise be explained. If a person who begins with an initial hypothesis does not exhibit a willingness to give it up in the face of counter-evidence, then that person is probably dogmatic; he is probably irrationally attached to his hypothesis; and he is being unreasonable.[203]

The problem is that this analysis depends on the existence of evidence not identified by the court, by the Nicolaus, or by Professor Quinn. In order to rectify the problem, there would need to be evidence that the facts presented to Haag were indeed "intractable counter-evidence," for which Haag could find no adequate explanation consistent with its opinion on causation. It appears from the opinions and briefs, the facts at issue simply did not have much significance under Haag's view of "how the world works," though they were significant under the different views of the Nicolaus' experts. It is not "dogmatic" to disregard evidence which, after due consideration, is reasonably viewed as not inconsistent with one's hypothesis. Moreover, even if there was evidence from which a jury could conclude that Haag was being dogmatic, there would also have to be evidence that State Farm knew or should have known that, despite its lack of engineering expertise.

In short, State Farm's "legal" decision that the claim need not be paid seems unassailable. Only if the jury is allowed to second-guess the "business" decision whether to pay a *questionable* claim (one subject to a bona fide dispute) could the verdict be supported by the evidence discussed by the court. For the reasons set forth above, I submit that the law should not permit the jury to do so.

This result is especially troubling because the claims at issue in *Nicolau* are a prime example of the sort of dubious claim that insurers ought to be free to contest, unless the facts show the particular claim is indisputably meritorious:

> In the early 1990's, it was common knowledge among lawyers practicing in South Texas that Haag Engineering hardly ever saw foundation damage it thought was caused by water leaks. At the same

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203. Quinn, *supra* note 85, at 503.

> time, many lawyers in the region believed the group of witnesses retained by the Nicolaus specialized in testifying that water leakage caused massive foundation damage. Each side of the engineering controversy emphasized the strong points of its case and ignored what it could not explain. The insureds' witnesses were a charming and articulate bunch, but at the same time many lawyers felt hesitant about them and thought them rascals and rogues.[204]

Even if the caustic view of the Nicolaus' witnesses was unduly harsh, an insurer vigilant to prevent abuse *ought* to test major claims (i.e., foundation claims) for which there are grounds for suspicion. *Nicolau* is a prime example of the dangers of exposing insurers to bad faith liability for denial of a claim which is the subject of a bona fide dispute.

A less egregious error resulting from *Nicolau* is the unpublished (and nonprecedential) decision in *State Farm Lloyds v. Johns.*[205] Like *Nicolau,* this case focused on whether a plumbing leak caused damage to a slab foundation. Once again there were conflicting expert opinions. A jury found coverage and bad faith and the court of appeals, under the guidance of *Nicolau,* affirmed. One factor said to support the verdict was that "State Farm had no procedure in place for resolving the dispute between two reputed experts."[206]

Absence of a procedure for resolving such conflicts should not matter, for existence of a conflict is enough to justify "testing the claim in court," as shown by *Lyons* and *Dominguez.* A California case on this point is *Allstate Insurance Co. v. Madan.*[207] Madan's home was burned during a wind-spread brush fire in the area. However, it was the only house on the street affected. Allstate retained a cause and origin investigator, whose report found burn patterns indicating that the fire originated inside the house and that the dried vegetation around the house had not burned. Bushes and trees around the house were burned only on the sides facing the

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204. *Id.* at 504.

205. No. 05-96-01039-CV, 1998 WL 548887 (Tex. App. Aug. 31, 1998). This unreported opinion is not precedential. *See* TEX. R. APP. P. 47.7. It warrants discussion because the error made by the court is likely to recur. Advocates and courts should avoid similar mistakes.

206. *Id.* at *6.

207. *See* 889 F. Supp. 374 (C.D. Cal. 1995).

house. A videotape of the fire showed interior flames on the first floor, while neither the roof nor the second floor was burning. Traces of accelerants were detected in the remains of the home. Both fire department investigators and a cause and origin expert retained by Allstate agreed that the burning of the house was not caused by the wildfire. But an expert retained by the Madans opined, after considering all the information developed, that the wildfire was the most likely cause.

The reports of Allstate's experts were found sufficient to preclude any possibility that the denial was in bad faith:

> Once the insurer determines that a genuine dispute over coverage exists, it is under no further duty to investigate the claim. If the insurance company's conclusion is not so unreasonable as to be a mere pretext . . ., the insurer is not liable for bad faith....[208]

The Madans argued that Allstate had breached its duty of good faith "by conducting a biased investigation and failing to consider exculpatory evidence."[209] The court found their authority inapposite where, as in *Madan,* the insurer had established a good faith reason for disputing the claim.[210] It also concluded that the evidence demonstrated that "Allstate investigators considered the [exculpatory] evidence and questioned their [own] conclusions," but had reasonable grounds for adhering to those conclusions. [211] Existence of such grounds established compliance with the duty of good faith.

As a California district court has put it, "when . . . the insurance company gives consideration to experts, retained by the insured, who offer opinions that conflict with those of its own experts, but then finds in good faith that the conflicting expert opinions are insufficient to pay the insured's claim, the insurance company has not acted in bad faith."[212]

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208. *Id.* at 380.

209. *Id.* at 381.

210. *See id.*

211. *See id.*; *see also* Packer v. Travelers Indem. Co. 881 S.W.2d 172, 175 (Tex. Ct. App. 1994) (difference among physicians as to necessity for surgery provided grounds for refusal).

212. Rigas v. Allstate Ins. Co., No. CV-97-3913BQRX, 1998 WL 422671 (C.D. Cal. April 16, 1998) (whether damage to insured's home was caused by Northridge earthquake or by noncovered soil settlement).

Before leaving the subject of experts, it is useful to examine cases from jurisdictions other than Texas which have also made negative comments about "outcome-oriented investigations."

C. Tomaselli v. Transamerica

Criticism of an allegedly outcome-oriented investigation appears in a California case, which does not present the same sorts of problems as *Nicolau*. The case of *Tomaselli v. Transamerica Insurance Co.*[213] involved a claim for a crack in the foundation slab of a house. A cause was earth movement, but a second cause was negligent construction. An exclusion for such concurrent causation was allegedly added by endorsement in 1984, though the Tomasellis denied knowledge of that exclusion. The crack was discovered and the claim submitted in May, 1987. Ultimately, the claim was denied based on the endorsement and the one-year suit limitation. A jury found coverage and bad faith, which the court of appeals affirmed (though vacating a punitve damage award). The apparent reasons for finding reliance on the endorsement unreasonable need not concern us here.

The initial communications with the Tomasellis did not mention the one-year issue (purportedly because there was no indication that the claim had not been reported as soon as discoverable). But the adjuster, Watanabe, immediately referred the matter to counsel, Zalma, and suggested that an inquiry be made. The soils engineer investigating the loss reported that areas inside the house had been patched and were beginning to crack again. He also said that Mrs. Tomaselli had described the stress features as "gradually worsening," a statement she later denied making.

Zalma took an examination under oath to ascertain the Tomasellis knowledge of progressive damage. Watanabe informed Mrs. Tomaselli that the EUO was simply a procedure to help settle the claim and that she did not need to have an attorney present. At the EUO, the Tomasellis disclosed their knowledge of a crack in the garage floor and a separation of the patio from the house; however, they regarded all of these things as insignificant. They also mentioned, for the first time, cracks in the bathroom. These were first discovered in 1979, when they took up carpet to lay tile. Cracks in the tile forced them to replace it in 1983, and the tile setter reportedly told them the cracking would recur. (At trial, the

213. 31 Cal. Rptr. 2d 433 (Cal. Ct. App. 1994).

Tomasellis amplified their description of the discussion with the tile setter in ways that minimized its significance.) The Tomasellis were not asked about the alleged statement to the soils engineer.

Arguably, the bathroom cracks were critical to the conclusion that the Tomasellis should have discovered the slab problem more than a year before they reported the claim.[214] Watanabe admitted that, had they been told that it was merely a shrinkage crack, they would not have been required to act at that time.[215] Yet he never asked whether it had been so characterized. Nor did he have the tile taken up to examine the crack. When, after the initial denial, the Tomasellis asserted that the crack had been characterized as a shrinking crack, he treated this information as insignificant in light of the EUO testimony that the tile setter had warned of recurring problems.[216]

Reviewing this evidence, the court stated that "an objective approach to the evidence would suggest appellant was merely negligent in denying coverage."[217] But a jury might have drawn inferences "paint[ing] a more sinister view: a scenario of an insurer searching for ways to avoid paying the claim."[218] The Tomasellis' expert testified that the investigation was inadequate and that even conducting an EUO was bad faith, as EUO's are ordinarily administered only to investigate fraudulent claims.[219] He also characterized the description of the EUO and the dissuasion from bringing an attorney as misleading.[220] While the insurer offered innocent explanations for its actions, the court concluded that the choice of inferences was for the jury.[221]

What the court apparently misunderstood was that the whole "sinister view" was simply irrelevant. The statement that, "under an objective

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214. *See id.* at 440.

215. *See id.* at 438.

216. *See id.*

217. *Id.* at 440.

218. *Id.*

219. *See id.* While suspected fraudulent claims are the most common use of the EUO, nothing in the policy limits them to that use. They are well suited to ascertaining when the insured discovered or should have discovered a loss. So the latter point seems simply wrong.

220. *See id.* The presence of an attorney might have produced answers which would have better clarified the insured's story in support of coverage, and the absence of an attorney to clarify arguably reduced the ability of the EUO to fully investigate the claim. (Of course, presence of an attorney may render the insured's responses less candid, thus reducing the utility of the EUO in detecting meritless claims.)

221. *See id.* at 441.

approach," the insurer, was "negligent" in denying coverage appears to mean either (1) that the insurer unreasonably failed to conduct further investigation (about the bathroom cracks) that would have required payment of the claim or (2) that the insurer's evaluation of the evidence (primarily about those cracks) could be found objectively unreasonable. Either meaning would establish bad faith, and either is consistent with the opinion. Under California law, the insurer's subjective attitudes and motivation are irrelevant to determination of bad faith, so no "sinister view" was required to sustain the bad faith finding.[222]

The dicta about the investigation are troubling, but inconsistent with fundamental principles of California bad faith law. There is, after all, nothing wrong with an insurer "searching for ways to avoid paying the claim," so long as it also considers evidence supportive of the claim and does not withhold payment without finding some fair ground to dispute the claim.[223] The problem in *Tomaselli* is that, as the court apparently viewed the record, the jury could find that (based on all facts a full investigation would have revealed) no such ground existed. Whatever the merits of that conclusion, it has no implications for the problem under consideration here.

D. Benke v. Mukwonago-Vernon

The earliest case suggesting impropriety in an outcome-oriented investigation (apart from failure to discover or consider evidence favorable to the insured) seems to be *Benke v. Mukwonago-Vernon Mutual Insurance Co.*[224] The insured's stable collapsed after a winter storm. Wind damage was covered by the policy, but snow and ice damage was not. The insurer

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222. *See* Powers v. United Servs. Auto. Ass'n, 962 P.2d 596, 604 (Nev. 1996). This case also criticizes failure to conduct an "objective investigation," but immediately ties that criticism to a conclusion that the evidence permitted the jury to find that such an investigation "would have discovered evidence to show that the claim should have been paid." Thus, the statement simply reflects the usual rule charging the insurer with knowledge of what investigation would have found. Additionally, there was a basis to infer that crucial evidence was tampered with while in the insurer's custody, a clear breach of the duty of good faith. Accordingly, this aspect of *Powers* is unremarkable.

223. *See* Packer v. Travelers Indem. Co., 881 S.W.2d 172, 175 (Tex. Ct. App. 1994) (credibility of adjuster not material to summary judgment, despite accusation of biased investigation: "whatever [adjuster's] desires were as to the disposition of Mrs. Packer's claim, ... they are not relevant to proving the existence of a conflict in medical opinion" that precluded liability for bad faith).

224. 329 N.W.2d 243 (Wis. Ct. App. 1982).

denied the claim. The Benkes had regularly shoveled snow off the roof prior to the collapse, and they had two experts who attributed the damages solely to wind, all of which supported the jury's finding of coverage.[225]

On the issue of the insurer's bad faith, the Benkes testified that the employee, Mr. Craig, who took the notice of claim, asserted that there was no coverage, without any inquiry about facts that might support a contrary conclusion. Indeed, Craig brushed off their protests that the snow had been shoveled off the roof. He and an adjuster visited the site, but without speaking to the Benkes. The adjuster noted possible causation by both wind and snow. The insurer hired an architect, Kopecky, who opined that the collapse was due to wind. The insurer immediately responded that it had never seen such a report and that it was "irresponsible." Kopecky was fired, and another expert engaged. The latter concluded that the cause was snow.[226]

As the court viewed the matter, this evidence permitted a jury to find bad faith. It could infer that Craig immediately took the immovable position that only snow could have been the cause and refused to even consider any evidence to the contrary. The jury could further infer "that the insurance company was not interested in a neutral investigation of the cause; rather it was concerned about getting an expert to back up its original theory that snow, not wind, caused the collapse."[227]

If these inferences were accepted,

> there is credible evidence to show that a reasonable insurer ... should not automatically determine the collapse to be caused by an excluded peril and then hire expert after expert until it finds one that comports with its initial determination. A reasonable insurer will conduct a neutral, detached investigation and will then determine whether the investigation proves a claim to be "fairly debatable" such that payment of benefits might not be its responsibility.[228]

225. *See id.* at 245.
226. *See id.* at 247.
227. *Id.* at 247.
228. *Id.*

Even so, the court emphasized that "this is a close case."[229] In particular, it emphasized that there was nothing wrong with seeking a second opinion:

> We are not holding that an insurance company is open to suit for bad faith every time it rejects the opinion of the first expert retained and hires a second or third instead. An insurance company may have perfectly good reasons for not relying on the first expert hired. The insurer may simply conclude, in good faith, that the particular expert's opinion is not as well-founded as that of another. The insurer may believe that the expert's opinion is too speculative to be worthy of belief . . . . There is no reason why an insurer cannot hire another expert if it believes prior investigation has yielded a debatable issue and the expert may have rendered a report not in keeping with the facts.[230]

But the jury could have concluded that this was not what had happened in *Benke*. Arguably, the insurer made up its mind before any arguable question had been found and then "conducted a biased initial investigation" and "hired an expert to back it up" in its preconceived position.[231] It did not "investigate in good faith or hire an expert to prepare an opinion in accordance with good-faith investigation, as it should have done."[232]

It is not possible to evaluate the result in *Benke*. For reasons developed below, the language of the case is overstated. What is missing is discussion of the basis, or lack thereof, for the second expert's opinion. If that opinion provided no good reason for rejecting Kopecky's conclusion, then the case is simply one where (after investigation), the insurer lacked any basis to deny the claim. But if it did provide such a basis, the insurer's arguably ill motivated decision to shop for another opinion ought not to matter. As in *Tomaselli*, intent should be irrelevant.

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229. *Id.*

230. *Id.* at 248.

231. *Id.*

232. *Id.* *Benke* was cited as authority in Fehring v. Republic Ins. Co., 347 N.W.2d 595 (Wis. 1984), *overruled on other grounds by* Dechant v. Monarch Life Ins. Co., 547 N.W.2d 592 (Wis. 1996).

VII. A CIRCUMSTANTIAL CASE MUST BE JUDGED AS A WHOLE.

State Farm Fire & Casualty Co. v. Simmons[233] may be seen as an application of the appellate review methodology advocated here, though the court did not articulate it in that manner. State Farm had denied a claim for fire damage to the Simmons home on the ground that the insureds had committed arson. It set out to prove this circumstantially by showing the "arson triangle" of (1) incendiary origin of the fire, (2) opportunity to set the fire, and (3) motive for doing so.[234] Incendiary origin was clear, and the Simmons's' opportunity to set the fire reasonably so.[235] Thus the apparent issue was motive.

State Farm claimed that the Simmonses had financial problems that provided a motive for them to set the fire.[236] For reasons explained below, the court apparently concluded that the jury could have found it unreasonable for State Farm to believe that the Simmonses had a motive to burn the house.

On the surface, this would satisfy the requirement that the insured show that the asserted reasonable basis for denial failed to create a bona fide dispute.[237] The fire loss to the Simmons home was recognized by all. Because arson is an affirmative defense, the prima facie case required no more. If the "arson triangle" could not provide a reasonable basis for denying the claim – because no motive could be reasonably asserted – then State Farm's only articulated basis would seem to fail. Under this view, the debate between the majority and the dissents about the allegedly deficient investigation would be a side issue, not critical to the result.[238]

The evidence on motive can be summarized as follows. The Simmonses were behind on their mortgage payments and under significant financial pressure.[239] State Farm initially made a mistake in analyzing their financial condition, thinking it far worse than it was, and may not have

233. 963 S.W.2d 42 (Tex. 1998).
234. *Id.* at 45 & note 1.
235. *See id.* at 44.
236. *See id.* at 46.
237. *See* discussion *supra* pp. 24-25.
238. *See supra* p. 47.
239. *See Simmons*, 963 S.W.2d at 46.

fully reconsidered the issue upon discovering the truth.[240] In fact, the Simmonses were not much worse off than was normal for them and they were managing their problems adequately, although they were never far from going under.[241] The insurance was not even enough to pay their mortgage, so a fire would destroy their home without removing the burden of the debt.[242] They had made extensive improvements to the home and would be far worse off after a fire than before.[243] Viewing all of the evidence in the light most favorable to the Simmonses, it is apparent that they had no reason to burn the house and every reason not to do so. State Farm's contrary position arguably could be found unreasonable, and thus the "arson triangle" would collapse.

While that interpretation is plausible, and may well reflect the underlying basis of the affirmance of the bad faith finding,[244] it misses deeper issues about circumstantial proof which should have concerned the court. For the "arson triangle" is not the only way to find circumstantial proof of arson, and an alternate analysis provides a seemingly substantial basis for State Farm's decision to "test the claim in court."

The issue is one of general importance. Arson is a particularly serious type of insurance fraud, of significant concern to both insurers and government agencies.[245] If its impact on insurance costs is to be controlled,

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240. *See id.* at 46-47. State Farm asserted that it had discovered and corrected the initial error before denying the claim and that, even after the correction, a motive to commit arson remained. But the court concluded that the jury could have found this mere "*post hoc* rationalization." *Id.* at 47.

241. *See id.* at 46.

242. *See id.*

243. *See id.* at 43, 46.

244. *See* Provident Amer. Ins. Co. v. Castañeda, 988 S.W.2d 189, 198 (Tex. 1998) (stating that basis of *Simmons* was insurer's unreasonable disregard of evidence that Simmonses had no motive for arson).

245. All states recognize the seriousness of arson and consider it a crime. *See, e.g.*, CAL. PENAL CODE § 451.1 (West 1999); FLA. STAT. ANN. § 806.01 (West 1999); 53 PA. CONS. STAT. ANN. § 3301, 3861 (West 1999); TEX. PENAL CODE ANN. § 28.02 (West 1999). Indeed, some states even increase the criminal punishment if the arson was committed for insurance fraud or other, similar profit motives. *See* PA. CONS. STAT. ANN. §3308 (West 1999). Most states also explicitly recognize the importance of finding and punishing arsonists and give insurance companies who are likely to have such information immunity from a civil action for reporting that information to the prosecuting authorities. *See* MASS. GEN. LAWS ANN. ch. 148, § 32 (West 1999) (no person such as an insurance investigator who furnishes information about suspected arson to the appropriate governmental agency can be held liable for damages in a civil action). Because arson is such a serious crime, an insurer who has facts warranting a belief that the insured committed arson will be shielded

insurers must rely on circumstantial evidence to detect and deny fraudulent arson claims, and they must do so at the risk of occasionally denying the claim of an innocent insured.

In the appellate briefing of *Simmons,* the parties divided the circumstantial evidence into two categories: opportunity and motive.[246] Consistent with the "arson triangle" metaphor, they apparently assumed that both must be shown to make out an arson defense. While this division is useful for some purposes, it is artificial.

The ultimate issue on the contract claim was whether the circumstantial evidence, taken as a whole, was strong enough to make it more probable than not that the Simmonses were the arsonists.[247] If the evidence in one category was strong enough, it might not matter whether evidence in the other category was weak or equivocal. In particular, if it could be shown that the Simmonses *and only the Simmonses* had the opportunity to set the fire, then it would not matter if one thought they lacked a motive to do so. As Sherlock Holmes often remarked, "when you have eliminated the impossible, whatever remains, *however improbable*, must be the truth."[248]

On that front, the briefs indicate that State Farm had a solid case, one not apparent from the opinions. The fire was set shortly after 2:00 a.m. By their own sworn statement, the Simmons family left the house (to drive to Louisiana to visit a relative) between 1:30 and 2:00, and probably closer to 2:00.[249] If their account was falsified or simply imprecise, their departure might have been even later.

Mr. Simmons locked up before leaving.[250] The fire was set at two separate places inside the house.[251] So either the Simmonses did it just

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from bad faith liability for failure to pay the claim. *See, e.g.*, Pieper v. Commercial Underwriters Co., 69 Cal. Rptr. 2d 551 (Cal. Ct. App. 1997); Lee v. Crusader Ins. Co., 57 Cal. Rptr. 2d 550 (Cal. Ct. App. 1996); Evry v. United Servs. Auto. Ass'n, 979 S.W.2d 818 (Tex. Ct. App. 1998); State Farm Lloyds, Inc. v. Polasek, 847 S.W.2d 279 (Tex. Ct. App. 1992).

246. *See* Simmons, Reply to Application for Writ of Error, 21-23; Petitioner's Reply Br. 6-7 & Appendices A&B; Response to Petitioner's Reply Br. 4-12.

247. *See* State Farm Fire & Cas. Ins. Co. v. Vandiver, 970 S.W.2d 731, 736, 738 (Tex. App. 1998) (finding that circumstantial evidence must be considered in totality and is probative of fact if inferences arising from the circumstances are not equally consistent with nonexistence of that fact; circumstantial evidence of arson provided reasonable basis for denial of claim).

248. ARTHUR CONAN DOYLE, *The Sign of (the) Four, in* THE COMPLETE SHERLOCK HOLMES (1988).

249. *See Simmons*, 963 S.W.2d at 44; State Farm Br. at 21.

250. 963 S.W.2d at 44.

before they left, or someone else entered the house to set it almost immediately after they left. There was no evidence of theft, though the fire itself might have concealed such evidence.[252]

The facts that the fire started at just about the time the Simmonses left the house, that it was set from inside, and that the house was generally secured show that they had an easy opportunity to set the fire, and that one has to assume a number of unusual circumstances for someone else to have had that opportunity without their connivance. This evidence points to their culpability, just as the oversized footprint near the body of Nicole Brown Simpson pointed in the direction of O.J. Simpson, even though it is not impossible that another person with feet of a similar unusual size committed the murder.

Even if an enemy or a vandal was inclined to burn the house (apparently without bothering to steal anything), it seems quite extraordinary that he or she would pick this particular time to do so. There is no indication that the Simmonses' impending one-day absence was known widely outside their family, and their own account indicates that the time of departure was not what they had planned. So either the hypothetical enemy/vandal simply happened by at 2:00 a.m. and seized the unexpected opportunity to enter and set a fire, or s/he lay in wait for them to leave and entered essentially as they were pulling out of the driveway. The improbability of these assumptions again points to the Simmonses.[253]

The lack of a motive to commit arson, and even the existence of a strong motive not to do so, does not preclude the possibility that the Simmonses committed arson. After all, people sometimes do stupid things, because they don't think them through. None of the briefs or opinions in *Simmons* offers any reason why the evidence on opportunity did not suffice to warrant "testing the claim in court," even if the motive evidence clearly favored the Simmonses. That is understandable, as the analysis presented here was not offered until two months after the case was argued in the

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251. *See id.*; State Farm App. at 24.

252. *See id.*; State Farm Br. at 21.

253. A Texas lawyer has suggested to me that an "enemy" might have driven by as the Simmonses were loading the car and then awaited their departure. This would render the hypothesis less implausible than the text assumes. Because the briefs describe the lot as wooded, I had assumed the driveway would not be clearly visible from the street. But even if it were visible, this still strikes me as sufficiently improbable to create a jury issue on the identity of the arsonist. Under the analysis advanced here, existence of a jury issue defeats any bad faith claim.

supreme court.[254] One hopes that future courts will not similarly overlook the complexity of the problems presented by circumstantial evidence.

The court's opinion is also extremely critical of State Farm's investigation. The jury might have found that State Farm did not try very hard to pursue the possibility that others might have set the fire.[255] In particular, it did not locate and interview those whom the Simmonses identified as having grudges against them.[256] Combined with the arguably unreasonable contention that the Simmonses had a strong motive to burn the house, this led the court to characterize the investigation as "outcome-oriented," designed solely to support the accusation against the Simmonses.[257]

While the dissents viewed the investigation less negatively than the majority, they focused on the absence of any evidence that the alleged defects in the investigation had caused any harm.[258] The majority responded that requiring the Simmonses to submit such evidence would "turn [the] duty [to investigate] on its head."[259]

Taken in isolation, this last point might suggest that deficient investigation could itself support bad faith liability, without any proof of resulting harm.[260] But other cases reject liability for mere bad faith conduct, in the absence of harm resulting from that wrong.[261] Perhaps the deficient investigation instead supports Professor Quinn's dogmatism argument.[262]

If proof of resulting harm is to be excused in any circumstances, it should be limited to cases, like *Simmons,* where the insurer asserts an affirmative defense instead contesting the insured's ability to prove a covered loss. With the insurer bearing the burden of proof on its defense, one might also shift to it some burden of producing evidence that no harm had resulted from its defective investigation.

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254. *See supra* note 12.

255. *See Simmons*, 963 S.W.2d at 45.

256. *See id.*

257. *Id.*

258. *See id.* at 50-52 (Enoch, J., dissenting), 48-50 (Hecht, J., dissenting).

259. *Id.* at 47.

260. *See* Michael Sean Quinn, *Struggle, Confusion and Diversity: Insurance Bad Faith in Texas – Recent Rapid Evolution*, 20 INS. LITIG. REP. 175, 190 (1998) (noting this possibility).

261. *See supra* note 88.

262. *See* text *supra* p. 50.

Precisely because proof of harm to the protected interest in contractual benefits is so fundamental to the law of bad faith, *Simmons* should not be read to undermine that requirement when it can instead be justified by lack of any reasonable basis for reliance on a supposed motive to commit arson.

Nor ought the characterization of an investigation as "outcome-oriented" itself be regarded as evidence of bad faith. There is nothing inherently wrong with an investigator forming a preliminary opinion as to the likely outcome of the investigation and seeking evidence to confirm that opinion. Arguably, it is impossible to conduct an investigation without some sort of hypothesis to help the jury sort significant evidence from insignificant. In any case, claims investigators are human, and humans commonly draw preliminary conclusions from incomplete evidence and then look for confirmation. Being human is not bad faith. And, in any case, insurers are surely entitled to look as hard as they want for evidence of fraud, even if the circumstances are less suspicious than the ones here.

It is wrong (and bad investigative technique) to fail to look for evidence which might contradict one's hypothesis, if there are obvious places where such evidence might be found. It is equally wrong to fail to take account of such evidence if it is found. In particular, the duty of good faith demands that insurers look for (and take account of) evidence supporting coverage, because they will be chargeable with knowledge if it turns out to exist and to be reasonably discoverable.

But the focus, for bad faith purposes, should not be on the quality of the investigation, in the abstract, but rather should be on the evidence favorable to the insured that the deficient investigation missed. That focus avoids penalizing insurers for failing to pursue every line of inquiry that an insured can dream up (after the fact if necessary). But it will still provide incentives to pursue inquiries that appear to have reasonable prospects of uncovering truly significant information.

The *Simmons* court suggested that one piece of evidence against State Farm was its failure to conform to the investigatory standards which it had set for itself.[263] But an *insurer* does not set the standards to which it must conform to act in good faith. The *law* sets those standards. An insurer sets standards by which it seeks to assure compliance with the law (possibly including a margin for error) and to implement what it regards as good business practices, which will generate and maintain customer goodwill. The violation of such internal standards does not constitute bad faith. At

263. *See Simmons*, 963 S.W.2d at 46-47.

most, an insurer's standards may tend to show what investigation it regards as reasonable. This could provide some support for charging the insurer with knowledge of facts that went undiscovered because it failed to satisfy its internal standards.

While the court does not mention it, the Simmonses also argued that the arson defense must not have been fairly debatable, because State Farm chose not to debate it with them before reaching a decision.[264] But the issue is not whether the claim was "fairly debated" before it was denied. The issue is whether it was one State Farm could fairly demand that the Simmonses debate in court. If so, State Farm might prefer not to preview its entire case before the litigation even started, perhaps giving the Simmonses an opportunity to fabricate evidence to meet that case (as arsonists might be tempted to do).

What State Farm lost by failing to explain its position in more detail before denying the claim was the opportunity to learn of its own misunderstandings that the Simmonses could have corrected, and of any exculpatory evidence it had not previously elicited. As the jury at least might have concluded that such a discussion would have been a reasonable investigative step, State Farm thus would have become chargeable with the information it could have learned by so doing.[265] The risk of being so charged provides a significant incentive for insurers to discuss their positions with their insureds whenever there is any apparent possibility that such a discussion might yield significant information.

CONCLUSION

The law of bad faith can be clarified, and appellate review simplified, by explicit endorsement of the structure of evidentiary burdens explained above. That structure also limits the authority of fact finders in a way necessary to control costs for the benefit of insurance buyers. In applying that structure, reliance on experts should be permitted unless there is evidence that the insurer knew or should have known that the expert was

264. *See id.*; Simmons Br. at 25-30.

265. The briefs suggest that the Simmonses would have had nothing new to say even had State Farm set out its position more fully before denying the claim. *See* State Farm's Post-Submission Br. at 4 (Mr. Simmons testified he did not know what he would have told State Farm had State Farm disclosed all of its information to him at the time the claim was being investigated).

unworthy of belief. When an insurer relies on circumstantial evidence, the circumstantial case must be considered as a whole, rather than subdivided into parts whose individual weaknesses can be attacked without considering the impact of stronger evidence in other parts of the case. While the insurer has a duty to investigate, performance of that duty should be judged on the basis of whether the investigation missed any significant evidence favorable to the insured, rather than on whether, in the abstract, more effort would have been desirable.

CONFERENCE REPORT: A CONFERENCE FOR LATIN AMERICAN REGULATORS ON INTERNATIONAL FINANCIAL SERVICES REGULATION

In October 1999, the Insurance Law Center at the University of Connecticut School of Law hosted and co-sponsored a conference for senior Latin American regulators from fourteen countries regarding the future direction of financial services regulation in Latin America. Participating countries included Argentina, Belize, Bolivia, Brazil, Chile, Costa Rica, El Salvador, Guatemala, Mexico, Panama, Paraguay, Peru, Uruguay and Venezuela. The other sponsors included the United States Department of Commerce, the Connecticut Insurance Department, the International Insurance Council, and the International Insurance Foundation.

For two and one-half days, senior regulatory officials from these countries, along with senior regulators from the United States and Canada, discussed the emerging new insurance and financial services products and their impact on commerce, the need for uniformity and transparency in financial solvency regulation and the pros and cons of various banking and insurance consumer safety-nets. Other topics of interest included cross-border regulation between the United States, Mexico and various other Latin American countries, how the design of a regulatory program can either encourage or discourage economic development, and the need for any workable and effective regulatory system to incorporate into its implementation and conflict resolution processes local cultural perspectives and values.

The conference was the first in a series of annual meetings that the Insurance Law Center will have for financial service regulators throughout the world. Each year the law school will focus on particular geographic area, market or subject of general interest. It will then bring together senior policy makers that are currently working in the region or topic and facilitate the exchange of information on best regulatory practices and market developments. Such meetings provide a unique opportunity for regulators from different countries to learn from one another and to strengthen relationships that are essential to effective regional and worldwide cooperation.

These types of exchanges are increasingly important as the globalization of financial services is placing enormous new demands on business and the financial services environment. Effective regulatory

strategies must cope with the fundamental fact that in today's world, money reinvents itself and recognizes few geographic, political or institutional boundaries.

SEXUAL MALPRACTICE AND PROFESSIONAL LIABILITY: SOME THINGS THEY DON'T TEACH IN MEDICAL SCHOOL – A CRITICAL EXAMINATION OF THE FORMATIVE CASE LAW

*David M. Lang**

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INTRODUCTION

Psychiatrist Renatus Hartogs told his patients he had a cure for them; that cure was sex.[1] When his unique medical "advances" proved deleterious, the patient brought suit and the psychiatrist sought insurance protection for his chosen therapy – repetitive and multiple doses of "Fornicatus Hartogus" perhaps known better under its generic name – sexual intercourse.[2] The question: is "fornication therapy" medical malpractice? The answer tends to be viewpoint dependent. For the injured patient, the answer is an unqualified yes; the insurer, on the other hand, rejects indemnification for sexual misconduct arguing that it is well outside the policy scope. Practitioners generally wish to be protected, though, admit that sexual interaction is not motivated by patient care concerns.[3]

Medical malpractice – mere mention of the words tend to afflict practitioners of medicine with *globus hystericus*.[4] Like tornadoes, claims

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1. *See* Hartogs v. Employers Mut. Liab., 391 N.Y.S.2d 962 (1977).

2. *See id.* at 963 (where the therapist Renatus Hartogs "prescribed, and personally administered multiple, repetitive does of Fornicatus Hartogs." *Id.*).

3. *See id.* at 964 (Hartogs advocated fornication 'therapy' as a cure for his lesbian patient. Hartogs, however, admitted ". . . that he at all times knew that the therapy he was administering was a violation of professional ethics and not within acceptable medical standards." *Id.*).

4. *Globus hystericus* is defined as "a difficulty in swallowing; a sensation as of a ball in the throat as if the throat were compressed. . ." STEDMAN'S MEDICAL DICTIONARY 726 (26th ed. 1995) (Known colloquially as a lump in the throat).

of medical malpractice are difficult to predict as to when they will strike and how much damage they may inflict when they do.[5] As with tornadoes, however, we may have a general indication of *where* they will strike.[6] The existing uncertainty has the predictable effect of causing anxiety for both the insurer and the practitioner, particularly those practicing medicine in the litigation equivalent of Tornado Alley.[7]

Sexual misconduct between a medical provider and patient has become an emerging issue for the professional insurance industry.[8] Plaintiffs injured by a medical provider often seek compensation against the insurer.[9] Likewise, the accused medical provider wishes to be defended and indemnified. The issue: does a medical malpractice policy provide coverage for intentional sexual misconduct? Jurisdictions are split on this controversial issue which involves aspects of contract interpretation pitted against patient expectations for compensation.[10] Part I of this Comment

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5. *See generally*, Larry M. Pollack, *Medical Maloccurrence Insurance (MMI): A First-Party, No-Fault Insurance Proposal for Resolving the Medical Malpractice Controversy*, 23 TORT & INS. L.J. 552 (1988) (for a discussion of the history of medical malpractice insurance).

6. *See* Betsy A. Rosen, Note, *The 1985 Medical Malpractice Reform Act: The New York State Legislature Responds to the Medical Malpractice Crisis with a Prescription for Comprehensive Reform*, 52 BROOK. L. REV. 135, 142 n.40 (1986); *see infra* note 156 (where some specialties such as neurosurgery and obstetrics are more risky and premiums are quite expensive).

7. "Tornado Alley" is an area including parts of Kansas, Texas, Oklahoma, and Nebraska, where the chance of a tornado occurring is far more common than in other locations. *Tornado Alley* (visited April 10, 1999) <http://www.windows.umich.edu/cgi-bin/redirect.cgi/earth/Atmosphere/tornado/alley.html>. Medical practitioners practicing in risky specialties, such as surgery, obstetrics, and anesthesia could be considered in the "tornado belt" of litigation.

8. *See* Linda Jorgenson et al., *The Furor Over Psychotherapist-Patient Sexual Contact: New Solutions to an Old Problem*, 32 WM. & MARY L. REV. 645, 648-49 (1991) (pointing out that in the past, few incidents were reported, whereas after 1980, reports of psychotherapist-patient sexual contact grew at an increasing rate); *see also* David S. Florig, *Insurance Coverage for Sexual Abuse or Molestation*, 30 TORT & INS. L.J. 699, 699 (1995) (noting that "virtually any kind of insurance policy can be implicated, with cases arising under comprehensive general liability (CGL), professional liability, homeowner's, educator's, day care, foster care, and other policies." *Id.*).

9. *See generally* Janet K. Colaneri & Bobbi Reilly, *Non-Actor Liability for Sexual Assaults in Texas and the Effect of Insurance on Recovery*, 2 TEX. WESLEYAN L. REV. 279 (1995).

10. Consider the following description of third party interests offered by Mark C. Rahdert, *Reasonable Expectations Revisited*, 5 CONN. INS. L.J. 107, 140-141 (1998). ("Compensability – The Objective of Protecting Victims from Catastrophic Loss. Once in a

will examine the different theoretical viewpoints and basic elements of malpractice policies. Part II will explore the exclusions and sublimits and how they have withstood scrutiny. Part III will examine different interpretations and tests used by courts when evaluating the malpractice policy and conclude by noting that sexual misconduct falls outside the typical policy coverage. Part IV examines the different treatment the mental health community has received and probe the rationale for that difference. Lastly, Part V will explore the neglected role of provider intent and conclude by postulating a two-part interpretive test that would eliminate non-medical acts from coverage entirely. This test would further restrict the scope of coverage where injuries stem from an instrumentality of medical practice if there is no intent to practice medicine. The Comment concludes by arguing against coverage for acts of misconduct noting that they are unrelated to the good faith practice of medicine, dentistry, and psychiatry.

I. BACKGROUND

Coverage for medical malpractice was first considered as a means to protect physicians from judgments stemming from their practice of medicine.[11] The number of medical malpractice claims skyrocketed in the 1970s.[12] The issue of sexual misconduct in terms of medical malpractice

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very great while, a court takes an even greater step into the realm of policy and uses the reasonable expectations doctrine to protect the interests of persons other than the insured. Insurance, of course, often vitally affects the interests of non-policyholders, such as family members, business partners, employees, customers, even strangers who suffer injury at the hands of the insured. These individuals also have an interest in how insurance policies are interpreted, and they may have 'expectations' – probably not actual beliefs about coverage as much as reliance interests or identifiable needs for protection – regarding the scope of insurance rights under the policy. Their interests frequently coincide with the policyholder's interests, but not always. In extremely rare situations, a court may find that these third-party interests require protection from adverse policy language, and it may act to safeguard these third-party interests by invoking the doctrine of reasonable expectations. This use of the reasonable expectations concept has been most evident in the field of liability insurance, where the court typically pursues the objective of *protecting victims from catastrophic loss*.").

11. *See* Hartogs v. Employers Mut. Liab., 391 N.Y.S.2d 962, 964 (1977) (where the court, considering liability policies generally, notes that: "No longer is it the law in this state that the liability policy existed solely for the protection of the insured." (citation omitted)).

12. *See* Bob Wyrick & Adrian Peracchio, *Both Doctors and Patients Pay for the Few*

coverage is a relatively new legal issue. Most of the cases have occurred in the last two decades, with the number increasing in the past decade.[13]

Medical malpractice actions may be sustained on theories of negligence and battery.[14] A negligence claim is predicated upon failure to use due care, while a battery action involves a treatment which may cause no harm itself but was undertaken without patient consent.[15] Sexual misconduct is generally alleged under a negligence theory. The remainder of this Comment will primarily deal with negligence based claims of sexual misconduct.

The *purpose* of medical malpractice insurance is an important preliminary issue. Failure to address the differing theoretical aspects of

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at Fault Series: Malpractice The Bitter Pill, NEWSDAY, Oct. 27, 1985. "The number of malpractice suits has risen sharply and steadily every year for the last decade. More than 90 percent of the medical malpractice suits filed in this country's history were brought in the last two decades." *Id.* at 7; *see* Emily Couric, *The Tangled Web: When Ethical Misconduct Becomes Legal Liability*, 79 A.B.A.J. Apr. 1993, 64, 66 (noting that "suing doctors made it socially acceptable to sue professionals" *Id.*).

13. *See, e.g.*,St. Paul Ins. Co. v. Cromeans, 771 F. Supp. 349 (N.D. Ala. 1991); Franklin v. Prof'l Risk Management, 987 F. Supp. 71 (D. Mass 1997); St. Paul Fire & Marine Ins. Co. v. Alderman, 455 S.E.2d 852 (Ga. App. 1995); Odegard v. Finne, 500 N.W.2d 140 (Minn. Ct. App. 1993); American Cas. Co. v. Corum, 917 P.2d 39 (Or. Ct. App. 1996); Rivera v. Nevada Med. Liab. Ins. Co., 814 P.2d 71 (Nev. 1991); St. Paul Fire & Marine Ins. Co. v. Torpoco, 879 S.W.2d 831 (Tenn. 1994).

14. *See* Paula Walter, *The Doctrine of Informed Consent: A Tale of Two Cultures and Two Legal Traditions*, 14 ISSUES L. & MED. 357, n.4 (1999) (which explains: "Early cases held that an unauthorized touching or treatment was a battery committed on the patient. Today, the theory of negligence has, generally, replaced battery as the basis for liability in a medical malpractice case." *Id.*). *See e.g.*, State v. Housekeeper, 16 A. 382 (Md. 1889) (holding that a surgeon is justified in performing an operation with his patient's consent). The notion that a physician is obligated to seek his patient's assistance in the decision-making process evolved in the 1960s, in the aftermath of Natanson v. Kline, 350 P. 2d 1093 (Kan. 1960).

15. *See* Mohr v. Williams, 104 N.W. 12 (Minn. 1905) (concluding physician committed battery by operating on patient's left ear rather than right ear), *overruled in part by* Genzel v. Halvorson, 80 N.W.2d 854, 858 (Minn. 1957). The case of medical or technical battery differs from other forms of battery in that medical battery may involve a technically flawless procedure to which the patient never consented. Lack of informed consent may be actionable under a more strict negligence theory; however, failure to demonstrate harm will preclude recovery. *See* Hernandez v. Schittek, 713 N.E.2d 203, 207-08 (Ill. App. Ct. 1999) ("Recovery in a medical battery case is allowed when the patient establishes a complete lack of consent to medical procedures performed, when the treatment is against the patient's will, and/or when the treatment is substantially at variance with the consent given." (citations omitted)).

coverage may ultimately result in a fundamental misunderstanding of the results encountered. The question is whether medical malpractice insurance exists for the protection of the community or protection of the practitioner. At this point, it is useful to explore this question in some detail.

A. Sure Looks Like Malpractice From Where I'm Sitting: The Patient/Plaintiff Viewpoint

Patients who seek the services of a health care professional have an expectation that they will be treated with dignity and respect.[16] When sexually mistreated, the patient often feels violated and embarrassed and manifests an inability to trust medical providers thenceforth.[17] From the examination table, the standard of care has been totally disregarded if not mocked. An act of sexual misconduct may spawn lifelong mistrust of the entire medical community.

Patients, frequently aware that many practitioners carry malpractice insurance, may not wait long to seek retribution. They may also have an impression that insurance exists as a means of self-protection.[18] It is armed with this knowledge that patients trade the "johnny-coat"[19] for the law suit and become plaintiffs seeking insurance proceeds to compensate them for losses; why not – that is the *purpose* of malpractice insurance – compensating harmed patients. From this viewpoint malpractice insurance represents a safety net for injured patients.

B. Don't Forget Our Deal - The Contract: The Insurer Viewpoint

The insured and insurer enter into a mutually binding contract after a meeting of the minds.[20] The insured agrees to underwrite the risks of

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16. *See* Donald Irvine, *The Performance of Doctors: The New Professionalism*, LANCET, Apr. 4, 1999 at 1174.

17. *See* Princeton Ins. Co. v. Chunmuang, 698 A.2d 9, 11 (N.J. 1997) ("Davis had not been able to seek medical assistance from another gynecologist because of the emotional distress that resulted from her examination by Chunmuang." *Id.*).

18. *See* Rahdert, *supra* note 10 at 140-41.

19. A "johnny coat" is that annoying short-sleeved collarless gown one wears while in the hospital or when undergoing a medical exam.

20. *See* RESTATEMENT (SECOND) OF CONTRACTS §§17-21 (1981) (This takes place

practicing in a certain field of medicine in return for a premium payment – that's the deal; there is a binding agreement. Physicians are free to contract with whomever they choose and do so as a means to protect their assets from a mistake made while practicing medicine. The coverage is limited to the insurance policy; nothing else is, or could reasonably be covered. Why would it? This is the *purpose* of malpractice insurance – it protects the doctor for *certain mistakes* in return for a premium payment. Under this viewpoint, malpractice insurance represents a personal shield for the practitioner. The focus, whether insurance is limited to the parties forming the contract or should be considered in terms of third party coverage plays a central role in how courts interpret policy language and the ultimate disposition of the cases.[21]

C. *Traditional Malpractice Coverage: The Duty to Defend and Indemnify, Policy Language, and Exclusions*

Under an insurance liability policy, the insurer has a contractually created duty to defend.[22] This duty is predicated upon the policy's language and is considered broader than the duty to indemnify. Further, this duty exists "even if a suit is groundless, false, or fraudulent."[23] A defense is owed the insured if the complaint's allegations are within coverage and if no exclusions apply.[24]

An insurer will generally have an obligation to defend even if evidence available to the insurer indicates that the claim may appear to be outside the

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through manifestation of mutual assent and does not exist if there is a misunderstanding or no intent to be legally bound).

21. Insurance for criminal acts is likewise under scrutiny. *See* Michael F. Aylward, *Does Crime Pay? Insurance for Criminal Acts,* 65 DEF. COUNS. J. 185, 198 (1998) (Noting, "[i]n 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.").

22. *See* ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW § 111 at 729 (2nd ed. 1996); *see generally* Susan Randall, *Redefining The Insurer's Duty to Defend,* 3 CONN. INS. L.J. 221, 226 (1997) (examining the duty to defend and the complaint rule which requires an insurer to defend any lawsuit where the complaint alleges a claim either covered or potentially covered by the policy).

23. See JERRY, *supra* note 22 at 729.

24. *See id.*

coverage.[25] The medical malpractice policy generally represents a contractual arrangement between a health care professional and insurer.[26] This contract requires the insurer to defend and indemnify the insured.[27] The medical malpractice policy often provides coverage for "professional services" or "medical treatment." Actions not falling within the definitions set forth in the policy language are not covered. Likewise, coverage is further limited by exclusions – conditions that would otherwise be covered by the policy but are expressly removed from coverage by the contract.

Where a claimant has alleged sexual misconduct, the insurer must decide whether to provide or deny a defense. In doing so, the insurer risks an adverse judgment for breach of contract if it is later found that a defense should have been tendered and was not.[28]

Like the duty to defend, the duty to indemnify is created by the contract language. The insurer's duty to pay proceeds in the event of an insured's loss is considered the most important duty the insurer undertakes.[29] In medical malpractice policies, the contract generally indemnifies, or covers, acts which are "professional services"[30] or constitute a "medical incident."[31] Some policies also cover harms "arising out of . . ." a professional service or medical incident.[32] In cases of sexual misconduct, the above language becomes especially important in determining whether an insurer has an obligation to indemnify the insured for actions which may be intentional,

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25. *See id.* at 735 (citing Aetna Ins. Co. v. Janson 377 N.E.2d 296 (Ill. App. Ct. 1978); Dochod v. Central Mut. Ins. Co., 264 N.W.2d 122 (Mich. Ct. App. 1978). *But see* Saylin v. California Ins. Guar. Ass'n, 224 Cal Rptr. 493, 497 (Cal. Ct. App. 1986) (where facts "reveal that potential liability does not exist under the policy, the insurer, at its own risk, may refuse to defend the suit"); Liberty Mut. Ins. Co. v. Metzler, 586 N.E.2d 897 (Ind. Ct. App. 1992) (insurer may refuse to defend when its own independent investigation reveals a claim patently outside the risks covered, but insurer does so at its own peril).

26. *See* Princeton Ins. Co. v. Chunmuang, 698 A.2d 9, 12 (N.J. 1997).

27. *See generally* Hirst v. St. Paul Fire & Marine Ins. Co., 683 P.2d 440, 443, 446 (Idaho 1984) (With the respective duties running from a broad to narrow interpretive duty respectively).

28. *See id.* at 446 (where the court found there was no duty to indemnify but: "[the plaintiffs] stated a claim broad enough to include potential liability of St. Paul to Donehue as its insured at the outset of the suit").

29. *See supra* note 22 at 559 (where this duty is considered the most basic of the insurer's obligations).

30. *See Hirst*, 683 P.2d at 446; *see also* St. Paul Fire & Marine v. Shernow, 610 A.2d 1281 (Conn. 1992).

31. *See* Snyder v. Major, 818 F. Supp. 68, 69 (S.D.N.Y. 1993).

32. *See* Princeton Ins. Co. v. Chunmuang, 698 A.2d 9, 14-15 (N.J. 1997).

and in some cases criminal and thus arguably inconsistent with the plain meaning of the terms medical or professional.[33]

II. EXCLUSIONS AND POLICY LIMITS FOR SEXUAL MISCONDUCT

In addition to the battle over what acts fall within policy language, there are frequent squabbles over exclusions or limits that have the effect of canceling or limiting coverage should an insured and his or her patient engage in sexual activities. Generally, exclusions will be enforced but they will be construed narrowly and read without poetic license.[34] Further, exclusions deemed ambiguous will be construed against the insurer.[35]

Most jurisdictions examining exclusions and sublimits find them valid and apply them in full force.[36] However, some exclusions have been held invalid or ambiguous[37] and sublimit provisions, likewise, have been determined to be ambiguous[38] or violative of public policy.[39] Exclusions frequently encountered in sexual misconduct cases are the criminal acts exclusion,[40] the intentional acts exclusion,[41] the undue-familiarity,[42] the

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33. *See generally* Tracy Raffles Gunn, *The Intentional Acts Exclusion*, 71 FLA. B. J. 86 (May 1997).

34. *See* Franklin v. Prof'l Risk Mgmt. Serv. Inc., 987 F. Supp. 71, 75 (D. Mass. 1997).

35. *See* L.L v. Med. Protective Co., 362 N.W.2d 174, 179 (Wis. Ct. App. 1984).

36. *See* Govar v. Chicago Ins. Co., 879 F.2d 1581 (8th Cir. 1989); *Franklin*, 987 F. Supp. 71; Aldrich v. Nat'l Chiropractic Mut. Ins. Co., No. 96-CV-847S, 1997 WL 662509 (W.D.N.Y. Oct. 14, 1997); Chicago Ins. Co. v. Manterola, 955 P.2d 982 (Ariz. 1998); Rivera v. Nevada Med. Liab. Ins. Co., 814 P.2d 71 (Nev. 1991); *Chunmuang*, 698 A.2d at 9; New Mexico Physicians Mut. Liab. Co. v. LaMure, 860 P.2d 734 (N.M. 1993); Piraro v. Dupuy, 618 So.2d 48 (La. Ct. App. 1993); Prior v. S.C. Med. Malpractice Liab. Ins. Joint Underwriting Ass'n, 407 S.E.2d 655 (S.C. Ct. App. 1991).

37. *See* Vigilant Ins. Co. v. Kambly, 319 N.W.2d 382 (Mich. Ct. App. 1982); *see also L.L.*, 362 N.W.2d 174; American Cas. Co. v. Corum, 917 P.2d 39 (Or. Ct. App. 1996).

38. *See generally* American Home Assur. Co. v. Cohen, 815 F. Supp. 365 (W.D. Wash. 1993), *aff'd*, 67 F.3d 305 (9th Cir. 1995).

39. *See id.*

40. *See Rivera*, 814 P.2d 71; *see generally Chunmuang*, 698 A.2d 9; *LaMure*, 860 P.2d 734. *See also* Illinois State Med. Ins. Serv. v. Cichon, 629 N.E.2d 822 (Ill. App. Ct. 1994); *Aldrich*, 1997 WL 662509.

41. *See generally Prior*, 407 S.E.2d 655 (insured did not have duty to defend or indemnify claims of battery, assault, negligence, and outrage where intentional act exclusion was contained. An intentional tort was alleged and was the act responsible for the purported negligence.); *Piraro*, 618 So. 2d 48.

42. *See* Franklin v. Prof'l Risk Mgmt. Servs. Inc., 987 F.Supp. 71 (D. Mass. 1997).

sexual acts exclusion,[43] the willful-violation[44] and medical treatment or medical services exclusions where coverage is sought against other policies.[45] Some courts encountering exclusions offer well reasoned explanations when they do invalidate exclusion provisions; other jurisdictions appear to be bent on providing compensation with less regard for the formalism they must endure to bestow it.[46]

A. Sexual Misconduct Sublimits: You Feel Like Gambling?

Policies frequently contain maximum liability sublimits for sexual misconduct.[47] For the most part, these limit provisions have been applied with success.[48] In *American Home Assurance Co. v. Cohen*,[49] the plaintiff alleged claims for sexual misconduct and nonsexual misconduct.[50] The plaintiff alleged that the therapist was liable for professional negligence,

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43. *See* Govar v. Chicago Ins. Co., 879 F.2d 1581 (8th Cir. 1989) (where sexual act exclusion precluded recovery); Cranford Ins. Co., Inc. v. Allwest Ins. Co., 645 F. Supp. 1440 (N.D. Cal. 1986) (where sexual intimacy exclusion was applied but was not dispositive because the injury could be attributable to a concurrent proximate cause - abandonment.); Chicago Ins. Co. v. Griffin, 817 F. Supp. 861 (D. Haw. 1993) (sexual act exclusion precluded coverage); Chicago Ins. Co. v. Manterola, 955 P.2d 982 (Ariz. Ct. App. 1998) (where provision to exclude sexual acts did not violate state's public policy.); Rivera v. Nevada Med. Liab. Ins. Co., 814 P.2d 71 (Nev. 1991) (where the court considered criminal, intentional, and sexual acts exclusions and found them applicable); *see also Franklin*, 987 F. Supp. 71.

44. *See* American Cas. Co. v. Corum, 917 P.2d 39 (Or. Ct. App. 1996).

45. Typically, coverage is sought against business owners or commercial liability policies. *See* D.D. v. Ins. Co. of North America, 905 P.2d 1365 (Alaska 1995) (business-owners policy's exclusion for "medical treatment" did not preclude coverage for sexual assault.); Mork Clinic v. Fireman's Fund Ins. Co., 575 N.W.2d 598 (Minn. Ct. App. 1998) (where commercial liability policy "medical services" exclusion did not exempt coverage for sexual abuse)

46. *See infra* text accompanying note 47. ("wrongful acts" exclusion was in conflict with a special section limiting liability for sexual misconduct).

47. *See* American Home Assur. Co. v. Stone, 61 F.3d 1321 (7th Cir. 1995); American Home Assur. Co. v. Bylund, No. CV 91-6091, 1992 WL 691795 (C.D. Cal. Feb. 4, 1992); American Home Assur. Co. v. Smith, 462 S.E.2d 441 (Ga. Ct. App. 1995); *but see Cohen*, 815 F. Supp. 365 (W.D. Wash. 1993), *aff'd*, 67 F.3d 305 (9th Cir. 1995) (where sexual misconduct aggregate limit conflicted with "wrongful act" exclusion.)

48. *See Stone*, 61 F.3d 1321; McConaghy v. RLI Ins. Co., 882 F. Supp. 540 (E.D. Va. 1995); *Smith*, 462 S.E.2d 441.

49. 815 F. Supp. 365 (W.D. Wash. 1993), *aff'd*, 67 F.3d 305 (9th Cir. 1995).

50. *See id. See also* Cassandra Warshowsky, *The Insurer's Right to Allocate Damages Between Covered and Uncovered Claims*, 5 No. 1 Coverage 1 (1995).

breach of fiduciary duty, and loss of consortium.[51] Specifically, the plaintiff alleged that Dr. Cohen induced Ms. Scott to engage in sexual intercourse with him during therapy sessions, failed to provide the plaintiff with any therapy, and failed to seek outside assistance from other professionals regarding his conduct toward her.[52] The alleged sexual intimacies lasted four years. When the patient stopped seeing Dr. Cohen, he threatened to take his own life if she revealed the full nature of the relationship.[53] The plaintiffs amended their complaint to include allegations that Dr. Cohen failed to anticipate two of Scott's suicide attempts, one of which occurred prior to the alleged sexual misconduct.[54]

The policy in question contained a $25,000 sublimit aggregate for all claims where sexual misconduct was alleged in any one or more count. Additionally, the policy contained an exclusion for "wrongful acts."

The court noted that the policy was reasonably susceptible to more than one interpretation as sexual misconduct could also be considered a "wrongful act." The policy contained *both* the sublimit and the exclusion. If sexual misconduct is, by nature, wrongful, then why include a special policy provision to deal with it? Needless to say, an ambiguity was created and the exclusion was not enforced.

More interestingly, however, the court held the policy's provision limiting all claims, after an allegation of sexual misconduct, to $25,000 was against public policy. In so doing, the court referenced several statutes aimed at eliminating unethical therapist behavior and noted that a plaintiff would be reluctant to make mention of sexual misconduct for fear of severely limiting potential compensation. This chilling effect was found to contravene established public policy of ending therapist misconduct and would result in plaintiffs omitting allegations of misconduct out of necessity.[55] The court noted that the plaintiff would be better off with an outright exclusion; an exclusion would not limit all other claims to an aggregate amount, but rather would just preclude recovery on those alleging sexual misconduct, leaving the other claims intact.

However, not all courts see sexual sublimits in the same way.[56] In

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51. *See Cohen,* 815 F. Supp. at 367

52. *See id.*

53. *See id.*

54. *See id.* at 369.

55. *See id.* at 370.

56. *Compare Cohen*, 815 F. Supp. 365, *with* American Home Assurance Co. v. Smith, 462 S.E.2d 441 (Ga. App. 1995).

American Home Assurance Co. v. Smith,[57] the court rejected the *Cohen* court's finding that public policy was not violated by allowing insurers to impose sublimits and that Georgia has a policy of protecting victims of sexual misconduct- the criminal code.[58] *Smith* also noted that the legislature has not mandated malpractice coverage and suggested that "absent a more definitive pronouncement by the Georgia legislature . . ." the court would not create public policy limitations.[59]

Thus, it may be too early to tell if sublimits will act to limit all causes of action where sexual misconduct is an element or if sublimits will be

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57. 462 S.E.2d 441 (Ga. App. 1995). The facts of *Smith* were as follows: "As part of the therapy, Smith assumed some of the characteristics of the perpetrators of past sexual abuse in order to elicit the "re-experiencing" of traumatic events so that the past trauma could be recognized and resolved. Kennedy suspected the therapy she was receiving from Smith was inappropriate, and she contacted the police. She was fitted with a concealed electronic transmitting device, and several sessions were recorded. During one session, Smith placed Kennedy under hypnosis and suggested that she felt very sensual. He then suggested that he lay beside her and hold her. In another session he asked one of Kennedy's alters, "Sabrina," to present herself. Smith then urged her to please him, and make him happy. He told her to lower her jeans and underclothes so that he could hold her closely and kiss her, ostensibly to create a scenario similar to an event she had previously described involving her father. At that point in the session, Kennedy gave a code word to police who interrupted the session." *Id.* at 442-43.

58. *See id.* at 444. "Georgia has a policy of protecting psychotherapy patients from sexual exploitation by therapists, and a psychotherapist who engages in a sexual relationship with his or her patient is guilty of a criminal offense. A civil remedy may also be available, although Georgia's criminal statute does not directly contemplate one. However, simply because the Georgia legislature has evinced an interest in protecting the public from sexual exploitation by therapists, it has not created a statutory obligation requiring psychologists to maintain malpractice liability insurance at all, much less insurance for claims of sexual misconduct. Therefore, it cannot be contrary to the public interest to allow insurers to limit their coverage for this specific risk, that is, their insured's sexual misconduct. Of course, a victim-patient awarded damages in an amount over a coverage limit is not precluded from attempting to recover any deficiency from the therapist personally. Absent a more definitive pronouncement by the Georgia legislature, this court declines to hold that an insurer's limitation of coverage in actions involving sexual misconduct violates public policy." *Id.* at 444.

59. *Id.* at 444; *See generally* Catherine S. Leffler, Note, *Sexual Conduct Within The Physician-Patient Relationship: A Statutory Framework for Disciplining This Breach of Fiduciary Duty,* 1 WID. L. SYMP. J. 501 (1996) (proposing a statutory mechanism for disciplining misconduct), *See also* Jeffrey A. Barker, *Professional-Client Sex: Is Criminal Liability an Appropriate Means of Enforcing Professional Responsibility?,* 40 UCLA L. REV. 1275, 1282 (1993) (where criminal liability should attach "when a professional-client sexual relationship is blatantly manipulative or when harm to the client results from conduct that would be considered "criminal" regardless of the perpetrator's occupation."). *Id.*

invalidated. Reliance on sublimits appears to be quite a gamble for insurers; if successful, all claims are held to the limit, if unsuccessful the provision is invalidated and the insurer may be responsible for all claims, including sexual misconduct, to the maximum policy limits.[60] With an exclusion, there is neither the potential benefit of limiting all surrounding claims nor the uncertainty of invalidation and thus may be more palatable to the risk adverse insurers.

Lastly, *Cohen* appeared to interpret the limitation as sharp and harsh - questioning why mere mention of sex should limit other claims. However, it is well known that plaintiffs will attempt to recover for sexual misconduct using other theories.[61] Given the large and unpredictable jury verdicts for these explosive cases, it makes sense that insurers treat these claims differently.

B. Some Vulnerability of "SEX"clusions

Some cases will invalidate exclusions outright. In *L.L. v. Medical Protective Co.*,[62] where a therapist was accused of sexually mistreating a patient, the policy contained an exclusion for criminal acts which the court refused `to enforce. In its refusal, the court found ambiguous an exclusion for acts ". . . which constitute or are evidence of malpractice but which are also defined as criminal."[63] In finding this ambiguity, the court was able to construe the policy against the insurer. However, it is profoundly unclear why the court had difficulty interpreting this provision; the wording of the exclusion seemed straightforward.

To be sure, we need only consider all of the interpretive options the court had at its disposal. The insurer could have meant to (1) exclude crimes which were also considered malpractice, or (2) exclude crimes which were not considered malpractice. However, is this a true ambiguity?

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60. *See* American Home Assur. Co. v. Levy, 686 N.Y.S.2d 639 (1999) (limit was not against public policy).

61. *See, e.g.* Denise LeBoeuf, *Psychiatric Malpractice: Exploitation of Women Patients*, 11 HARV. WOMEN'S L.J. 83 (1988) ("It has been suggested that the difficulties with malpractice claims be circumvented by opting for another cause of action.") *Id.* at 108. (". . . .[a] victim must go to the deep pockets of an insurance company in order to receive full compensation.) *Id.* at 107. ("In most cases, the courts uphold the victim's right to compensation and refuse to accept insurance company tactics.") *Id.*

62. 362 N.W.2d 174 (Wis. Ct. App. 1984).

63. *Id.* at 179.

Under what strained theory could the second option be considered, in any event, a covered item? An act which is not a professional service is not covered; an exclusion does not apply to something not otherwise covered by the policy. One reaches the issue of exclusions if and only if the act in question was covered by the policy; it is only then that the focus should turn to any applicable exclusions.[64] By considering option (2), the court considered an act which was not within the reach of the original policy language. This act was therefore incapable of being excluded. In this sense the court appears to have created a false ambiguity. As mentioned above, this result appears to be directly preordained by the desire to compensate a third party.[65]

A further vulnerability of the policy exclusion has been encountered.

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64. Other courts expressly noted this point. *See* Princeton Ins. Co. v. Chunmuang, 698 A.2d 9, 18-19 (N.J. 1997), where the court noted:

> The interpretation of a policy containing an exclusion has a somewhat different focus. Logically, to give any meaning to the exclusion, it must be interpreted to exclude something that would otherwise be covered. Therefore, we cannot agree with the majority in the Appellate Division and our dissenting colleague that "the 'criminal acts' exclusion was reserved for situation where the criminal conduct has no relation to the professional services sought.

Id. at 18.

65. *See L.L.*, 362 N.W.2d at 179 (noting that "[f]urther, Wisconsin law recognizes that a liability insurance contract exists for the benefit of injured members of the public as well as for the benefit of the insured." *Id.* However, the court cites to a statutorily required auto insurance policy. These policies have been found to be different because they are required by statute); *see* Wheeler v. O'Connell, 9 N.E.2d 544, 545 (Mass. 1937) (stating that mandatory auto insurance is considered different: "The policy here in question was issued to meet the requirements of our statute of compulsory motor vehicle insurance, and it is to be construed in connection with that statute and the public policy embodied therein." *Id.* at 545. "The purpose of the compulsory motor vehicle insurance law is not, like ordinary insurance, to protect the owner or operator alone from loss, but rather is to provide compensation to persons injured through the operation of the automobile insured by the owner." *Id.* at 546.); Where expanded to medical malpractice, the same result occurs. *See* State v. Liggett , 576 P.2d 221, 227 (Kan. 1978) (holding that mandatory medical malpractice existed for, *inter alia*, public protection.); Missouri Med. Ins. Co. v. Wong, 676 P.2d 113, 120 (Kan. 1984) (where a policy of malpractice insurance is issued to an insured *in compliance with requirements of a statute*, pertinent provisions of the statute must be read into the policy, and no provisions of the policy in contravention of the statute can be given effect). *But see Smith*, 462 S.E.2d at 446 (where the court notes that insurers are free to craft exclusions which are not illegal). The solution to the problem encountered by the court is best solved in the legislative arena.

In *Cranford Insurance Co., Inc. v. Allwest Insurance Co.*,[66] the court considered an interesting problem. *Cranford* involved a patient who sought treatment for childhood sexual molestation. She received two years of psychiatric treatment - then she received a sexual relationship.[67] The patient eventually filed an action alleging medical malpractice and infliction of emotional distress. The policy contained an exclusion for claims "involving . . . sexual intimacy."[68] The psychiatrist was also alleged to have abandoned his patient.[69] The presence of at least one non-sex based claim generated a new direction for the development of case law.

Thus, the court was left with two competing theories responsible for the damages sustained by the patient. Under the *concurrent proximate cause theory*, if there are two possible causes for a set of damages, and one is excluded, the other cause will allow recovery. Put simply, if a non-excluded, competing cause for injuries exists along side the excluded cause, the exclusion will not be enforced. This theory is important because often in therapist cases, numerous potential alternate causes for a set of given damages can be advanced. The presence of this theory will give plaintiffs as many bites-at-the-apple as claims they allege providing that any one can serve as a temporary stand-in for the sexual misconduct. This strategy has been articulated in the literature as a mechanism to bypass exclusions and secure policy proceeds.[70] The proper countermeasure would be a limitation on sex-based evidence. If it was not alleged as its own freestanding claim, it is doubtful if the probative value as to other claims will outweigh its prejudicial effect on the fact finder.[71]

A contrasting view seems to uphold the exclusion if sexual misconduct

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66. 645 F. Supp. 1440 (N.D. Cal. 1986).

67. *See id.* at 1445

68. *Id.* at 1442.

69. *See id.* at 1443.

70. Coverage for sexual misconduct may be reached despite exclusions. Parties may advance theories of boundary violations, transference, abandonment, and other non-excluded concurrent alternate causes which would allow recovery. *See* Linda Jorgenson et al., *Therapist-Patient Sexual Exploitation and Insurance Liability*, 27 TORT & INS. L.J. 595 (1992) (where Cranford is described as the leading case in this area designed to "circumvent insurers' specific exclusionary language and policy caps. . ." *Id. See also* Zipkin v. Freeman, 436 S.W.2d 753 (Mo. 1968) (an early case where the court found coverage irrespective of the alleged sexual misconduct).

71 *See* FED. R. EVID. 403, providing that "[a]lthough relevant, evidence may be excluded if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of cumulative evidence." *Id.*

is found to be an "essential element" of any claim.[72] If a claim mentions sexual contact and that contact is indispensable to the claim, the claim is excluded from coverage. To date, the essential element examination has allowed sexual misconduct to be excluded where the evidence presented at trial demonstrated that sexual misconduct was an essential element,[73] and where sexual activity itself was found to be mishandling of transference - the asserted claim.[74] Whether it ultimately proves to be more "exclusion-friendly" than the concurrent proximate cause theory remains to be seen. At present, the concurrent proximate cause theory seems to be the most "plaintiff-friendly" viewpoint - allowing the plaintiff to launch multiple theories in the hope that one will be found as potentially responsible for the sexual misconduct in explaining the stated damages. Nevertheless, if a plaintiff's entire case is centered on sexual misconduct, the plaintiff will have to demonstrate harm suffered from some non-sexual source in order to escape the exclusion.[75]

Policy sublimits are likewise subject to alternate interpretations. One viewpoint limits policy proceeds if sexual misconduct is "alleged at any time either in a complaint, during discovery, at trial or otherwise."[76] If sexual misconduct is part of the proceedings, the sublimit is automatically imposed. Until overruled, another court advocated an apportionment scheme in cases involving policy sublimit provisions.[77] In that setting, both sexual misconduct and professional misconduct existed and sublimits were applied to damages arising from the sex-based claims, while the non-sex based claims were subject to the standard policy limits.[78] Courts have

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72. *See* Govar v. Chicago Ins. Co., 879 F.2d 1581, 1582 (8th Cir. 1989).

73. *See id.*

74. *See* Chicago Ins. Co. v. Griffin, 817 F. Supp. 861, 865 (D. Haw. 1993).

75. In the concurrent proximate cause theory, it appears that the sexual misconduct itself may not defeat a claim if another present factor, such as boundary violations, coexist. The question is then: when will sexual misconduct not involve "boundary violations," mishandling of transference, or some other purported act of misconduct? If that is the case however, the admittance of sexual misconduct testimony would appear generate to an extremely low probative/prejudicial ratio and thus ought be excluded entirely when the above "professional misdeeds" are what is to be proved. *See* FED. R. EVID. 403.

76. *See* American Home Assur. Co. v. Stone, 61 F.3d 1321, 1323 (7th Cir. 1995).

77. *See* American Home Assur. Co. v. Stephens, 130 F.3d 123 (5th Cir. 1997) (*Reh'g granted, withdrawn*) 140 F.3d 617 (1998), *certifying questions to* 982 S.W.2d 370 (1999), 164 F.3d 956 (1999).

78. *See id.* Although this apportionment scheme has been overruled, it is mentioned here, as the reasoning may be adopted by another jurisdiction. It may be considered because

commented on a possible chilling effect that could occur when plaintiffs, fearing the sublimit, fail to detail instances of sexual misconduct.[79]

C. *Trading Places: Insurers and Plaintiffs Dealing With the Corporate/Business Policy – the Medical Treatment/Medical Services Exclusion*

Some providers have opted not to protect themselves with professional liability insurance but have purchased business or corporate policies. Frequently, business or corporate policies will have exclusions for practicing medicine, dentistry, nursing and other services traditionally rendered in the healthcare setting.[80] When a suit is filed, the litigants get to trade shoes for a day. Owing to the exclusion in business policy for acts of medical malpractice, it is now the insurer arguing that sexual misconduct should properly be considered medical practice and excluded; the plaintiff - aghast at the mere suggestion that such acts could be considered medical practice.

In an interesting twist of events, one case allowed the plaintiff recovery by upholding an exclusion for medical treatment against a policy- holder's business policy. *D.D. v. Insurance Company of North America*[81] involved a physician, Dr. Erkmann, who owned the building he practiced in. He did not carry a professional liability/malpractice policy, but rather a business owner's policy. Dr. Erkmann referred a new patient to another physician who practiced in his building, Dr. Ake, who then sexually assaulted the patient and was subsequently imprisoned. The plaintiff sought recovery from Dr. Erkmann's business owner's insurance policy which contained an exclusion for the practice of, *inter alia*, medicine, dentistry, or nursing.[82]

Ironically, the plaintiff in this case argued that the sexual assault did not constitute medical services or treatment, but rather that Dr. Erkmann was negligent in referring the plaintiff to Dr. Ake and in failing to take reasonable steps to protect her.[83] The court held that a duty to defend

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it offers a third option to courts contemplating between 1) enforcing the sublimit on all claims, and 2) refusing to enforce the limit at all, as in *Cohen*.

79. *See* American Home Assur. Co. v. Cohen, 815 F. Supp. 365, 370 (W.D. Wash. 1993).

80. *See* D.D. v. Ins. Co. of N. Am., 905 P.2d 1365, 1366 (Alaska 1995).

81. *See id.*

82. *See id.*

83. *See id.* at 1367. *See also* Rochelle Rubin Weber, *"Scope of Employment"*

existed and that the exclusion did not apply. The majority reasoned that the duty to defend was created by the allegation that the business owner owed a duty to protect an invitee from a person Dr. Erkmann had reason to know would be dangerous. Further, the court found that the sexual assault was not "medical treatment" and was not excluded. However, the court added that coverage should receive "broad construction" and exclusions should receive "a narrow meaning." Justice Eastaugh criticized this distinction noting that "identical language in coverage parts and exclusionary parts in insurance contracts should be read consistently. . . ."[84]

D.D. is useful in illustrating the distinction some courts make when interpreting exclusions and policy coverage. Further, it illustrates the persuasiveness of a plaintiff's refusal to accept sexual assault as professional services or medical treatment. It likewise indicates that insurer liability for sexual assault may exist under several theories and be recoverable against several policies.[85]

III. POLICY COVERAGE FOR NON-THERAPIST SEXUAL MISCONDUCT

Now that we have considered exclusions, it is useful to examine whether sexual misconduct itself is considered a "professional service" or a "medical incident" and therefore whether coverage should be extended. Likewise, it is useful to examine cases where those acts were not considered covered. Plaintiffs frequently will argue that sexual misconduct is unreasonable for a physician or therapist. Further, they may suggest that insurance coverage is reasonably expected by the general public. In such cases, the doctrine of reasonable expectations may be invoked as a mechanism to secure coverage by the injured third party plaintiff.[86] The defense will generally argue that sexual misconduct does not trigger the policy language and indemnification for wrongful acts is against public policy.

Redefined: Holding Employers Vicariously Liable for Sexual Assaults Committed by Their Employees, 76 MINN. L. REV. 1513 (1992).

84. *See D.D.*, 905 P.2d at 1370 (Eastaugh, J., dissenting).

85. *See also* Mork Clinic v. Fireman's Fund Ins. Co., 575 N.W.2d 598 (Minn. Ct. App. 1998).

86. *See* RAHDERT, *supra* note 10, at 140-41.

A. It's Not the Actor that Counts, it's the Act: The Marx/Hirst Rule

In *Hirst v. St. Paul Fire & Marine Insurance Co.*,[87] a wrestler was given a sedative and sexually mistreated when he sought treatment for a wrist injury.[88] The court declined to consider the act malpractice or a professional service simply because the actor was a doctor. However, the court did not stop there; it expressly relied upon the fact that the sedatives used did not, in and of themselves, cause any injury to the patient. *Hirst* has become a frequently cited case.[89]

Hirst, therefore, arguably saw a difference between a situation where injury would be sustained from the sedatives and the conclusion reached by the court - that the sedatives themselves caused no injury. It is remarkably unclear why the court felt the need to address the question of causation when the medical panel clearly found the acts non professional and the sedatives merely "render[ed] [the boy] susceptible . . . ." to the ensuing mistreatment.[90] *Hirst* seems to produce a means-ends disconnect.

Thus, the following question must be asked. If the ends, meaning the assault, were not professional, and the means used to achieve those ends were undiluted by any therapeutic or treatment considerations, was it improvident for the court to address the issue of causation? Sedating the boy was no more a "professional" service than if a doctor gave an overdose of sedative medication to a hypothetical patient from whom he wished to steal. Certainly both involve an act or service arising out of, and generally utilized in a "calling, occupation, or employment," but viewing that act in a vacuum ignores the reality that an act requiring technical skill is not automatically a professional service. No "calling, occupation, or

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87. 683 P.2d 440 (Idaho Ct. App. 1984) (noting that *Hirst* is the most frequently cited case which found sexual assault outside the definition of professional service).

88. *See id.* at 442. The facts were described as follows: "Dr. Donehue gave Mark Hirst a physical examination so that Hirst could participate in high school wrestling. Hirst later suffered a wrestling injury to a finger and thumb of one hand. After an initial consultation concerning the injury, Donehue asked Hirst to return a few days later. When Hirst returned, Donehue drugged him with valium and librax--two mild tranquilizers-- and performed sexual acts, including oral sex and masturbation, on Hirst against Hirst's will. Donehue told Hirst that Hirst might also have mononucleosis. Donehue scheduled several more appointments at his office and at the Hirst home, for treatment of the injury and testing for mononucleosis. His sexual activities with Hirst recurred during each visit." *Id.*

89. *See* Princeton Ins. Co. v. Chunmuang, 698 A.2d 9, 14-15 (N.J. 1997).

90. *See Hirst*, 683 P.2d at 442.

employment" allows one to render a harmful or corrupt act or service and label it as "professional service."[91] The means as well as the ends would appear to be invalidated as a "professional" if there is no *intent* to practice medicine justifying the course of therapy. Plainly, if a means is used to achieve a non-medical end, that means is no longer a professional service.

As will be examined, *Hirst's* causation analysis opens a Pandora's box from which will flow claims of malpractice where "medical" *means* were employed to achieve non medical *ends*.

B. Too Close to Call: The Intertwined and Inseparable Rule

In *St. Paul Fire & Marine Insurance Co. v. Asbury*,[92] a gynecologist was accused of improperly manipulating his patients during exams.[93] The court examined the policy language covering the "providing or withholding of professional services" and noted that no applicable exclusions applied.[94] *Asbury* held that the acts were " . . . committed in the course of and as an inseparable part of the professional services rendered."[95] *Asbury* also rejected public policy concerns over the indemnification of intentional misconduct by noting "the public policy of Arizona favors protecting the interests of injured parties."[96]

The "intertwined and inseparable" path is problematic for at least three reasons.[97] The court struggles, on the one hand, to provide access to insurance for the injured party, and, on the other hand, to retain accountability for the terrifically injurious actions. The offspring of these

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91. No medical professional could advance such a theory. It is quite possible, though unexplored here, that one who is skilled in the art of assault or attack may be considered to be both performing professional services and committing an assaultive act. (i.e. police officer, bodyguard, etc.). However, even these professionals would still not be guilty of wrongdoing if they conform to the law in both circumstantial propriety and substantive performance of their art (i.e. a bodyguard assaulting a person while not on duty; a police officer shooting a person in the head as opposed to the limb, etc.).

92. 720 P.2d 540 (Ariz. Ct. App. 1986).

93. *See id.* at 542. Dr. Asbury was accused of improperly manipulating the clitorises of his patients when performing gynecological exams.

94. *See id.* at 541.

95. *Id.*

96. *Id.* at 542.

97. In addition to the three mentioned here, *Asbury* also had been criticized for its exclusive reliance on therapist cases which have received different treatment due to the "transference phenomenon." *See* St. Paul Ins. Co. v. Cromeans, 771 F. Supp. 349, 353 (N.D. Ala. 1991).

two masters is a theory which allows any one act to be classified as an intentional assault as well as a professional service.[98] Common sense and other jurisdictions make short work of this doctrinally awkward hatchling.[99]

Secondly, the creators of this rule have speculated that it would be too difficult or otherwise unwise to engage in elucidation of what exactly occurred; but this assumption may be unfounded. Certainly expert testimony would allow the trier of fact to make a decision as to the professionalism of the exam given the contextual backdrop. Standards of medical practice exist and would vividly illustrate examination techniques which are not professional.[100] In fact, other jurisdictions have expressly noted that an affidavit may serve to illustrate what is professional therapeutic conduct and have flatly rejected notions that misconduct is hopelessly ensnared with proper practice.[101] Intertwined, perhaps, but as long as the patient can recount her experience and the defense may call witnesses who are subject to cross examination, there appears to be nothing particularly inseparable about where a medical exam ends and sexual exploitation begins.[102]

Asbury also chooses sides in a public policy debate that seems to have two well-matched arguments. The court decides that public policy is not offended by indemnifying an insured party for intentional sexual misconduct because the insured party does not benefit; it is only the

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98. *See Asbury,* 720 P.2d at 541.

99. Most jurisdictions considering the intertwined and inseparable rule have declined to follow it. *See Cromeans,* 771 F. Supp. at 352-53; St. Paul Fire & Marine Ins. Co. v. Alderman, 455 S.E.2d at 854 (Ga. App. 1995); Roe v. Fed. Ins. Co., 587 N.E.2d 214, 218-19 (Mass. 1992); Princeton Ins. Co. v. Chunmuang, 698 A.2d 9, 14-15 (N.J. 1997) (citing, D.D. v. Ins. Co. of N. Am., 905 P.2d 1365, 1369 n.8 (Alaska 1995)); Niedzielski v. St. Paul Fire & Marine Ins. Co., 589 A.2d 130, 132-33 (N.H. 1991); New Mexico Physicians Mut. Liab. Co. v. LaMure, 860 P.2d 734, 739 (N.M. 1993); Standard Fire Ins. Co. v. Blakeslee, 771 P.2d 1172, 1176-77 (Wash. App. 1989).

100. Standard procedures exist for most medical examinations; gynecological exams are no exception. *See* BARBARA BATES, A GUIDE TO PHYSICAL EXAMINATION AND HISTORY TAKING 5, 390-408 (1991).

101. *See Cromeans,* 771 F. Supp. at 353.

102. Of course, the exam itself must be for a proper purpose. Insisting on an gynecological exam for a finger sprain, even if performed within proper standards, if totally unconcerned with an appropriate clinical justification, would be an improper, unprofessional act and would most likely be the harbinger of malintent. *See* Illinois State Med. Ins. Serv. V. Cichon, 629 N.E.2d 822, 824 (Ill. App. Ct. 1994) (unnecessary rectal exams constituted part of a complaint).

"innocent victim" who will be compensated.[103] It is suggested here that almost anyone examining this statement will immediately find difficult-to-swallow notions that an indemnified party is not benefited by virtue of that very indemnification. Indemnification would seem not only to be *a* benefit, but *the principal* benefit for which one routinely pays premiums.[104]

Thus, this hatchling wobbles on an unsteady public policy rationale that favors third-party protection over the rights of both the parties to the contract as well as over broader concerns of societal interest. Moreover, it does so with reasoning inconsistent with the most basic concepts of insurance law.

C. Two Out of Three Ain't Bad: The Substantial Nexus Test

If a creature more unbecoming than the hatchling exists, surely it would be incarnated as the substantial nexus test. In *Records v. Aetna Life & Casualty Insurance*,[105] the court held that a physician's assault of a nurse was covered under the physician's malpractice policy because that policy provided coverage for any claim "arising out of professional services." Further, the court notes hypothetically that even an accident occurring during a consultation where a physician "negligently stepped on [the nurse's] toe" would be covered because of the "substantial nexus" to the rendering of professional services.[106]

The New Jersey Supreme Court adopted this reasoning in *Princeton Insurance Co. v. Chunmuang*,[107] holding that a gynecologist's improper

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103. *See* Vigilant Ins. Co. v. Kambly, 319 N.W.2d 382, 385 (Mich. Ct. App. 1982).

104. *See* JERRY, *supra* note 29 at 559. "The insurer's duty to pay proceeds in the event of the insured's loss is, from the insured's perspective, undoubtedly the most important duty the insurer undertakes." *Id.*

105. 683 A.2d 834 (N.J. Super. Ct. App. Div. 1996), *cert. denied*, 700 A.2d 876 (N.J. 1997).

106. *See id.* at 837. Thus, the act need only "a[rise] out of" a circumstance where there is some "professional service" rendered, ostensibly, somewhere in the building. The court states: "Although plaintiff's discussion with [the nurse] may have had a less direct relationship to his professional services than this [toe injuring] hypothetical, we are nevertheless satisfied that it "arose out of" the rendering of those services." *Id.* Could not every act, event, occurrence, or incident, according to this reasoning, be said to have "arisen out of" the rendering of a professional service? After all, the rendering of professional services is what brought all parties to work on any given day; of course anything which happens would be, at least, loosely connected to the overall purpose of the parties and location in question.

107. 698 A.2d 9 (N.J. 1997).

manipulations in his office during what he represented to be a gynecological exam constituted a medical incident.[108]

To be sure, in both *Records* and *Chunmuang*, there is a substantial nexus occurring between the event and the practice of medicine with regard to *time*, and *place*; however what is lacking in *Chunmuang* and most obviously *Records* is any relation to "professional services." In fact, it is hard to imagine how *Records* does not rewrite the physician's malpractice policy into one for general liability.[109]

D. Pandora's Box Is Opened

In *St. Paul Fire & Marine Insurance Co. v. Shernow*,[110] the potential problem created by the *Hirst* decision becomes realized and the Pandora's box is opened. *Shernow*, a Connecticut Supreme Court case, dealt with a dentist who, during a dental visit with a long-term patient, placed her under an excessive concentration of nitrous oxide for a prolonged period of time whereupon he sexually assaulted her. The plaintiff, a singer, sustained permanent lung damage when she inhaled stomach acid as a direct result of the dentist's misuse of the gas.[111] It appears as though Dr. Shernow performed no dental work during the hour and one-quarter in question.[112]

The court held that unlike *Hirst*, where the wrestler was not hurt by the sedating medications, this case involved a use of a sedative which did, itself, cause direct injury and accordingly found the incident covered. The majority also noted the complained of acts were related to ". . . a treatment in progress."[113] Further, the court found that public policy was not harmed

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108. *See id.* at 17-18. However, the court held that the policy's exclusion for criminal acts precluded coverage. *See id.* at 18.

109. It is not difficult to descend down what remains of the steep slope *Records* has erected. Consider a physician who negligently spills water upon the floor and a visitor subsequently slips. According to *Records*, this is actionable malpractice. Is this not similar to the hypothetical offered in *Records*? What about an auto accident in the parking lot while driving to work? *Records* considered a non-medical act to be actionable malpractice. It started down a slippery slope where time and place take precedence over the reasonable expectation of the parties and the substantive spirit and express intention of the policy.

110. 610 A.2d 1281 (Conn. 1992). *See generally* Vickie I. Simon, Comment, *Assault as a Professional Service – To Cover or not to Cover*, 13 BRIDGEPORT L. REV. 1023, 1041 (1993) (which predicts Shernow will have a great impact on professional liability law in Connecticut).

111. *See id.* at 1282 n.3.

112. *See id.* at 1286 (Borden, J., dissenting).

113. *Id.* at 1284.

by indemnifying the innocent party when there was no intent to harm.

Shernow demonstrates that a means used to accomplish assaultive end may be construed as a "professional service" if the means is capable, in a proper setting, of being utilized to achieve nonassaultive medical end. What is unclear about the decision is what, in fact, was the ". . . treatment in progress?"[114] Given the absence of any dentistry, we are forced to consider the administration of the nitrous oxide itself as the "treatment."[115] However, was the gas intended to allow for the practice of dentistry or not? Does it even matter?

It seems that absent intent to practice dentistry, the gas could be considered an instrumentality of restraint for commission of a criminal act. If so, is this restraining device then likewise a "professional service?" It would appear that intent plays a key role in examining the act of sedation; where there is no intent to practice dentistry it becomes improbable that actions fall within the letter or spirit of the insurance contract.[116]

Lastly, though not the factual situation here, what if Dr. Shernow had filled three cavities during this visit and all other factors were held constant? Now, we have a situation where intent may be mixed. Indeed, this is a more complex situation which would require exploration of intent to distinguish if over-use of the gas was good faith negligence which fortuitously happened to coincide with the assault or was the action taken

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114. This becomes important because it creates the illusion that actual provision of medical or dental services occurred.

115. The only other possibility is the sexual misconduct itself. Additionally, it is possible, though unlikely, that the majority was referring to the entire 10-year relationship as "treatment in progress."

116. Of course, one may argue that a "professional service" merely represents technical proficiency in a given area and that even a purely criminal action could be a professional service. Consider a doctor who agrees to enter into an organ thieving agreement with others and that his job would merely be to remove the kidney once the patient had been "sedated." However, is this definition of "professional" compatible with either the plain meaning of the word or the reasonable expectations of the parties? If so, would the diabolical dentist who tortured people by drilling into their teeth in the movie Marathon Man be able to bill for his "professional services" after uttering his famous line ". . . Is it safe?" To be sure, the means used (i.e. the drill, hook, etc.) are modalities generally used in the professional practice of dentistry, and to an outside uninformed observer this event may look like a dental visit, albeit a painful one. Does this constitute a "treatment in progress?" I submit that it stretches the imagination too far to suggest that anyone, upon learning the intent of the dentist, could consider dental torture a professional service, especially given that the "dentist-torturer" himself is fully aware of his intent and ramification of his actions. *See* MARATHON MAN (Paramount Pictures 1976).

chiefly for the purposes of restraint.

Proponents of the intertwined and inseparable rule would likely claim that distinguishability or apportionment is not possible. Yet, evidence would undoubtedly and effectively shed light on the propriety of the actions and thereby the intent of the actor. There is little need to suffer from self-imposed doctrinal blindness caused by the intertwined and inseparable path. Needless to say, the substantial nexus test would most certainly find coverage as long as there was some arguable practice of dentistry in the area.

IV. TRANSFERENCE AND THE THERAPIST: SUBSTANCE OR SUBTERFUGE

It is unquestionable that mental health therapists have received different treatment from the courts.[117] This difference is largely attributable to a phenomenon known as *transference* which is often used in the psychotherapeutic setting.[118] The result frequently permits professional liability coverage for sexual acts committed between the patient and therapist.

There is a second major difference between therapist and non-therapist cases. In non-therapist patient sexual misconduct there is generally no defense contention that the patient consented to the complained of acts. Yet, in many of the therapist cases consent is not withheld, in the traditional sense, but rather coerced and misappropriated via the transference mechanism.[119] Thus, patients may superficially "agree" to engage in what appears to be a consensual sexual relationship. In response,

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117. *See* Odegard v. Finne, 500 N.W.2d 140, 143 (Minn. Ct. App. 1993) (noting that transference is not part of the non-therapist relationship). *See generally* Linda Jorgenson et al, *Therapist-Patient Sexual Exploitation and Insurance Liability*, 27 TORT & INS. L.J. 595 (1992); *See also* Linda Jorgenson, *The Furor Over Psychotherapist-Patient Sexual Contact: New Solutions to an Old Problem*, 32 WM. & MARY L. REV. 645, 653-57 (1991).

118. Transference is defined as: "Displacement of affect from one person or one idea to another; in psychoanalysis, generally applied to the projection of feelings, thoughts and wishes onto the analyst, who has come to represent some person from the patient's past. STEDMAN'S MEDICAL DICTIONARY 1837 (26th ed. 1995).

119. *See* Jordana Berkowitz Glasglow, *Sexual Misconduct By Psychotherapists: Legal Options Available to Victims and a Proposal For Change in Criminal Legislation*, 33 B.C. L. REV. 645, 647 (1992) (noting that after consent as a defense is eliminated therapists can be prosecuted more easily).

there is an emerging trend to classify patient-therapist sexual relations as incapable of including traditional consent, and in that way tortious[120] or even criminal.[121]

At this point, we will briefly explore the transference phenomenon and the rationale for the disparate treatment between therapists and non-therapists.

A. Love is Blind. . .?

In *St. Paul Fire & Marine Insurance Co. v. Love*,[122] a psychologist, ironically Dr. Love, was sued after having a sexual relationship with one of his patients.[123] After the sexual relationship began, the therapist told the patient the meetings between them were not professional and terminated billing for sessions after the first sexual encounter.[124] The *Love* court found the insurer had a duty to cover damages sustained by the plaintiff. Because *Love* addresses many of the issues and arguments involved in the general topic it shall be examined in some detail now.

B. Unpacking the Love Decision

First, in considering whether or not therapist sexual misconduct constituted "professional services," the *Love* court distinguished between therapist and non-therapist sexual intimacies by noting that the sexual misconduct between an ordinary doctor and patient is ". . .undiluted by any

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120. *See id.* at 680; *See also* Denise LeBoeuf, *Psychiatric Malpractice: Exploitation of Women Patients*, 11 HARV. WOMEN'S L.J. 83, 100 (1988) ("There are two facets to the problem: the victim's diminished capacity to consent or withhold consent, and the differentiation made by several courts between consent 'under guise of treatment' and full consent.").

121. *See* Glasglow, *supra* note 119, at 680. "Criminalization of sexual misconduct is a positive trend that recognizes the seriousness of the problem of sexual misconduct by psychotherapists. Such criminalization creates numerous benefits both to victims of the sexual misconduct and to society in general. First, criminal statutes may be useful in deterring certain therapists from engaging in sexual misconduct. Second, criminalization benefits the victim by publicly punishing the therapist. Finally, criminalization benefits society because therapists who are imprisoned as a result of the criminal statutes are unable to harm additional patients." *Id.* at 681.

122. 459 N.W.2d 698 (Minn. 1990).

123. *See id.* at 699.

124. *Id.*

treatment consideration[s]."[125] However, as the dissenting Justice, and ironically Dr. Love note there appeared to be no "treatment considerations" with respect to sexual misconduct.126 Dr. Love's own words and the courts own findings repudiate any contention that he had envisioned some treatment objective relating to sexual interaction.[127]

Second, the majority argues that in other cases of doctor patient misconduct the underlying condition was not exacerbated as it was in *Love*.[128] This exacerbation analysis itself hardly seems rationale for inclusion of an act within a policy.[129] There are many factual scenarios where non-therapeutic acts could worsen a patient's condition. Of course, not all acts which would cause a patient's condition to worsen ought be properly construed as a "professional service" or "medical treatment" by virtue of the fact that the act in question tended to worsen a condition.[130]

Third, how a patient's desire for the therapist becomes an "occupational risk" as noted in *Love* is unclear. An occupational risk connotes an environment or situation itself potentially harmful. In the case of transference, nothing is "hazardous" about the actual induction of the transference phenomenon;[131] that is, nothing would preclude the therapist

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125. *See id.* at 701.

126. *Id.*

127. Dr. Love recognized that his sexual relationship "[b]asically eliminated my effectiveness and helpfulness as possible ongoing therapy basis [sic]." *Id.* at 699. The majority's opinion also notes as much: "Dr. Love says he did not consider their relationship to be that of therapist and patient and so he told Mary." *Id.* at 699.

128. *See id.* at 701.

129. The exacerbation analysis has been employed in other cases as well. *See L.L.*, 362 N.W.2d at 178.

130. Consider instead of a therapist having sex with a emotionally fragile patient, a cardiologist having sex with a fragile cardiovascular patient and that this action precipitates a heart attack. Both involve actions which could harm the patient and, more importantly, both involve actions which are not medical or professional. Consider further a situation where a cardiologist arguing with his patient over a bill takes to chasing him up the stairs with a knife. This action then precipitates a heart attack. This example illustrates the difficulty in using the exacerbation analysis, and moreover the problem with using it to define what is or is not a "professional service."

131. That is to say nothing is "hazardous" from the therapist's standpoint. An unaddressed issue is a course of treatment which would lead a patient to make advances toward a third party, to his or her detriment. This course of treatment would properly be considered a "mishandling of the transference phenomenon" and accordingly fall within policy coverage because the third party was not the doctor who was fully aware of the effects of such therapy. However, a therapist exploiting a side effect of therapy is not engaged in "professional services" by virtue of that exploitation.

from properly dealing with the "side effect" of his or her chosen therapy. The missing element, of course, is the therapist's willful exploitation of the induced state. Thus, it appears as though policyholder is fully aware of the situation and yet chooses to exploit it and moreover that this somehow represents an insurable "professional service."

Fourth, it is also interesting to note the court's recognition that the therapist exhibited a "failure on the part of the insured doctor [therapist] to discover or treat an ailment that should have been discovered or treated."[132] However, the dissent correctly points out that the complaint had nothing to do with the discovery and treatment of her underlying condition, but rather to the assault itself.[133]

Lastly, the court notes that sexual conduct while being "aberrant and unacceptable" is "inextricably related to the dynamics of the therapeutic relationship."[134] If this is truly so, then are the legislative initiatives described above fair to the unfortunate therapist who loses himself in the relationship - a victim of his own intervention? The answer is yes; because transference has been successfully commissioned to cloak misconduct as "inextricably related to . . . [a] therapeutic relationship" while utterly failing to explain *how* sexual misconduct is inextricably related to anything except malfeasance.

Transference, albeit an impressive sounding "phenomenon," when explored amounts to little more than a patient's desire for the therapist and accordingly seems problematic when explaining *therapist* misconduct.[135]

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132. *Love*, 459 N.W. 2d at 701 (quoting Smith v. St. Paul Fire & Marine Ins. Co., 353 N.W.2d 130, 132 (Minn. 1984)).

133. *See id.* at 703 (Coyne, J., dissenting). Further, the majority's position that because a therapist engaged in sexual interaction with his patient it is suggestive of a "failure on the part of the insured doctor (therapist) to discover or treat an ailment that should have been discovered or treated" is tenuous. This reasoning is convenient and useful as it attempts to establish professional negligence through a paper-thin presumption that a therapist will *never* willfully take action which will harm a patient. In essence, the issue is reduced to competing probabilities; that is, was it more probable that the therapist did not recognize the underlying condition and that intimacy would worsen it or, alternatively, that he acted with disregard of this knowledge for prurient reasons. Given the weight of authority condemning therapist-patient sexual interaction, the therapist's own assertions and common sense, it appears far more likely that Dr. Love was aware that his actions could have detrimental effects on the patient. Put plainly, the majority's argument, by necessity, falters on any occasion where a therapist's priority shifts from protecting his patient to satisfying his own desires. *See id.* at 703-04 (Coyne, J., dissenting).

134. *Id.* at 702.

135. The transference phenomenon has been criticized as not unique to the

Other jurisdictions have employed similar arguments, all of which giving excessive weight to the phrase "mishandling of the transference phenomenon."[136]

In considering intent, it could be argued that by engaging in sexual interaction with the patient the therapist did not intend to harm the patient. However, once a therapist has intended to act, that is, engage in sexual interaction, there appears to be only a weak argument for professional conduct and that argument hinges on a genuine belief that sexual interaction is in fact therapeutic.[137]

Lastly, *Love* argues that it is no more against public policy to insure a therapist in instances of sexual misconduct for the ultimate benefit of the patient, than it is for an insurer to insure a motorist who injures a person while driving drunk. Apart from the plainly obvious problems with the analogy cited by the dissent, namely that the insured motorist does not intend a collision while a therapists intends sexual interaction, there is a more profound problem with the comparison.[138] The other defect, one elaborated by many courts considering the issue, is that in the motorist example, the *state legislature has spoken for the good of all its citizens when it commanded the requirement that all motorists possess valid auto insurance.*[139] In jurisdictions where medical malpractice is not mandatory

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psychotherapeutic setting. "However, it is certainly not unheard of for a patient to fall in love with a surgeon who has relieved a physical problem. . ." *Id.* at 703 (Coyne, J., dissenting).

136. *See also* Vigilant Ins. Co. v. Employers Ins. Co. of Wausau, 626 F. Supp. 262, 266 (S.D.N.Y. 1986) (where transference permitted sexual misconduct to be considered "sufficiently related" to professional services); Zipkin v. Freeman, 436 S.W.2d 753 (Mo. 1968) (where sexual exploitation was considered mishandling of transference and resulted from professional services); St. Paul Fire & Marine Ins. Co. v. Mitchell, 296 S.E. 2d 126 (Ga. Ct. App. 1982) (where a duty to defend was created by allegation of mishandling of transference); L.L. v. Medical Protective Co., 362 N.W.2d 174 (Wis. Ct. App. 1984) (after discussing transference held that sexual interaction with patient was inseparable from the therapeutic relationship).

137. This suggestion was flatly rejected in Hartogs v. Employers Mut. Liab., 391 N.Y.S.2d 962 (1977) (where "lesbian fornication therapy" did not constitute treatment). *But see Vigilant*, 626 F. Supp at 266 (where "primal therapy," which involved sexual interaction, was found to be "sufficiently related" to the therapy notwithstanding the therapist's own acknowledgment that sexual interaction and therapy were unrelated).

138. One could argue that both intend actions that have a reasonable probability of causing a foreseeable harm and both willingly choose to take that risk.

139. By statute, all motor vehicle operators must obtain insurance for the purpose of providing compensation to all people injured in an automobile accident. *See* MINN. STAT. §§ 65B.42, 48 (1996).

the comparison is simply not apt and the contract theory should prevail.[140] With a legislative mandate, insurance may properly evolve into an area less governed by traditional contract law and more governed by public policy and third party rights.

C. Countertransference

The case of countertransference may logically produce a somewhat different result, notwithstanding the fact that it is generally considered similar to transference and sometimes confused as a proper response to transference.[141] In countertransference, it is postulated that it is the *therapist* who is affected by the therapist patient relationship, and is unable to properly care for the patient. It may be argued that countertransference itself not only is different from transference, but also may correctly involve the policyholder-insurer relationship. If a factual determination is made that the therapist is 1) unable to recognize the occurrence of countertransference, and/or 2) arguably unable to resist its effects, countertransference could be considered an inherent risk in the practice of medicine and thus substantially different than simple transference. If the above two presumptions were possible, therapist sexual misconduct under the effect of countertransference could be considered "an occupational risk;" unlike simple transference, where the therapist recognizes the effects of the intervention and chooses to exploit it, counter-transference involves the therapist who is unaware or unable to control the situation.[142]

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140. *See* Princeton Ins. Co. v. Chunmuang, 698 A.2d 9, 12 (N.J. 1997).

141. Countertransference: "In psychoanalysis, the analyst's transference (often unconscious) toward the patient of his emotional needs and feelings, with personal involvement to the detriment of the desired objective analyst-patient relationship." STEDMAN'S MEDICAL DICTIONARY 405 (26th ed. 1995). *But see* Aetna Life & Cas. Co. v. McCabe, 556 F.Supp. 1342, 1346 (E.D. Pa. 1983) (countertransference was misconstrued and erroneously described "as a phenomenon in psychiatric practice by which the patient transfers feelings toward everyone else to the doctor, *who then must react with a proper response, the countertransference*, in order to avoid emotional involvement and assist the patient in overcoming problems.") (emphasis added). Countertransference does not appear to have been addressed by any jurisdiction exclusively or sufficiently distinct from simple transference. *See generally* Rhoda Feinberg, Ph.D. and James Tom Greene, Ph.D, *Transference and Countertransference Issues in Professional Relationships*, 29 FAM. L.Q. 111 (1995).

142. Compare countertransference with the transference in *Love* where the court noted that the therapist must deal with the patient's advances and concludes: "This may be difficult to do and presents an occupational risk." St. Paul Fire & Marine Ins. Co. v. Love,

D. A Parallel: Medication-Induced Attraction Mimicking Transference Attraction

In *Snyder v. Major*,[143] the plaintiff brought action for declaratory relief that the defendant plastic surgeon's insurer was liable for damages. The plaintiff alleged that the doctor engaged in sexual intercourse with her after he administered sedating drugs to the plaintiff during the course of a medical procedure. The drugs "rendered plaintiff unconscious and thereafter stuporous and mentally impaired and had the foreseeable side effect of stimulating her libido and diminishing her sexual inhibitions and that defendant knew or should have known of those potential effects."[144]

Judge Kimba Wood, reversing in part her previous decision, held that the term "medical incident" excluded the doctor's sexual misconduct, but that a genuine issue of material fact existed as to whether the patient's injuries resulted from the providing of medical services as opposed to mere acts of sexual misconduct.[145] The court reasoned that the utilization of the sedating agents may have caused her advances to Dr. Major and may therefore be the cause of her injuries. *Snyder* held that the issue was a matter of fact for jury's consideration. *Snyder v. Major* presents a fact pattern that contains some commonalities shared with the therapist cases. The *Snyder* court postulated that the jury could find the administration of the medications negligent, that is, that Dr. Major knew or should have

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459 N.W.2d at 701. Justice Coyne likens this "difficulty" to other temptation-based "risks" by stating the following: "the presence of money subjects a bank teller to the occupational hazard of embezzlement; but, of course, that risk has not heretofore been insurable." *Id.* at 703 (Coyne, J., dissenting). Thus, there is the "risk" or temptation to commit an act of misconduct; however, it appears imprudent to consider this a "risk" in terms of an insurable "professional service." *Id.* Mark Twain's comments here are illustrative: "There is a charm about the forbidden that makes it unspeakably desirable." Mark Twain, *Notebook*, *in* THE INTERNATIONAL THESAURUS OF QUOTATIONS 634 (Eugene Ehrlich et al. eds., 1935). But does forbidden desirability or opportunism transform the "difficult" and "tempting" to an insurable risk of a "professional service?" What is likewise unclear is how often true countertransference would so incapacitate the judgment of the therapist to the point where he or she was unaware of the situation or unable to resist engaging in sexual relations with the patient. Common sense seems to indicate that this occurrence, particularly the absolute inability to resist sexual interaction, would be rare if ever present at all.

143. 789 F. Supp. 646 (S.D.N.Y. 1992), *rev'd in part by* 818 F. Supp. 68 (S.D.N.Y. 1993).

144. *Snyder*, 818 F. Supp. 68, 70 (S.D.N.Y. 1993) (internal quotes omitted).

145. *See id.* at 69-70.

known that the medications would have side effects. The court further noted that a jury's finding that the abuse did not occur "in the furnishing of . . . health care services" would prevent indemnification.[146]

The anesthetic medications given to the plaintiff, which were alleged to stimulate the plaintiff's libido and cause her to make sexual advances toward Dr. Major, created a situation somewhat similar to the induction of transference in the therapist cases. Both involve a therapeutic intervention which is known to cause a patient to possibly make advances to the physician/therapist. Examining the relationship between the policyholder and the insurer, the logical framework of both the induction of transference and the libido-stimulating intervention is similar but also differs in an important respect. For example, consider the fact that Dr. Major did *not* know but *should have known* that the anesthetic given would cause Ms. Snyder to make sexual advances toward him. His intent in administering the medication was rightful and his consummation of sexual activities was not done in an exploitative manner.[147] Yet it remains that sex is still the offending aspect of this encounter and itself should not, under an act-based test, be considered "professional services" or medical practice.

The two paths diverge when considering that the administration of the medication itself was the negligent act, and that the physician's sexual involvement was a matter of chance, not design or necessity.[148] It would be equally probable that administering of the medication would cause Ms. Snyder to make sexual advances to a third party. Injuries stemming from those advances toward a third party, owing to the administration of the medication, would clearly seem to be malpractice.[149]

Here, because the physician was an unknowing participant,[150] his status is no more important than if he were a third party. This is so because

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146. *Id.* at 70.

147. This argument assumes that patient-physician sexual relationships, by nature, have no exploitative component.

148. What makes the administration of the medication negligent is not the ensuing sex but the lack of knowledge that the medication caused the patient to make sexual advances.

149. As would the theoretical case discussed *supra* where transference would cause the effects not on the knowing therapist but on an unknowing third party. *See supra* note 129.

150. Clearly the physician would know that he was engaging in sexual intercourse. The participation is unknowing to the extent that a truly negligent or ignorant physician would not be aware of a connection between his professional actions and the sexual encounter. The question of personal knowledge and probability of knowledge deficit are questions for the fact finder after taking all circumstances into account.

within the physician's frame of reference he conducted medical practice, and then engaged in sexual contact wholly unrelated to the medical actions. Thus, in this specific and admittedly unlikely situation, the plaintiff is claiming damages based on the administration of the anesthetic given without notification of the side effects and the results stemming from that administration, and not from a physician who took advantage of the situation with the knowledge that his intervention created the conditions for sexual exploitation.[151]

The above illustration and this one possible contingency in *Snyder* are rather improbable occurrences. It seems quite unlikely that therapists will be unaware of the transference phenomenon and its effects on patients, the patient therapist relationship, and the proper way of handling it. Likewise, it is improbable that a physician would be unaware of the side effects of the medication, particularly a medication producing bizarre or unusual side effects such as the ones alleged in *Snyder*.

V. THE NEGLECTED ROLE OF INTENT

Holding an action constant and varying the actor's intent yields wildly differing probabilities that the act was intended to be a professional act.[152] The courts have not formally addressed the issue of intent in defining professional or medical services.[153]

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151. In contrast, the administration of the medication with the knowledge of the side effect here would not be negligent if the physician engaged in sexual relations with the patient. Rather, it would be opportunistic because the sexual relations were engaged in with knowledge of the medication's side effect profile. Thus, knowledge of a medication's side effect profile invalidates further claims of negligence if the side effect were utilized to commit a non-medical intentional act.

152. An overdose of insulin by a doctor meaning to genuinely care for a patient is professional negligence and covered by the policy; however, an overdose of insulin by a doctor meaning to kill the patient is not a professional service, nor should it fall within policy terms. Notice that the actor does not change, nor does the act itself. One observing this situation, for example, by video, would have no way to determine whether the act is one of professional malpractice or murder. Intent should be examined as it is in criminal proceedings and as it was in *Snyder*. *See* Snyder v. Major, 818 F. Supp. 68, 70 (S.D.N.Y. 1993). However, unlike criminal proceedings, the question focuses on whether one had a *medical intent* to engage in a given act. It, of course, follows that a doctor intending to commit murder, robbery, rape or any other crime lacks medical intent.

153. In *Shernow*, the dissent notes that nitrous oxide is generally a tool of the trade but mentions dosage and motivation when exploring the misuse. *See* St. Paul Fire & Marine

Assuming the complained-of act is medical, examining practitioner intent will invalidate those actions which appear on the surface to be medical acts but where the actor does not intend, even remotely, to practice medicine. Instead of considering intent as a conclusive presumption, irrefutably tethered to a "medical act," it is suggested that a rebuttable presumption of *medical intent* be considered.[154] A rebuttable presumption of a medical intent will allow a demonstrable non-medical intent to be distinguished from legitimate attempts at practicing medicine and receive proper judicial scrutiny when one asserts "professionalism" for actions.

The result will be that malpractice policy interpretation will be made easier. Professionals who have non-medical, nonprofessional intent will be properly separated from the majority who do. These providers will henceforth be unable to shield themselves and their nonprofessional conduct with insurance policy language which is at the ultimate expense of other members of their profession and normative standards of conduct.[155] Professional services and sexual misconduct are simply mutually exclusive and clear distinctions between them should be drawn in law and medicine. The medical act/intent test will restore protection to those so deserving while offering no refuge to miscreants who wish to add insurers and peers to their list of exploits.[156]

Ins. Co. v. Shernow, 610 A.2d 1281, 1286 (Conn. 1992) (Borden, J., dissenting). However, it is unlikely that the lack of "proper dosage" provides any basis for avoiding coverage. Normally, an overdose of medication would be covered under a malpractice policy. Therefore, it appears that the lack of "proper motivation" is the factor that makes this case different; the prolonged dosage and time of administration provide some evidence of that motivation and lack of *medical intent. See id.*

154. This intent analysis would be distinct for either an intent to act or intent to harm analysis. *See generally* Tracy Raffles Gunn, *The Intentional Acts Exclusion*, 71 FLA. B.J. 86 (1997).

155. *See infra* note 159.

156. Peers will pay for miscreants in the form of higher premiums. Consider this aspect of cost shifting: "The biggest cause of the increase [in insurance rates in 1990], claims Richard Imbert, head of the American Professional Agency [broker for programs sponsored by the American Psychological Association, the National Association of Social Workers and the American Association of Marriage and Family Therapists], is a steady increase in the number of claims filed against psychotherapists and a pattern of liberal court decisions which broaden the responsibility of professionals. "Our society, unfortunately, doesn't get less litigious and we're seeing more high awards." He points to California as the source of many professional liability woes. *See generally supra* note 70. "Law seems to be rewritten in court there. We've had California judges tell us: 'I don't care if the policy doesn't cover this, you must pay it.'" *Id.* at n.28 (quoting 16(11) PSYCHOTHERAPY FINANCES 2-4 (1990)).

CONCLUSION

Sexual misconduct has become an increasingly important aspect of professional liability insurance. It is a hard sell to argue that these acts are covered within the letter or spirit of the insurance contract for non-therapist medical professionals and therapists alike. Well-drafted exclusions and sublimits appear the best way to eliminate these acts from coverage. Where intent is non-medical, coverage should not be extended. However, noting the courts comments in *Chunmuang*, it bears admitting that what is explicitly excluded in the policy appears to be implicitly recognized under the scope of coverage. By adding certain exclusions, insurers admit that sexual misconduct is within the reach of standard policy language.[157] This apparent trend may well be unavoidable. What is avoidable, however, is the internal conflict in terminology which frequently operates to defeat exclusions and limits.[158]

Taking the patient/plaintiff viewpoint may indeed produce different results, but is best confined to jurisdictions requiring insurance by statute. If insurance is required, it will conform to the statute, and then may follow the path of auto insurance where third party interests become the driving force in developing case law.[159] When that day comes, the contract will

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157. *See supra* note 64.

158. *See* American Home Assur. Co. v. Cohen, 815 F. Supp. 365 (W.D. Wash. 1993), *aff'd*, 67 F.3d 305 (9th Cir. 1995) (sexual misconduct aggregate limit conflicted with "wrongful act" exclusion). *See supra* text accompanying notes 49-54.

159. Kansas has taken this path in mandating medical malpractice insurance. "[P]rofessional liability insurance...shall be maintained...by each resident health care provider as a condition to rendering professional service as a health care provider." KAN. STAT. ANN. §40-3402(a) (1998).

Perhaps then [medical malpractice insurance] may qualify for some state subsidy to provide much needed relief to those stranded, by specialty, in Tornado Alley. *See* Stephen G. Reed, *From the Operating Room, to the Courtroom. Tort Reform Bills Pending in the State Legislature Could Affect Medical Malpractice Cases. Members of the Medical and Legal Professions Disagree About Whether the Reforms are Necessary,* SARASOTA HERALD-TRIB., Mar. 22, 1999, at 14 ("thoracic surgeons would pay $66,000 for a year's worth of insurance. Obstetricians would pay $72,000. And neurosurgeons are faced with a $99,000 annual insurance tab."); *see also* Tyler Bridges & Stephen Smith, *Florida Doctors Protest Bill Requiring Malpractice Insurance,* KNIGHT-RIDDER TRIB. BUS. NEWS: THE MIAMI HERALD, Apr. 16, 1998 (comparing a legislative initiative mandating malpractice insurance to existing mandatory auto insurance). Again the premiums were reported to be high:

become somewhat less important in determining policy coverage. Until that day however, medical malpractice insurance is best viewed not as a safety net for the community but as a shield for practitioners – a shield which healers of all variety willingly drop along with their clothes when they partake in sexual misadventure.

"Particularly at peril are the most specialized of specialists, neurosurgeons and obstetricians and doctors performing other complex operations. In Dade and Broward, it can cost $100,000 – or more – to buy a year's worth of malpractice insurance providing $250,000 of coverage. A South Florida neurosurgeon with five years' experience, for instance, pays $113,533 in premiums, according to figures from Florida Physicians Insurance Corp." *Id.* Perhaps a light at the end of the tunnel exists – if insurance becomes mandatory, it must be affordable.

FROM THE JOURNALS: INSURANCE LAW ABSTRACTS

*Edited by Jeffrey E. Thomas**

INSURANCE – GENERAL

Thomas G. Buchanan, III, Note, *Franklin v. Healthsource of Arkansas: Arkansas Adopts the Made-Whole Doctrine*, 51 ARK. L. REV. 773 (1998).

This Note examines *Franklin v. Healthsource of Arkansas*, 942 S.W.2d 837 (Ark. 1997), in which the Arkansas Supreme Court revived the made-whole doctrine in subrogation claims, thereby rejecting conventional subrogation and requiring that the insured be fully compensated for her injuries before the insurer's right to subrogation arises. Buchanan analyzes the decision and rationale for adopting this doctrine noting that the court ignored the important distinction between equitable and conventional subrogation. He then explores various arguments for and against the made-whole doctrine, and describes the potential impact *Franklin* could impose on insurance companies, insureds, and the legal community.

James D. Cox, *Private Litigation and the Deterrence of Corporate Misconduct*, 60 LAW & CONTEMP. PROBS. 1 (1997).

This article considers several theories addressing why employees engage in corporate misconduct and various corporate responses. The author closely examines professors Jennifer Arlen and Reinier Kraakman's theory that calls for reduced sanctions when employers maintain a reasonable system of detection and deterrence for employee wrongdoing. Cox criticizes Arlen and Kraakman's duty-based system and argues in favor of the current strict liability approach.

Cox then goes on to examine the effect of the directors and officers policy coverage on employee misconduct. Cox concludes that neither entity liability nor the prevalence of insurance interferes with the deterrent value of private litigation.

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Luke A. Sobota, Comment, *Does Title III of the Americans with Disabilities Act Regulate Insurance?*, 66 U. CHI. L. REV. 243 (1999).

This Comment considers whether the Americans with Disabilities Act ("ADA") will apply to insurance industry practices toward people with disabilities. Specifically, Sobota examines Title III of the Act, which prohibits discrimination against disabled people in the "full and equal enjoyment" of the goods and services of "any place of public accommodations." The author explores competing interpretations of the Act by various courts and concludes that Title III is designed not to regulate the terms of insurance but merely to require physical access to public accommodations.

David D. Hallock, Jr., *Recent Developments in Marine Hull Insurance: Charting a Course through the Coastal States of the Fourth, Fifth, Ninth, and Eleventh Circuits,* 10 U.S.F. MAR. L.J. 277 (1998).

This Article contends that an increasing number of cases interpreting marine hull insurance in the context of recreational boats threatens to erode Federal maritime insurance precedent. Recreational boat owners tend to be more sympathetic claimants, and the expansion of insurance coverage for recreation boat owners has resulted in an interpretation of maritime insurance law more favorable to the insured. These decisions are at odds with traditional maritime insurance law, which imposes strict duties on the insured such as, for example, the duty of the insured to make various warranties.

Hallock surveys recent developments in marine hull insurance policy interpretation under both State and Federal maritime law. He addresses the interpretation of the policy when there is a breach of an implied or express warranty, the insured's duty of full disclosure and utmost good faith at the time of policy formation, claim presentation and handling laws in light of potential bad faith damages, and the scope of coverage under marine hull insurance policies.

Brent R. Lindahl, Comment, *Insurance Coverage for an Innocent Co-Insured Spouse*, 23 WM. MITCHELL L. REV. 433 (1997).

This Comment suggests that Minnesota should adopt a rule that affords the innocent co-insured spouse coverage under a fire insurance policy

where the fire has been intentionally caused by the other spouse, especially where the case is rooted in domestic violence. Lindahl examines relevant case law and describes six competing theories or rules employed by courts in deciding whether an innocent spouse should be entitled to coverage. He then explains how Minnesota courts have dealt with issues of innocent co-insureds outside the marital context.

At the core of his analysis is the examination of the recent Minnesota case of *Watson v. United Services Automobile Ass'n*, 551 N.W.2d 500 (Minn. Ct. App. 1996), *review granted* (Minn. Sept. 20, 1996), the first Minnesota case to deal specifically with the issue of coverage for an innocent spouse. Although in this case the policy language unambiguously precluded coverage for innocent spouse, the court nonetheless held that the innocent spouse was entitled to recover under the insurance policy by making the policy terms conform to the minimum statutory Standard Fire Insurance Policy requirements in Minnesota.

Lindahl argues that the Minnesota Supreme Court should affirm the decision in the *Watson* case and establish a rule that innocent spouses can recover their proportional one-half interest in the lost or damaged property. He contends that the court should further the underlying reasoning and establish such a rule based both on public policy (against domestic violence, under a notion of fairness, and because of the minimal risk of insurance fraud) and on traditional rules of contract interpretation.

HEALTH INSURANCE

Jeremy J. Best, Comment, *Community Rating: New York's Empire Blues*, 46 BUFF. L. REV. 467 (1998).

This Comment describes and analyzes the community rating system in the health insurance industry, focusing in particular on New York State's attempt to use community rating to address an insurance crisis with Empire Blue Cross/Blue Shield.

Community rating provides all people in a given community with health insurance coverage regardless of their medical history. It protects individuals from having their policies terminated by an insurer because of the claims they have filed. Companies set premiums based on the average number of claims in the community and the level of risk reflected by those claims.

Best finds that community rating has not been successful in New York State for a number of reasons. For instance, insurance premiums were

continually raised, which forced many people to drop coverage altogether. As a result, the number of people with insurance has decreased since implementation of the community rating system.

Meredith A. Jagutis, Comment, *Insurer's Access to Genetic Information: The Call for Comprehensive Federal Legislation,* 82 MARQ. L. REV. 429 (1999).

This Comment considers the various methods of regulating genetic information being used by insurers with increasing frequency. Jagutis proposes a framework for State and Federal legislation to protect the individual's privacy while at the same time meeting the insurer's need to access to the information.

Jagutis describes the important changes in the insurance industry that are likely as a result of greater understanding of genetic information. Knowledge about genetics is being advanced by the Human Genome Project ("HGP"), which is designed to map out the human genome in hopes of creating widely available diagnostic tests and cures for diseases that are caused by genetic defects. Although the HGP brings hope for a new ability to diagnose and treat diseases, the tests are not yet able to predict the date that the actual disease will manifest itself, the severity of the symptoms after manifestation, or the efficacy of treatment.

Jagutis proposes that too much information could destroy the central function of insurance – spreading risk – because there is no risk if an individual knows his or her future to some degree of reasonable certainty. Although it is logical for insurers to discriminate based on genetic information, as they discriminate based on other personal information, such as age, sex, and smoking, it is possible that genetic testing could lead to unfair discrimination by insurers.

Mark A. Hall, *Public Choice and Private Insurance: The Case of Small Group Market Reforms*, 1998 U. ILL. L. REV. 757.

This Article argues, in response to Professor Richard Epstein's book *Mortal Peril: Our Inalienable Right to Health Care*? (1997), that insurance regulation has a positive impact in the area of small markets. Hall endorses market interventions such as certain affordability provisions, which limit the variation in premiums charged by different providers. He also contends that placing limits on pre-existing condition exclusions, guaranteeing

renewals, and having open enrollment can help make insurance available to all willing purchasers.

Hall argues that such regulations can restore the small markets, defined as employers having between two and fifty employees, to its earlier healthier state. He criticizes Epstein's categorical views against regulation and in favor of less government intervention. Although Hall agrees that government regulation does complicate the insurance industry, he maintains that a certain degree of complication is desirable and necessary to achieve the basic goals of insurance, especially in small markets.

Hall concludes by discussing his empirical studies in the area of small market insurance and government regulation. He feels his studies show that government intervention has been successful and has not created the type of widespread problems Epstein describes. Hall states that the government has done an admirable job of managing the complex regulatory scheme to achieve socially productive means.

Richard L. Kaplan, *Taking Medicare Seriously*, 1998 U. ILL L. REV. 777.

This article critiques Richard Epstein's book *Mortal Peril: Our Inalienable Right to Health Care*? (1997). Although Kaplan agrees with some of Professor Epstein's arguments, such as the fact that Medicare needs to be reformed, he takes issue with most of Epstein's criticisms, and challenges Epstein's failure to provide any reform suggestions.

Kaplan contends that Epstein failed to recognize Medicare's value, despite its obvious and well-documented shortcomings. Kaplan considers Epstein's description of the coming Medicare insolvency to be "hysterical," his criticism of Medicare's inefficiency to be misplaced, and his fixation with errant cost estimates as irrational and an example of Epstein's failure to see the "big picture."

Kaplan then shifts from a critic to a reformer and offers several substantive suggestions on how to improve Medicare, including Medical Saving Accounts, reform of prescription drug and nursing home coverage, and greater use of preventive care.

Russell Korobkin, *Determining Health Care Rights from Behind a Veil of Ignorance,* 1998 U. ILL. L. REV. 801.

This article addresses whether society should establish positive rights to health care that each citizen can claim. Korobkin analyzes this issue with reference to John Rawls' theory that a just society is one that individuals would agree to form if they had no knowledge of their individual skills or natural endowments. Korobkin extends this notion to the health care arena, and argues that in order to create a just health care system, decision-makers must operate under the veil of ignorance, without any knowledge of whether they were sick or healthy, weak or strong, rich or poor. He contends that individuals behind such a veil would have to balance the free market approach with the idea of a safety net of rights. Ultimately, he argues that it is a decision between risk aversion and inefficient incentives that would reduce net social wealth. The question therefore becomes a case-by-case analysis of proposed rights, which turns on how inefficient any particular right would be.

In his analysis, Korobkin demonstrates how the veil of ignorance approach might be implemented by considering two policy issues: mandatory community rating of private health insurance premiums, and guaranteed emergency medical care. He concludes that in these two cases, the inefficient incentives created by establishing rights are probably small and/or controllable enough to lead individuals behind the veil of ignorance to favor a regime of positive rights. He therefore suggests that the veil might cause decision-makers to choose a society that is far different from the one in which we live today.

LIABILITY INSURANCE

Willy E. Rice, *Insurance Contracts and Judicial Discord Over Whether Liability Insurers Must Defend Insureds' Allegedly Intentional and Immoral Conduct: A Historical and Empirical Review of Federal and State Courts' Declaratory Judgments – 1900-1997*, 47 AM. U. L. REV. 1131 (1998).

This article examines declaratory judgments involving alleged intentional or immoral acts. The author begins by providing an overview of state and federal declaratory judgment statutes and scope of third party insurance contracts. Additionally, Rice explores the duty to defend, whether this duty exists when intentional and immoral conduct is alleged,

and the legal standard for determination of such duty. Rice further notes the discord between states and federal courts dealing with declaratory judgments involving third-party insurance. Lastly, Rice examines specific liability policy relationships, including doctors, lawyers, and homeowners.

Rice focuses upon the judicial system's highly variable imposition of moral imperatives. The article further discusses public policy behind liability insurance and the unfair treatment minority or minor third party victims often receive from courts. Rice concludes by arguing that insurance companies benefit from denying a defense and courts should find a duty to defend where negligent or intentional actions are alleged. Further, Rice concludes that the legislature should compel an insurer to defend where intentional conduct is alleged.

Jeffrey W. Stempel, *Unreason in Action: A Case Study of the Wrong Approach to Construing the Liability Insurance Pollution Exclusion*, 50 FLA. L. REV. 463 (1998).

This Article examines *Deni Associates of Florida, Inc. v. State Farm Fire & Casualty Insurance Co.*, 711 So. 2d 1135 (Fla. 1998), which interprets the so-called "absolute" pollution exclusion contained in the standard Commercial General Liability policy. Stempel criticizes the interpretive method utilized by the court, which he calls textual literalism, and argues that a reasonable expectation analysis would have been more sound. The author discusses the fallibility of rigid textual construction and suggests that a preoccupation with contractual text often leads to unreasonable, unintended results notwithstanding Deni's reassurance that 'absurd' results would not be enforced.

Stempel concludes by noting that the Florida Supreme Court squandered an opportunity to incorporate the Doctrine of Reasonable Expectations to its armamentaria of interpretive options and thus has bound the jurisdiction to a simplistic method of policy analysis.

Thomas D. Morgan, *Whose Lawyer are You Anyway?*, 23 WM. MITCHELL L. REV. 11-41 (1997).

In this article, Morgan examines the conflict generated when an attorney represents both the insured and the insurance company as co-clients. Morgan explores five main areas involving such conflict including: attorney selection, directing defense, privilege, settlement negotiations, and

the right to sue for malpractice. Morgan concludes by noting that courts will typically view the typical tripartite relationship, between the insurer, client, and attorney, as one where the attorney has two clients. However, where there is a conflict between co-clients courts favor the insured client. It is further concluded that an insurer risks a claim of bad faith if the insurer's interests are furthered at the client's expense.

D. Heath Bailey, Comment, *Auto-Owners Insurance Co. v. Harrington: Resisting the Impulse to Judicially Rewrite Exclusion Clauses*, 1998 BYU L. REV. 1645.

This Comment explores whether a liability insurance policy's exclusion for expected or intended bodily injury applies to acts of self-defense. Bailey analyzes the 1997 Michigan Supreme Court case, *Auto-Owners Ins. Co. v. Harrington*, 565 N.W. 2d 839 (Mich. 1997), which held that the expected or intended exclusion relieved an insurer of the duty to defend or indemnify an insured who is sued for intentionally injuring another, even if the injuries caused were effectuated in self-defense. Currently, there is a split among State courts regarding this issue, although the majority of states agree with the result reached by the Michigan Court.

The minority of states who allow for coverage cite ambiguous language and set forth various public policy arguments in an attempt to justify that coverage, which Bailey dismisses as unwarranted judicial rewriting of the exclusion. Bailey concludes that the "freedom of contract" reasoning followed by the majority of states is sound and that intentional acts taken in self-defense by an Insured are "expected or intended" and are therefore properly excluded from coverage under the bodily injury exclusion.

Samuel R. Gross, *Make-Believe: The Rules Excluding Evidence of Character and Liability Insurance,* 49 HASTINGS L.J. 843 (1998).

This Article focuses on two Federal Rules of Evidence, Rule 404 and Rule 411, concerning character evidence and liability insurance, respectively. Gross contends that Rule 404 expresses a fundamentally false view of the content of common-law trials, while Rule 411 embodies an equally basic misrepresentation of the context of personal-injury litigation.

Gross first discusses the inconsistencies in the character evidence rule, and describes the rule as complicated, arbitrary, and poorly misunderstood. He finds that what we regulate as character evidence is only a small part of

the evidence and arguments that lawyers use to develop competing versions of the characters of the actors in the events that are subject to the litigation. Character arguments, whether or not they speak in terms of propensity, can influence the fact finder by creating sympathy or antipathy, which is usually the point in making them.

Gross then discusses liability insurance as another important element of trials, one that determines who will ultimately be responsible to pay a judgment. Rule 411 states that evidence of insurance is not admissible upon the issue whether the person acted negligently or otherwise wrongfully. The traditional reason for withholding this information from the jurors is the belief that they will be influenced to find for the plaintiff because the defendant does not have to pay the judgment. Gross argues, however, that it is unclear whether mentioning insurance does any harm. Because of the prevalence of insurance, most jurors assume that defendants are insured.

Gross concludes that the routine practice of arguing cases to juries is not consistent with the strict application of these rules.

Eberhard Feess and Ulrich Hege, *The Role of Insurance in the Adjudication of Multiparty Accidents*, 19 INT'L REV. L. & ECON. 69 (1999).

This Article addresses situations in which the fault of defendants cannot be established accurately because of lack of information about their actions prior to the accident (such as environmental liability problems, plane crashes, and mass highway collisions). Feess and Hege give various examples of different liability schemes, and propose an insurance-based liability rule as a remedy.

In an insurance-based liability scheme, damages are apportioned according to the insurance policies of the defendants. The central idea is that liability contributions will increase steeply if the injurer has not signed an insurance policy giving her the desired incentives. As a consequence, the insurer must design the insurance contract "in a way that gives the right incentives to the insured for care, given the liability rule in place." These incentives include deductibles, coinsurance, insurance caps (policy limits), and bonus-malus systems. The liability rule is easy to characterize, efficient, and avoids the use of punitive damages.

Ellen S. Pryor, *The Tort Liability Regime and the Duty to Defend*, 58 MD. L. REV. 1 (1999).

In recent years, there has been much debate over the nature and scope of "defense insurance." This Article analyzes the defense obligation and its connection to the tort litigation system.

Pryor first gives a detailed description of the theoretical structure of defense insurance – why insurers and insureds are so willing to sell and buy it, and why it is closely related to indemnity insurance. She then examines the decisional structure of the insurance, and why courts always find that defense insurance has a different decisional structure than other forms of first-party insurance. Pryor agrees with this decisional structure for overlapping scenarios, and argues that it justifies using the complaint-allegation rule to determine whether there is a duty to defend. Pryor also argues that the insurer generally should not be allowed to contest its defense obligation on the basis of the actual facts in a declaratory judgment suit.

For non-overlapping scenarios, Pryor argues that the defense obligation should be given the *same* decisional structure as other forms of first-party insurance. Therefore, she feels that an insurer in these cases should be permitted to pursue a declaratory judgment action using the actual facts relating to coverage, and should not be required to pursue the complaint allegation rule.

Douglas R. Richmond, *Reimbursing Insurers' Defense Costs: Restitution and Mixed Actions*, 35 SAN DIEGO L. REV. 457 (1998).

This Article examines liability insurers' legal entitlement to recover from insureds their costs attributable to the defense of uncovered claims. Richmond traces the development of the law surrounding the insurer's right to reimbursement of defense costs in California. He then examines the recent case of *Buss v. Superior Court*, 939 P.2d 766 (Cal. 1997). In *Buss*, the court held that an insurer may seek reimbursement of defense costs from its insured for claims that are not even potentially covered under the policy. However, the court found that the insurer bears the burden of proof and must establish its right to reimbursement by a preponderance of the evidence. Richmond then discusses earlier decisions from other states, concluding that they tracked pre-*Buss* California law. Therefore, he suggests that it is reasonable to expect *Buss* to influence law beyond California's borders.

Richmond considers whether there should be a right to reimbursement from both the policyholders' and insurers' perspectives. He does not find merit in any of the arguments against recognizing an insurer's right to reimbursement, so he goes on to examine the nature and extent of the reimbursement right. Specifically, the author describes how the insurer's right to reimbursement of its costs incurred defending clearly uncovered claims is grounded in the law of restitution. He concludes by suggesting that the insurer's right to restitution should be determined on a case-by-case basis.

Gregory T. Lawrence, Note, *Maryland's High Court Misconstrues CGL to Cover Excluded Economic Loss Caused by Negligent Misrepresentation*, 27 U. BALT. L. REV. 189 (1997).

This article analyzes *Sheets v. Brethren Mutual Insurance*, 679 A.2d 540 (1996), for its effect on Comprehensive/Commercial General Liability (CGL) policy coverage. In the analysis, Lawrence details the precedential underpinnings of the coverage of negligent misrepresentation and explains the court's construction of 'property damage', 'accident' and 'loss of use' under CGL policies.

Lawrence explains the majority rule, stating that CGL's do not cover negligent misrepresentation. This denial of coverage is based largely on two factors: (i) the relief sought was not for property damage (which would have been covered) but for economic loss, and (ii) the misrepresentation was not an 'accident' or 'occurrence' covered under the standard CGL policy. Despite the majority opinion, Lawrence agrees with the *Sheets'* holding, that negligent misrepresentation can constitute an 'accident.'

However, Lawrence takes issue with the decision concerning the interpretation of the 'loss of use' prong of the CGL. He maintains that the court failed to follow customary rules of construction when it allowed CGL coverage for economic loss formerly excluded from CGL coverage. Additionally, Lawrence claims the court failed to properly interpret the 'loss of use' prong, resulting in coverage where it was never intended.

In conclusion, Lawrence maintains that this decision, while clarifying issues of coverage concerning negligence, more importantly returns insurers to the dreaded 'Serbian Bog' and exposes CGL policy writers to liability for claims of economic loss which were previously, and intentionally, not covered.

INSURANCE REGULATION

Steven J. Williams, Note, *Distinguishing "Insurance" from Investment Products Under the McCarran-Ferguson Act: Crafting a Rule of Decision*, 98 COLUM. L. REV. 1996 (1998).

This Note argues that innovations in financial services have blurred the traditional distinction between bank-authorized investment and insurance, and therefore that a new test is needed to decide whether a product is subject to regulation under Federal law, or whether the product should be regulated by State insurance law pursuant to the McCarran-Ferguson Act. Williams uses the decision in *American Deposit Corp. v. Schacht,* 84 F.3d 834 (7th Cir. 1996) to show the shortcomings of the current "*Pireno* test" developed in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) and *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982). *Schacht* held that a "Retirement CD" should be considered insurance for purposes of the McCarran-Ferguson Act, and thus subject to state regulation. Williams argues that a Retirement CD is not insurance, and that the court's analysis in *Schacht* shows the insufficiency of the *Pireno* test.

Williams proposes a new four-part test to distinguish between insurance and non-insurance financial products under the McCarran-Ferguson Act: (1) is there a shifting of risk from the customer to the insurer; (2) is the risk distributed among those insured; (3) is the risk addressed an "insurable" risk, meaning one presenting only the possibility of loss with no accompanying opportunity for gain; and (4) are those aspects of insurance of sufficient importance to the activity as a whole so as either to constitute the defining quality of that activity or to make the involvement of state insurance authorities necessary for effective regulation? Williams applies this proposed test to the facts in *Schacht*, demonstrating that under this test the Retirement CD would not be considered insurance.

Richard A. Epstein, *Exit Rights and Insurance Regulation: From Federalism to Takings*, 7 GEO. MASON L. REV. 293 (1999).

This Article considers when the state should regulate the terms and conditions under which goods and services are supplied in the marketplace, using in particular the case of insurance. Epstein notes that insurance is generally competitive, yet is still subject to extensive rate regulation in many states. He contends that under these circumstances rate regulation is

not justified. He argues that the use of rate regulation holds the price of insurance down, increases the level of coverage that must be provided, or both, which he contends has negative social consequences.

Epstein then considers constitutional theories that could justify the toleration of laws that may have such negative social effects. In particular, he discusses the law of takings and the law of federalism. New Jersey, Massachusetts, and Florida are cited as examples for analysis of states in which insurance companies are unable to exit the state at will. These states are described as so inhospitable to insurers that they are unwilling to voluntarily continue doing business there.

Florida's Wind Insurance is then discussed in detail, describing the Hurricane Andrew disaster, and widespread cancellations that occurred afterwards in accordance with insurance companies' contract rights, higher rates for new policies, and more restrictive coverage. The Florida Legislature responded to these cancellations by imposing extensive restrictions on the ability of insurance companies to cease writing "wind insurance" within the state.

Epstein disagrees with the Florida Legislature's decision. He feels that competition is the best way to organize markets in both good times and bad.

Dave Luxenberg, Comment, *Why Viatical Settlements Constitute Investment Contracts Within the Meaning of the 1933 & 1934 Securities Acts*, 34 WILLAMETTE L. REV. 357 (1998).

This Comment focuses on the controversy surrounding whether the sale of viatical settlements constitutes the sale of securities and thus is subject to federal securities regulations. Luxenberg argues that a viatical settlement satisfies the definition of an "investment contract" and therefore should be subject to securities regulation. He focuses his analysis on the case *S.E.C. v. Life Partners, Inc.*, 87 F.3d 536 (D.C. Cir. 1996), which he criticizes as making an erroneous distinction between pre and post purchase services by because a viatical settlement involves essential management efforts. He rejects the court's conclusion that post purchase essential services were required *by S.E.C. v. Howey*, 328 U.S. 293 (1945), *reh'g denied,* 329 U.S. 819 (1946), and further argues that, even assuming post purchase essential services were required by *Howey*, they are present in the typical brokered viatical settlement.

Eun Sup Lee and Jeong-Hwa, *Regulation of the Insurance Industry in Korea,* 6 J. INT'L L. & PRAC. 29 (1997).

Korea occupies the number six position in life insurance and the twelfth in non-life insurance worldwide in terms of premiums received. According to Eun Sup Lee and Jeong-Wha, Korea's insurance market success in past years is a consequence of many factors, including the increase of Korea's National Income, the Korean government's close control over the insurance industry, the realization of the necessity for insurance protection, and the peculiar Korean closed market structure among others. Although these factors created undesirable side effects, the authors argue that the government's paternalistic attitude impeded domestic insurance companies' ability to compete with their homologous competitors in a global insurance market. As a solution to this problem, the Korean government changed its policy regarding this protectionism, and the vehicle to achieve these changes was the creation of new rules. The authors point out that in recent years, especially beginning in 1997, the Korean government allowed foreign insurance companies to enter the domestic market and, since then, is making efforts to encourage self-regulation and self-discipline.

The intended change is evidenced in the new rules adopted by the Korean government regarding many regulatory issues. As an example,

since April 1997, the new applicants for insurance business do not need to meet the stringent Economic Need Test ("ENT") any more. Therefore these new applicants will have permission to enter the market as long as they meet the minimum capital requirement which is thirty million won (about thirty-three million U.S. dollars). Moreover with respect to chartering, entry and licensing, rules were considerably relaxed regarding aspects of financial statements, disclosure of principals and organizers, and the acceptance of regulatory obligations. Traditionally insurers were not allowed to engage in business other than insurance. However, banks, securities firms and insurance companies are now getting involved in each others' businesses.

Another issue discussed in the article is the regulation of products and rates. The authors point out that insurers are able to independently calculate the rate of risk and interest that will affect the premium. In the non-life insurance business insurers do not have to wait for the Minister's approval anymore (except for long-term life policies and auto insurance), as long as it stays within a certain acceptable range. In the area of reinsurance, the Korean government is no longer treating domestic companies with favoritism over foreign insurance companies. According to Eun Sup Lee and Jeong-Wha, the Korean people are in favor of deregulation in most of the economic sectors, and the government is taking the necessary steps to create this free and innovative environment in which corporations can succeed. Thus, the authors point to a promising market for the insurance industry to further develop in Korea.

AUTOMOBILE INSURANCE

Kathryn Cameron Walton, Note, *North Carolina Farm Bureau v. Bost: Does a Covenant Not to Enforce Judgment Compromise a Claim for Underinsured Motorists Benefits?*, 76 N.C. L. REV. 2482 (1998).

This Note analyzes a recent amendment to North Carolina's Motor Vehicle Safety and Financial Responsibility Act (the "Act") that preserves an injured party's underinsured motorist ("UIM") claim even though that injured party executes a covenant not to enforce judgment against the tortfeasor as part of the settlement of the claim. This amendment codifies the North Carolina Court of Appeals' decision in *Farm Bureau Mutual Insurance Co. v. Bost*, 126 N.C. App. 42, 483 S.E.2d 452, *disc. Rev. denied*, 347 N.C. 138, 492 S.E.2d 25 (1997), which held that a settlement agreement and release signed by the injured motorist did not constitute a

general release of all claims and therefore did not preclude her claim for UIM benefits.

After discussing the facts and opinion of *Bost* in detail, Walton explores the relevant cases leading up to the court's decision, including a review of cases that interpret the effect of settlement and cases that address the issue of inter-policy stacking of UIM coverage. She points out the inconsistencies among these cases, and the effect of the amendments to the Financial Responsibility Act on the settlement with a tortfeasor when the case includes a UIM claim. Walton concludes that the court appropriately interpreted the then-current version of the Act, and correctly decided the case.

Harvey Rosenfield, *Auto Insurance: Crisis and Reform*, 29 U. MEM. L. REV. 69 (1998).

This Article briefly describes the history of modern automobile insurance reform and analyzes the political and economic implications of both tort reform, specifically the no-fault system, and insurance industry reform. The no-fault system posits that the costs of insurance have risen due to the rise in litigation and excessive damage awards. It seeks to reduce insurance costs by limiting or abolishing awards for non-economic damages. Insurance industry reform posits that the costs of insurance have risen because of changes in the insurance industry. It seeks to reduce insurance costs through stronger regulatory oversight as part of the solution to rising premiums.

Rosenfield contends that the no-fault approach is on the decline. The most recent proposals in the no-fault area, known as "consumer choice" no-fault plans, cannot accomplish the goals of premium reduction because consumers maintain the option to use the traditional tort coverage system. He argues that insurance industry reform is the superior approach. He relies on California's model of Proposition 103 as the basis for reform, and maintains that this approach will more effectively reduce premiums.

Barbara J. Tyler & Thomas S. Tyler, *Holt v. Grange Mutual Casualty Co.: Children Not "Insureds" Under Policy are Entitled to Death Benefits*, 45 CLEV. ST. L. REV. 699 (1997).

This article analyzes the Ohio Supreme Court's decision detailing the conflict between narrow policy language contained in an automobile

insurance contract and public policy behind wrongful death and uninsured/underinsured motorist statutes. *Holt* involved an insured who was killed by an uninsured motorist. The insurer argued that, under the contract terms, Holt's two adult sons were not "insured" because they did not live at home. The authors discuss the supreme court's finding that insurance company attempts to limit coverage by narrow policy definitions were in conflict with the public policy behind uninsured motorist and wrongful death statutes. Such statutes allow broader recuperative rights to family members.

The authors conclude that use of the restrictive policy language would provide no coverage in any instance where all "insureds," as defined by the insurance contract language, did not survive the accident.

Additionally, the article dismisses insurer forecasts of rising premiums resulting from the *Holt* decision. The Tylers argue that premiums are based on risk, and claim that because *Holt* will not increase the number of uninsured motorists, it will not increase insurer risk. The Tylers describe the Court's decision as consumer friendly, but question the decision's staying-power given the slim majority and intense pressure from the legislature and the insurance lobby to limit coverage.

Joel S. DeVore, *Vega v. S.B. 645: Underinsured Motorist Coverage and the Exhaustion Clause,* 34 WILLAMETTE L. REV. 327 (1998).

This Note addresses Oregon's treatment of the exhaustion clause included in most underinsured motorist coverages, which typically provides: "We will pay under this [underinsured motorist] coverage only after the limits of liability of any applicable bodily injury or property damage liability policies or bonds have been used up by payment of judgments or settlements." In 1996 the Oregon Supreme Court refused to enforce the exhaustion clause in the case *Vega v. Farmers Ins. Co.*, 919 F.2d 95 (Or. 1996). The court held that injured persons may sue their UIM insurer without first exhausting the limits of the tortfeasor's liability insurance. The court reasoned that because an exhaustion clause was not expressly included among the model policy terms of ORS 742.504, an insurer could not include such an unfavorable and restrictive clause in its policy.

DeVore argues that the ramifications of this decision were profound. Whenever an injured person's UIM limits exceed the tortfeasor's liability limits, the injured party could bring a single UIM contract claim for all

damages in lieu of the traditional personal injury claim. After *Vega*, UIM insurance became the insurance of first resort.

The Oregon Legislature responded to *Vega* by enacting Senate Bill ("S.B.") 645 in 1997, which validated the exhaustion clause by codifying it in ORS 742.504. With the enactment of S.B. 645, the Oregon Legislature has overruled the Vega decision, and re-established liability coverage as insurance of first resort.

ENVIRONMENTAL INSURANCE

David M. Smith, *Sudden Exposure: Accessing Historic Insurance Policies for the Environmental Liabilities Associated with Newly Acquired Properties or Operations*, 25 ECOLOGY L.Q. 439 (1998).

Smith's article describes a wrinkle in environmental coverage cases, in which a policyholder faces liability for environmental harm associated with newly acquired property or operations. In this context, the policyholder's liability arises not from the policyholder's operations, but from the operations of the prior owner. Some recent cases suggest that a company acquiring pollution-suspect operations or properties faces an enormous risk of "sudden exposure": unexpectedly uninsured environmental liability. The article discusses pre-acquisition policies and predecessor policies, along with "fairness concerns" and policy concerns of both types of policies.

Pre-acquisition policies are issued to the successor company, but expire prior to the successor company's acquisition of the operations or property giving rise to liability. The dispositive question in these cases is whether such a policy covers the successor company even though the policies expired prior to the acquisition of the operations or property giving rise to liability.

Predecessor policies are those policies issued to the predecessor company that expired prior to the successor company's acquisition of the operations or property giving rise to its liability. With these policies, the insured owned the property or operations while the damage was occurring, and was therefore "involved" in some way in that damage. However, the issue in these cases is whether there is coverage even though the insured no longer owns the property.

Courts have been reluctant to find coverage under either pre-acquisition policies or predecessor policies. As a result, a company acquiring operations or property with pollution liability may have an

unexpected insurance coverage gap, even though both the predecessor and successor companies had valid liability insurance at the time of the pollution. This coverage gap seems unjustified by a traditional analysis of the policy language and legal principles applicable to transfer of coverage rights.

Smith suggests that insurers and insureds did not contemplate the environmental liability from the Comprehensive Environmental Response and Cleanup Liability Act ("CERCLA"), much less the unique coverage issues arising from each liability. However, he feels that settled insurance doctrines have been abandoned in dealing with this issue, such as the policy language underlying the traditional focus on timing of harm, the public policy justifying the insurable interest doctrine, the reasons for common-law doctrines that permit avoidance of policy language, the rationale for no-assignment clauses, and the common law of assignment.

Joren S. Bass, *The Montrose Decision and Long-Tail Environmental Liability: A New Approach to Allocating Risk Among Multiple Third-Party Insurers*, 5 HASTINGS W.-N.W. J. ENVTL. L. & POL'Y 209 (1999).

This Note suggests a comprehensive rule for allocating insurance coverage in environmental liability cases in California, by analyzing the California Supreme Court's decision in *Montrose Chem. Corp. v. Admiral Ins. Co.*, 913 P.2d 878 (Cal. 1995).

Bass provides background on Comprehensive General Liability ("CGL") policies, together with a history of the Standard Form CGL policy. Allocation methods are discussed, including joint and several allocation and a pro rata scheme of allocating liability. The concepts of "stacking" and "vertical exhaustion" are also discussed.

Bass then turns to the *Montrose* decision in which the California Supreme Court adopted a continuous injury trigger, whereby bodily injuries and property damage that are continuous or progressively deteriorating throughout successive policy periods are covered by all policies in effect during those periods. The author focuses on the court's analysis of contract language, case law, and public policy.

Based on principles of insurance law and public policy, Bass suggests that this provides an efficient, predictable model that California and other courts can rely on when determining who pays for the clean-up of environmental pollution.

Ryan S. Fehlig, Note, *CERCLA Response Costs and CGL Policies: Insureds Find a Favorable Forum in Missouri, Farmland Industries, Inc. v. Republic Insurance Co.*, 63 MO. L. REV. 767 (1998).

This Note addresses the issue of whether CERCLA response costs constitute insurable "damages" within the meaning of that term as used in Commercial General Liability ("CGL") Insurance policies. Environmental cleanup costs (or response costs) under CERCLA are considered by some to be a form of equitable relief. Insurers contend that the term "damages" is limited solely to legal damages, not equitable remedies. Insureds, on the other hand, argue that the undefined term "damages" is broad enough to include both legal and equitable relief.

Fehlig focuses on the Missouri Supreme Court case *Farmland Indus., Inc. v. Republic Ins. Co.*, 941 S.W.2d 505 (Mo. 1997). In *Farmland*, the court held that the term "damages" encompassed equitable relief. The Note begins by analyzing the legal background and precedent-setting cases concerning the definition of "damages." Although early cases separated law and equity, and held that damages did not include costs incurred in complying with an injunction, this distinction was beginning to erode in the 1980s. Nevertheless, some recent cases hold that environmental cleanup costs are not "damages" within the meaning of a CGL policy, while other cases hold that they are. The majority view, however, among both Federal and State courts is that environmental cleanup costs are covered.

Fehlig criticizes the majority rule and the holding in *Farmland* as posing a threat to the continuing availability of environmental liability insurance. He notes that the lack of uniformity among courts has created the problems of forum shopping and inefficient use of resources. He fears that insurers are either going to substantially increase policy prices or forego providing environmental liability insurance altogether. The *Farmland* regime, therefore, is a double-edged sword; it threatens both the continued existence of the environmental liability insurance market and the solvency of insureds.

RECENT CASE DEVELOPMENTS

*Jeffrey W. Stempel**

LIFE INSURANCE BENEFICIARY MAY NOT BE CHANGED THROUGH WILL WHEN POLICY SETS FORTH SPECIFIC CONTRARY PROCEDURE FOR CHANGING BENEFICIARIES

McCarthy v. Aetna Life Ins. Co., 704 N.E.2d 557 (N.Y. 1998).

As a one-time employee of J.C. Penney in New York, Stephen Kapcar received a group life insurance policy issued by Aetna Life Insurance Company. In 1972, he married Christine McCarthy and she was designated as his beneficiary under the policy. Sadly, Kapcar developed multiple sclerosis, which led to severe tremors, blindness, and eventually quadriplegia. Kapcar and McCarthy were separated in 1977 and divorced in 1978. The property settlement in their divorce did not mention the Aetna policy, but did provide that they relinquished and released any claims upon one another's property.

After his separation from McCarthy, Kapcar lived with his father until his death in 1984. Kapcar's holographic will, written in 1977 and probated in Pennsylvania, stated: "I will all my personal belongings, stock certificates, bank accounts, insurance benefits, and any other earthly belongings to my father . . . . This will voids my previous will bequeathing my belongings to Christine B. Kapcar." *McCarthy*, 704 N.E.2d at 559.

However, Kapcar did not change the beneficiary designation on his Aetna life insurance policy. After Kapcar's death, a struggle ensued between Kapcar's father and former wife over the $16,000 life insurance policy proceeds. McCarthy sued Aetna in an attempt to collect. Aetna brought

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Emil Kapcar into the action as another interested claimant, deposited the funds with the court, and then was dismissed from the case.

The trial court ruled for the former wife, who was the designated beneficiary. The intermediate appellate court ruled in favor of the father, who was designated in the will. The New York Court of Appeals, the state's highest court, resolved the issue in favor of the former wife, essentially electing to follow contract law more than the seeming equity concerns presented by this sad case.

The New York Court of Appeals applied conventional contract and insurance rules. In particular, the court noted that under Pennsylvania law (decedent Kapcar's home state), New York law (the place of contracting), and Delaware law (the applicable law designated in the policy), the agreed rule was that the method for designating or changing beneficiaries set forth in the insurance policy itself must be followed in order to effectively change a beneficiary. Because decedent Kapcar had not followed the Aetna procedure for changing beneficiaries, his obvious desire to leave the money to his father rather than his former wife would not be enforced, despite being part of his last will and testament.

Because the controlling law would be the same under any of the three states interested in the case, the court did not engage in any choice of law analysis because "the result would be the same" in all three jurisdictions. *See id.* at 560. The court approved the basic rationale of the rule that policy procedures control beneficiary designation because the rule "serves the paramount goals of ensuring that life insurance proceeds are disbursed consistently with an insured's stated intent and of preventing the courts and parties from engaging in rank speculation regarding the wishes of the deceased." *Id.* The court also noted that the rule is necessary to protect insurers from possible lurking liability if they pay the policy benefits to a beneficiary designated on the face of the policy but then later are confronted with heirs or others making a claim to the policy on the basis of another document. *See id.*

However, the court also stated that "[s]trict compliance with the rule is not always required." *Id.* Rather, it is sufficient if there is substantial compliance or attempted compliance that reflects the intent to change the beneficiary. However, mere intent is not enough. There must be some affirmative act that seeks to accomplish the intended beneficiary change, even if the action falls short of strict adherence to the policy procedure. Some of the case law cited by the New York court suggests that the compliance, even if not strict, must be substantial in that the record must show that the insured "made every reasonable effort" to follow the policy

procedure for changing a beneficiary. (Internal quotation marks omitted.) *See id.*

Applied to Kapcar's case, these general rules made ineffective his attempt to change a life insurance beneficiary through his will. The will and the life insurance policy are two separate documents. The will cannot change the life insurance policy any more than a rider on the life insurance policy can alter a last will of the decedent. Consequently, the Aetna policy continued to have the same beneficiary as it had in 1972 – Christine McCarthy, Kapcar's former wife.

Although Kapcar was obviously not in good health, the court found no evidence that he was incapable of effecting the beneficiary change during the 1977-84 period, suggesting that physical or mental inability to arrange the change might be grounds in rare cases for seeking a beneficiary change on the basis of something other than normal policy procedure. Consequently, despite what laypersons would probably regard as Kapcar's clear intent to give the money to his father who had faithfully cared for him during his declining years (rather than to a former spouse), the court unanimously found the issue to be clearly controlled by definitive contract principles.

RECEIPT OF WORKERS' COMPENSATION BENEFITS BY AUTO ACCIDENT VICTIM MAY BE DEDUCTED ONLY ONCE FROM UNDERINSURED MOTORIST BENEFITS AVAILABLE TO VICTIM

Roberts v. Northland Ins. Co., 705 N.E.2d 762 (Ill. 1998).

Kirk Roberts was seriously injured driving a truck while working. Because he was acting in the course of his employment, he was eligible for workers' compensation, and he received more than $196,000 in benefits. He also received social security disability benefits of $300 per month. The driver of the other vehicle had only $50,000 in liability coverage, all of which was paid to Roberts. Despite these amounts, Roberts was not fully compensated and made a claim under two separate insurance policies – his own and that of his employer.

One policy issued by the Chicago Motor Club Insurance Company provided underinsured motorist ("UIM") coverage of $300,000, while the Northland Insurance Company policy had $500,000 of underinsured motorist coverage. The Chicago Motor policy was primary (meaning that its policy limits would need to be exhausted first) while the Northland policy was excess (meaning that it would begin to pay its UIM benefits after the last

dollar of Chicago Motor's UIM coverage was spent). The Chicago Motor policy had language stating that UIM benefits "will be reduced by . . . the present value of all amounts payable under any workmen's compensation, disability benefits or similar law." *Roberts*, 705 N.E.2d at 763. The Northland policy had similar language.

Both Chicago Motor and Northland argued that they should be able to reduce their respective UIM benefits otherwise available to Roberts by the amount of the workers' compensation benefits paid to Roberts. In other words, Chicago Motor argued that it need only pay $100,000 (not its $300,000 UIM limits) and Northland argued that it need only pay $300,000 (not its $500,000 UIM limits). This prompted a lawsuit by Roberts, who sought a declaration that the UIM benefits would not be reduced by the workers' compensation benefits.

The trial court ruled largely for Roberts, holding that the workers' compensation benefits should be set off only once against combined applicable policy limits and that Roberts' social security disability benefits could not be set off against the insurance to reduce available benefits. The appellate court reversed as to the workers' compensation benefits and ruled that these funds should be separately set off against each of the two UIM policies.

The Illinois Supreme Court reversed the appellate court and ordered one deduction of the workers' compensation benefits. Even though there were two policies that provided for reduction of coverage by the amount of workers' compensation benefits paid, state substantive law and public policy were held to limit the reduction to one setoff of the workers' compensation benefits.

The court reasoned that allowing the workers' compensation funds to be set off twice against auto insurance coverage would defeat the purpose of UIM coverage, since underinsured motorist coverage exists to place the insured in the same position he would have occupied if injured by a motorist who carried liability insurance equal to that of the policyholder and sufficient to compensate the victim for the amount of damage.

In other words, Roberts successfully argued that if he had been hit by a tortfeasor with adequate insurance, in view of his serious injuries, Roberts would have available to him at least $800,000 in coverage, an amount limited by the amounts of Roberts' own coverage, but still apparently not enough to fully compensate Roberts for his injury. Consequently, the court ruled that fairness and the state's interest in having accident victims fully compensated through the insurance markets militated against permitting more than one reduction of UIM benefits because of the workers' compensation payments. "Although the insured receives his workers' compensation award only once,

the insurers nevertheless attempt to subtract that award twice from the insured's coverage. Allowing such a double setoff would frustrate the [legislature's] intention [in the state's UIM regulation]." *Id.* at 765.

> Defendants repeatedly assert that because the instant plaintiff held two separate insurance policies, two setoffs should be allowed. Public policy allows one setoff, however, because the setoff prevents the plaintiff from receiving an unfair windfall through his workers' compensation benefits, while still guaranteeing plaintiff the level of coverage he would have received had he been injured by an adequately insured tortfeasor. A double setoff, on the contrary, deprives the victim of the level of coverage he would have received if the tortfeasor had been adequately insured, and therefore violates public policy.

Id. at 765-66.

The Illinois high court emphasized the general applicability of its decision for similar cases in the future, stating "[w]e hold that when an accident victim is covered by more than one insurance policy providing underinsured-motorist coverage, public policy permits only one setoff to that coverage for the amount of workers' compensation benefits received by the insured." *Id.* at 766.

Having limited the workers' compensation setoff to one amount, the Illinois Supreme Court also needed to determine the manner in which the $196,000 setoff would be allocated. The court permitted primary insurer Chicago Motorist to reduce its $300,000 UIM liability by this figure, effectively requiring Chicago Motorist to pay $100,000 to Roberts while Northland was required to pay $800,000.

The court reasoned that the Chicago Motorist policy was primary, and that as a primary policy Chicago Motorist was at greater risk than the excess insurer because it is closer to the risk and more likely to pay out its policy proceeds than is an excess insurer. "Because it bears this greater burden, the primary carrier should also be the first to receive the benefit of the setoff in order to reduce the coverage upon which the insured has first claim." *Id.* The court made this holding generally applicable.

The court was unanimous in holding that workers' compensation benefits could be set off only once to reduce available UIM coverage, and that social security benefits could not be used to reduce applicable insurance. Three justices dissented, however, on the issue of allocation. The dissenters

argued that the workers' compensation setoff benefit should be prorated among the applicable insurers because both insurers bore similar risks, and because both the Chicago Motorist and the Northland policies contained clear language entitling both of them to reduce benefits because of workers' compensation funds received by the claimant.

The issue of apportionment in a case like this is indeed more difficult than the issue of whether to reduce the victim's available insurance by twice deducting his workers' compensation benefits. The majority opinion is analytically sound in distinguishing between primary and excess insurer obligations. Ordinarily, primary insurers should both be obligated to respond at the initial levels of a claim and reap the benefit of any setoff because of collateral sources of compensation, since the primary insurer had the first obligation to pay.

However, as applied to the facts of the *Roberts* case, the practical effect of this unapportioned setoff is to give a windfall to the primary insurer by effectively cutting its policy limits by two-thirds. In effect, the workers' compensation setoff almost makes for illusory UIM coverage by the Chicago Motor Club policy. After *Roberts*, that policy provides not $300,000 of benefits, but only $300,000 minus workers' compensation funds. Where the workers' compensation funds are significant, the primary policy not only pays far less than one might expect, but the excess insurer's attachment point is lowered from its stated $300,000 to an actual attachment point of $100,000, greatly increasing the excess insurer's obligations and risk of being tapped by a claim. In effect, the Northland policy was required to attach at $100,000 rather than $300,000.

In the wake of *Roberts*, excess insurers should give serious consideration to revising their policy language to provide for reduction in benefits to the extent that underlying primary coverage is reduced by workers' compensation setoff. In the alternative, excess and primary insurers could agree to prorate any setoff by equal shares, policy limits, or premium ratios. Although cases like *Roberts* seem comparatively rare (most serious injuries covered by workers' compensation do not involve applicable auto insurance coverage as well), the potential detriment of the decision to excess insurers is clear.

EMPLOYEE INJURED WHILE DRIVING CO-WORKER'S CAR IS NOT BARRED FROM RECOVERING UNINSURED MOTORIST BENEFITS BECAUSE OF RECEIPT OF WORKERS' COMPENSATION BENEFITS

Gardner v. Erie Ins. Co., 722 A.2d 1041 (Pa. 1999).

Lorren Gardner was injured by a hit-and-run driver while operating an automobile owned by Steven Ward, a co-worker. Gardner received $15,000 from his own auto insurer as well as receiving workers' compensation benefits since he was driving the Ward automobile in the course of his employment at the time of the accident. However, because Gardner was seriously injured, the benefits he received were insufficient. The hit-and-run driver was not located, which made his liability insurance, if any existed, unavailable to pay Gardner's claims. Gardner thus sought to recover uninsured motorist ("UM") benefits under the Ward policy.

Ward's insurer, Erie Insurance Company, argued that Gardner's receipt of workers' compensation benefits precluded his receipt of uninsured motorist benefits as well. The trial court agreed, but the superior court (Pennsylvania's intermediate appellate court) reversed. The supreme court affirmed and held for Gardner, finding that the exclusivity of the workers' compensation remedy did not extend so far as to prevent injured workers from recovering otherwise available automobile insurance benefits.

Erie's argument was premised upon a part of Pennsylvania's workers' compensation law found in virtually all state workers' compensation laws – the ban on negligence actions against a co-employee for work-related injury. In particular, Pennsylvania's law stated:

> if disability or death is compensable under this act, a person shall not be liable to anyone at common law or otherwise on account of such disability or death for any act or omission occurring while such person was in the same employ as the person disabled or killed, except for intentional wrong.

77 PA. CONS. STAT. §72 (1992).

Both the supreme court and the superior court reasoned that a claim for uninsured motorist benefits was not a claim against the co-employee who owned the policy providing such benefits. Rather, Gardner's negligence claim was against the third party tortfeasor, a hit-and-run driver and

nonemployee. Because this third party had no accessible insurance, Gardner turned to the UM provisions of the policy covering the automobile in which Gardner was riding at the time of the accident, which only incidently happened to be the automobile of a co-worker. As the supreme court observed, the "plain language [of the statute] is directed to providing relief from liability to the co-employee," not to a third party or the co-employee's insurer (which provides coverage in the event the third party is uninsured). *See Gardner*, 722 A.2d at 1046.

This characterization of UM coverage as a substitute for third-party liability coverage is consistent with much of insurance law. However, there is also case law rejecting Pennsylvania's approach and holding that a claim against a contract held by a co-employee is the essential equivalent of a claim against the co-employee, a view taken by the trial court in *Gardner*. On balance, however, the Pennsylvania Supreme Court's view appears preferable. The *Gardner* ruling does not permit an injured employee to avoid the exclusive remedy provisions of the workers' compensation statute and reinstate the pre-existing system of common law torts against co-workers or employers (including common law defenses of the employer). Rather, Gardner was permitted to seek compensation for the damage done by a non-employee in a manner that does not undermine the workers' compensation scheme of the state.

The *Gardner* opinion also dealt with some nuances of relatively recent state statutory revision that the trial court had read as strengthening the bar to suits against a co-employee, including the co-employee's UM coverage. The supreme court rejected this view and distinguished a 1995 precedent in ruling for Gardner. According to the court, the recent statutory revisions did not have the effect of reducing any available UM benefits through set off of workers' compensation benefits. However, the workers' compensation carrier is "given the right of subrogation for any benefits paid to the employee under workers' compensation." *Id.* at 1045.

ERISA DOES NOT PRECLUDE CLAIMS AGAINST HEALTH INSURER

Pappas v. Asbel, 724 A.2d 889 (Pa. 1998).

At 11:00 one morning, Basile Pappas went to the emergency room ("ER") of Haverford Community Hospital complaining of paralysis and numbness in his arms and legs. The ER physician diagnosed Pappas as suffering from an epidural abscess pressing against his spinal column and

posing a serious threat of injury. A neurologist and neurosurgeon were consulted and confirmed that Pappas faced a neurological emergency. The ER doctor arranged to transfer Pappas to Jefferson University Hospital ("Jefferson") for further specialized treatment. As the ambulance arrived, Pappas's insurer, U.S. Healthcare of Pennsylvania ("U.S. Healthcare"), denied authorization for treatment at Jefferson.

Continuing efforts to authorize treatment ensued, with U.S. Healthcare continuing to deny treatment at Jefferson, but approving treatment at Hahnemann University, Temple University, or Medical College of Pennsylvania. The ER physician ultimately arranged treatment for Pappas at Hahnemann, but the HMO-required shuffle of hospitals resulted in approximately a three-hour delay in treating Pappas, who today is a permanent quadriplegic as a result of the compression of his spine caused by the abscess.

Pappas filed suit against his primary care physician and Haverford Community Hospital, alleging negligence in the delay of transferring him to a hospital that could address his neurological emergency. Haverford filed a third-party complaint that brought U.S. Healthcare into the case as a defendant. Haverford's allegation was that the delay was the fault of U.S. Healthcare, which had refused to authorize the original, timely transfer of Pappas to Jefferson. U.S. Healthcare filed a motion for summary judgment seeking to be removed from the case on the ground that any claim against it under state law was precluded and preempted by the Employee Retirement Income Security Act of 1974 ("ERISA").

In particular, ERISA contains broad preemption language that states that ERISA supersedes "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. §1144(a)(1988). HMOs like U.S. Healthcare that provide health insurance coverage under an employer's group plan are almost always classified as part of an "employee benefits plan" within the meaning of ERISA. *See* 29 U.S.C. §1002(1)(1988). State law includes not only statutes but also court decisions and state regulations. *See* 29 U.S.C. §1144(c)(1)(1988).

The trial court granted the motion and released U.S. Healthcare from the case. The intermediate appellate court (the "Superior Court" in Pennsylvania) reversed, holding that the broad preemption language of ERISA could not be read with full literal breadth where HMOs are concerned because HMOs were not a major part of the health care scene at the time of ERISA's enactment. The Pennsylvania Supreme Court rejected the reasoning of the Superior Court but affirmed on other grounds, keeping U.S. Healthcare in the *Pappas* case as a third-party defendant. In particular, the supreme court found HMOs sufficiently within the contemplation of

Congress at the time of ERISA's enactment. The Pennsylvania high court noted that a year prior to ERISA's enactment, Congress passed the Health Maintenance Organization Act of 1973. According to the court, "[t]he HMOs described in that act are too similar to a contemporary HMO for us to conclude that Congress, when crafting ERISA, was ignorant of the cost containment procedures utilized by HMOs." *Pappas*, 724 A.2d at 893 n.6.

The supreme court permitted the claim of negligence against U.S. Healthcare based on its reading of the most recent United States Supreme Court decisions regarding the scope of ERISA preemption. According to the Pennsylvania court, federal precedent of the 1980s and early 1990s did read ERISA's preemption language with near-literal breadth and these cases were heavily relied upon by U.S. Healthcare. However, according to the Pennsylvania court, the United States Supreme Court "noticeably changed tack" in 1995 when it handed down *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995), a decision rejecting an ERISA preemption challenge to a New York statute requiring hospitals to collect surcharges from patients covered by commercial insurance but not by the Blues. *See Pappas*, 724 A.2d. at 892.

As seen by the Pennsylvania court, the U.S. Supreme Court has in *Travelers* and subsequent precedents moved away from a text-based assessment of ERISA preemption and toward a purpose-based analysis. In particular, the U.S. Supreme Court has, since 1995, permitted state claims involving an ERISA plan so long as this does not have the effect of subjecting employee benefit plans to a multiplicity of regulation, and where the state law is not directed specifically at ERISA plans. Thus, where a law of general applicability (such as negligence) is applied to an HMO or other ERISA plan entity, there is no preemption problem unless the state law invoked is in actual conflict with ERISA's substantive provisions or purpose.

Applying this precedential yardstick, the Pennsylvania court concluded that negligence claims against an HMO do not "relate to" an ERISA plan within the meaning of the ERISA statute. These laws govern the provision of safe medical care, not the structure of employee benefits plans or relations between the plan administrator and the health insurer. The court observed: "We acknowledge that by allowing negligence claims, there will be a financial impact on HMOs. Yet, that is not enough to countermand the conclusion that these claims are not preempted. . . . [A]n incidental increase in the costs imposed on an ERISA plan will not mandate a finding of preemption." *Id.* at 894 (citing *DeBuono v. NYSA-ILA Med. and Clinical Servs. Fund*, 520 U.S. 806 (1997).

Although U.S. Healthcare had substantial Supreme Court precedent supporting its argument, the Pennsylvania court found that *Travelers*

> and its progeny have thrown the expansive holdings of those earlier cases into question. We thus believe that it would be improper to adopt U.S. Healthcare's position that we must reflexively interpret the preemption provision in the broadest possible manner. Instead, we believe that the proper course of action is to follow the reasoning contained in the Travelers line of cases, even though we recognize that the [United States Supreme] Court's earlier cases have not been expressly overruled.

Id. at 893 (footnote omitted).

To date, the U.S. Supreme Court has not ruled on the specific question of whether an HMO may be sued for negligence resulting in a patient's injury. The *Pappas* court acknowledged that a number of United States Court of Appeals decisions have found HMOs immune from such state law claims. *See id.* n.5.

> Yet, the bulk of these cases were handed down prior to Travelers. The only one of these cases which was decided subsequent to Travelers – Cannon [*Cannon v. Group Health Servs. of Oklahoma, Inc.*, 77 F.3d 1270 (10th Cir. 1996)] – fails even to mention Travelers. Since we find the recent trend of the Supreme Court to be so compelling, it would be inappropriate for us to utilize the reasoning of these courts of appeal cases as they fail to discuss the Travelers line of decisions.

Id.

Undoubtedly, further chapters remain to be written regarding the relationship between state tort law claims stemming from medical treatment and the scope of ERISA preemption, with the story's conclusion in doubt until the Supreme Court acts. In the meantime, *Pappas* will likely provide considerable ammunition to plaintiff patients' lawyers (and their initial target defendants who may want to point the finger at HMOs) and may well be influential in the ongoing debate.

OVERRULING OLD PRECEDENT, FLORIDA ADOPTS MAJORITY VIEW THAT "ACCIDENT" ENCOMPASSES NOT ONLY ACCIDENTAL EVENTS, BUT ALSO UNEXPECTED OR UNINTENDED DAMAGES FROM VOLITIONAL ACTS

State Farm Fire and Casualty Co. v. CTC Development Corp., 720 So. 2d 1072 (Fla. 1998).

Even the most venerable of precedents is subject to change – especially when it is out of sync with modern decisions of other courts and leading academic commentary. In *Hardware Mutual Casualty Co. v. Gerrits*, 65 So. 2d 69 (Fla. 1953), the Florida Supreme Court had held that an intentional act by an insured resulting in unintended injury, damage, or liability could not be an "accident" under a liability policy. Some forty-five years and nearly 700 volumes of Southern Reporter later, the court overruled ("recede[d] from," in the parlance of the court, *see State Farm*, 720 So. 2d at 1072.) *Gerrits*, holding that an insured's conduct may constitute an "accident" under a liability policy even when the actions were volitional so long as the resulting injury was not expected or intended from the standpoint of the insured.

Gregory Uzdevenes was a professional architect and the sole owner of CTC Development, a construction company, both of which were insured under a State Farm "Contractor's Policy." While building a home, CTC sited the house too close to lot lines in violation of the neighborhood's restrictive covenants. CTC was well aware that the house was within fifteen feet of the lot line and intentionally located the house at that distance but believed it had been granted a variance by the homeowners' association.

After the home was sixty percent done, CTC was informed of "a possible problem with the variance." *Id.* at 1073. At that point, according to CTC, it would cost $275,000 to tear down the home and rebuild it at further setback. CTC declined to remediate the home's location, was sued by the structure's neighbors, and settled for $22,500 after being refused a defense by its insurer. State Farm denied coverage, contending the lawsuit did not arise out of an occurrence as required under the Contractor's Policy which, like most general liability policies, defines an occurrence as an "accident." CTC sued State Farm for the settlement amount and $29,400 in counsel fees and costs. Based on the old *Gerrits* case definition of an accident, the trial court ruled for State Farm. However, the First District Court of Appeals reversed, correctly anticipating that Florida's legal landscape had changed during the intervening half-century.

The Supreme Court affirmed the First District opinion and rejected the *Gerrits* analysis. In particular, the *CTC* court criticized *Gerrits* for using tort law reasoning to define an accident rather than the contract law reasoning that should be applicable to insurance coverage disputes. *Gerrits* found that an architect's building too close to a lot line could not be an accident if it was the effect of a "natural and probable consequence of an act or course of action." *Id.* at 1074.

But between the time of *Gerrits* and *CTC*, Florida law had for some time stated that "foreseeability," a well-established tort doctrine, was a suitable yardstick for construing accident-based liability policies. Almost by definition, a policyholder who is sued for negligence is accused of failing to notice what was reasonably foreseeable. Put another way: if negligence in the construction of a building vitiates insurance coverage under a contractor's policy, it is difficult to see any real value in the policy. To fulfill its purpose, a liability policy should cover policyholders for unintended damages even where the acts giving rise to allegations of negligence were voluntary.

In particular, the *CTC* court noted the policy's exclusion for claims of injury expected and intended from the standpoint of the insured (a typical term in liability insurance) and read this *in pari materia* with the term "accident" to conclude that the policy's design was to cover unintended injury but not to cover intentional injury (as opposed to unintended injury from intentional action, which is covered). The court also noted that this was the view of leading scholars, specifically citing ROBERT E. KEETON & ALAN I. WIDISS, INSURANCE LAW, §5.4(c) at 511 (1998). *See State Farm* at 1076.

The *CTC* court further viewed the term "accident" as at least ambiguous since it was undefined in the policy itself and was susceptible to the reading offered by CTC. Under the standard insurance maxim of *contra proferentem* (ambiguities are construed against the drafter), CTC would be accorded a favorable construction conveying coverage. *See id.*

The *CTC* court, however, affirmed a line of precedent holding that some actions by a policyholder might be "so inherently dangerous or harmful that injury was sure to follow" and that these activities as a matter of law could not be deemed accidents even where the policyholder claimed that the resulting injury was unintended. *See id.* (citing *Landis v. Allstate Ins. Co.*, 546 So. 2d 1051 (Fla. 1989) (sexual abuse by insured not an "accident" or "occurrence.")

With the *CTC* decision, Florida law regarding the meaning of "occurrence" and "accident" squares far better with the bulk of modern cases which have, like *CTC*, focused on whether the injury was intended by the policyholder rather than whether the injury resulted from intended activity.

The *CTC* view and modern Florida law fit far better with the purpose of liability insurance, which is to provide coverage for tort liability rather than to provide coverage only for involuntary activity. If the latter view and the *Gerrits* decision were to prevail, policyholders might arguably be covered only for reflex actions and spasms.

For example, under *Gerrits*, an insurer could argue that lawsuits resulting from speeding or driving under adverse conditions were not covered "accidents" under an automobile policy. Of course, in the forty-five years between *Gerrits* and *CTC*, Florida cases had not taken such an extreme view and had subtly confined *Gerrits* to its most narrow realm, usually by implicitly assuming that bad driving or the like was not intended. Because the *CTC* case involved essentially the same type of contractor error at issue in *Gerrits* and both involved clearly volitional action (home building), the Florida Supreme Court could not easily distinguish or confine *Gerrits* without reversing it, leading to the court's candid and unanimous burial of the now-discredited *Gerrits* precedent and its erroneous reasoning regarding "accidents" and liability claims.

SUPREME COURT HOLDS RIGHT TO CLAIM WORKERS' COMPENSATION BENEFITS NOT A "PROPERTY RIGHT" UNDER CONSTITUTION; UTILIZATION REVIEW OF INJURED EMPLOYEE'S MEDICAL BILLS NOT "STATE ACTION"

American Manufacturers Mutual Insurance Co. v. Sullivan, 526 U.S. 40, 119 S. Ct. 977 (1999)

Pennsylvania has a typical workers' compensation system in which employers are held liable without fault for work-related injury to employees (subject to certain exceptions such as employee misconduct or fraud in the claim). In return, the employee's rights of compensation against the employer for such injuries are determined "exclusively" by the remedies of the workers' compensation statute. The employee may not sue the employer for additional damages beyond those set forth in the prevailing schedule of benefits under the prevailing workers' compensation statute.

To ensure that workers' compensation claims are paid, Pennsylvania requires that the employer obtain private insurance, obtain insurance from the State Workers' Insurance Fund, or obtain state permission to self-insure. If liability for a work-related injury is not at issue, the statute requires that employers or insurers pay the "reasonable" and "necessary" medical expenses

of the employee within thirty days after receiving the bill. Once the insurer has paid the medical provider, the matter is final. The insurer may not seek reimbursement even if it comes to find that the charges were unnecessary or excessive.

However, the reasonableness or necessity of a medical bill may be challenged under a system of "utilization review," in which the insurer (or self-insuring employer) files a notice with the Workers' Compensation Bureau of the Department of Labor and Industry. The Bureau then notifies the parties of the requested review, which is conducted by a private "utilization review organization" ("URO"), comprised of licensed health care providers for the type of treatment at issue. The URO then determines "whether the treatment under review is reasonable or necessary for the medical condition of the employee" according to "generally accepted treatment protocols," with any doubts to be resolved in favor of the employee. 34 PA. CODE §§127.470(a); 127.467, 127.471(b) (1998). The statute also requires that the review be completed within thirty days. If the insurer prevails, the employee may seek to have the decision overturned by a workers' compensation judge or further judicial review by the general jurisdiction courts of the state. If the employee prevails, the insurer must pay immediately with ten percent interest on the money and must also pay the costs of the review itself.

A class of employees subjected to utilization review challenged the statute as an unconstitutional deprivation without adequate due process of law of their property right to receive prompt payment of medical benefits. The United States Court of Appeals for the Third Circuit agreed and specifically found that the utilization review procedure was faulty in that it did not notify the employees themselves of the insurer's or employer's challenge and did not give the employees a right to participate in the procedure and defend the reasonableness and necessity of their medical bills. *See Sullivan v. Barnett*, 139 F.3d 158 (3d Cir. 1998). As a result, Pennsylvania changed its review procedures.

Insurers did not challenge the "new, improved" procedures designed to give injured employees notice and opportunity to be heard. However, workers' compensation insurers did successfully petition for Supreme Court review of the constitutional premises underlying the employees' victory. Specifically, insurers and employers argued that the review procedure was not "state action," that is, conduct by the state government or its agents that subjects the state to scrutiny and regulation under the Due Process Clause of the United States Constitution. Due process requirements, when applicable, require that a person not be deprived of a property interest without notice and opportunity to be heard in a timely manner and reasonable fashion before a

sufficiently neutral and qualified factfinder. Insurers and employers also argued that the employee's claim for payment of medical benefits was not "property" within the meaning of the Due Process Clause.

The Supreme Court agreed with the insurers and employers on both constitutional questions. Specifically, the Court held that utilization review conducted by private entities was not "state action" even though it was authorized by the state, with insurers required to notify the state when the procedure was invoked. The Court also held that the injured employee's claim for medical benefits is not a "property right" until it has been officially determined as such by the review process or the courts that the employee is in fact entitled to the benefits claimed.

Reviewing precedent, the Supreme Court noted at the outset of the opinion that the Constitution does not reach "merely private conduct, no matter how discriminatory or wrongful." *Sullivan*, 119 S. Ct. at 985 (quoting *Blum v. Yaretsky*, 457 U.S. 991, 1002 (1982) and *Shelley v. Kramer*, 334 U.S. 1, 13 (1948)). To have state action, there must be (1) a violation of a rule of conduct imposed by the state that is (2) committed by a state actor. In *Sullivan*, the Court found that a private insurer's decision to withhold payment for disputed medical treatment is not "fairly attributable" to the State. "[T]he mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the [Due Process requirements] of the Fourteenth Amendment." *Id.* at 986 (quoting *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974)). "Faithful application of the state-action requirement in these cases ensures that the prerogative of regulating private business remains with the States and the representative branches, not the courts." *Id.* Further, "[a]ction taken by private entities with the mere approval or acquiescence of the State is not state action." *Id.* (citations omitted). Because the State of Pennsylvania was not controlling the utilization review decisions, the Court held that there was no state action in any reduction or denial of medical claims. The Court found that these decisions are made by private parties and that the standards of generally accepted medical protocols were also deemed to be privately generated (by the medical community) rather than established by the State.

The Court also rejected the employees' argument that state workers' compensation laws essentially delegate to the private sector powers traditionally reserved to the states and therefore should be viewed as "state action." In light of the history of state workers' compensation laws, the Court found it clear that no-fault compensation for work injuries was not a historical function of the state or the private sector. Rather, it was imposed on employers by the state as part of early twentieth century labor law reforms that overruled the common law.

Although the Court could have rested its reversal of the Third Circuit upon the state action ground alone, it also went on to decide the matter of whether claims for statutorily required medical benefits are "property" under the Constitution. The Court, in the twentieth century, has extended constitutional protection to nontraditional forms of property such as licenses, government contracts, government jobs, and public assistance benefits. However, the *Sullivan* Court did not place workers' compensation claims in the same category of constitutional protection received by these nontraditional forms of "new property." Public assistance entitlements (recognized as "property" in *Goldberg v. Kelly*, 397 U.S. 254 (1970)) are perhaps the outer boundary of protected property and could be analogized to workers' compensation benefits. However, the Court distinguished the instant situation from the statutory entitlement in *Goldberg v. Kelly*, where the individual's initial right to receive a determined level of benefits was clear and he had been receiving those benefits prior to being cut off by the State.

> [F]or an employee's property interest in the payment of medical benefits to attach under state law, the employee must clear two hurdles. First, he must prove that an employer is liable for a work-related injury, and second, he must establish that the particular medical treatment at issue is reasonable and necessary. Only then does the employee's interest parallel that of the beneficiary of welfare assistance in *Goldberg* and the recipient of disability benefits [held to be constitutionally protected property in *Matthews v. Eldridge*, 424 U.S. 319 (1976)].
>
> [The employees] obviously have not cleared both of these hurdles. While they indeed have established their initial eligibility for medical treatment, they have yet to make good on their claim that the particular medical treatment they received was reasonable and necessary. Consequently, they do not have a property interest – under the logic of their own argument – in having their providers paid for treatment that has yet to be found reasonable and necessary. To state the argument is to refute it, for what [the employees] ask in this case is that insurers be required to pay for patently unreasonable, unnecessary, and even fraudulent medical care without any right, under state law, to seek reimbursement from providers. Unsurprisingly, the Due Process Clause does not require such a result.

119 S. Ct. at 990. The key determinant of when a statutory entitlement becomes a property right appears to be the degree to which the full value and legal claim to the entitlement has been sufficiently determined. Until workers' compensation claims have been determined to be reasonable and necessary there is no property right protected by the Constitution. Where such a determination has been made, however, the statutory entitlement presumably becomes a property right and Due Process protection presumably attaches.

Justice Ginsburg concurred separately in *Sullivan* and joined only the "property" definition portion of the Chief Justice Rehnquist's majority opinion. Justice Ginsburg found that claims for medical benefits are not property under the Constitution to be dispositive and that the portion of the opinion attempting to "clean up and rein in our 'state action' precedent" was unnecessary and should not have been decided. *Id.* at 991.

Once a claim for statutory entitlement has become sufficiently established to constitute constitutionally protected "property," Justice Ginsburg found "that due process requires fair procedures for the adjudication of respondents' claims for workers' compensation benefits, including medical care." *Id.* This view is not inconsistent with the majority opinion. Concurring specially, Justices Breyer and Souter made a similar point. While they also agreed with the majority that the mere claim for benefits was not property, "there may be individual circumstances in which the receipt of earlier payments leads an injured person reasonably to expect their continuation, in which case that person may well possess a constitutionally protected 'property' interest." *Id.*

Justice Stevens was the lone dissenter. He considered the utilization review process to be state action in view of the States' pervasive involvement in workers' compensation matters even if the State did not directly control individual determinations of the reasonableness and necessity of claimed medical benefits. He added that procedures prior to the litigation were defective in failing to notify employees and provide an opportunity to participate in the review process but endorsed the changes made in the wake of the case.

The *Sullivan* decision is important for a number of reasons. First, it holds that workers' compensation insurers and utilization review panels may not, under ordinary circumstances, be subjected to the same constitutional requirements to which governments must adhere. Whether the decision is in fact a "reining in" of state action precedent as suggested by Justice Ginsburg's dissent is a matter for deliberation among constitutional scholars. Without doubt, however, *Sullivan* resisted any expansion of state action doctrine and emphasized that Constitutional constraints generally will not reach purely

private conduct. There will undoubtedly be future litigation, as there has been throughout the century, as to the definition of "purely private." In addition, the "state action" aspect of *Sullivan* will probably be important in other contexts. For example, claims of discrimination alleging a violation of the Equal Protection Clause of the Fourteenth Amendment of the Constitution are not actionable unless the discrimination results from state action.

Second, *Sullivan* holds that workers' compensation insurance benefits are not the sort of property rights to which constitutional protection attaches, at least not until there has been a determination of the employee's entitlement to the benefits. Presumably, the reasoning of *Sullivan* would obtain and apply to other insurance policies and programs operated as a result of a state statutory system or mandate. The key factor for future applications of *Sullivan* would appear to be the degree, if any, to which state officials themselves are involved in the active operation and decisionmaking of a utilization review process or benefits dispute.

NO AMBIGUITY IN BOILER POLICY ABOUT MEANING OF "EXPLOSION" AND TYPES OF OBJECTS EXCEPTED FROM EXCLUSION; ALL-RISK INSURER MUST PROVIDE COVERAGE ARISING OUT OF WOOD PULP MANUFACTURING DISASTER

Stone Container Corp. v. Hartford Steam Boiler Inspection & Insurance Co., 165 F.3d 1157 (7th Cir. 1999), *reh'g denied*, Nos. 97-1860, 97-1989, 1999 U.S. App. LEXIS 3607 (7th Cir. Mar. 4, 1999).

Policyholder Stone Container Corporation ("Stone"), a manufacturer of wood products, operated a "pulp digester" at its plant. This machine makes pulp by having wood chips placed in a tank with chemicals and then heating the contents under pressure from steam piped into the tank, all of which cause the wood chips to decompose into woodpulp fiber. A thin area of the steel shell of the tank ruptured and blew a twenty-eight-ton (yes, twenty-eight-ton, not a misprint) fragment of the pulp digester tank into the air. According to the Court, the fragment "landed more than 200 feet away with disastrous results. Besides much property damage, several workers were killed. The plant was forced to shut down for months. Stone Container incurred total losses in excess of $80 million." *Id.* at 1159.

In the wake of this disaster arose a contest between two insurers over their respective coverage responsibilities. Stone had a boiler and machinery insurance policy from Hartford Steam Boiler Inspection as well as an all-risks policy from Lloyd's. The boiler insurer argued that it was not responsible because of an exclusion in its policy for losses caused by "explosion," while the policyholder and the all-risk carrier argued that (a) the incident was not an "explosion," and alternatively (b) if an explosion, the pulp digester was an object falling under the terms of a list of exceptions to the exclusion for explosion-related losses in the boiler policy. In a procedural oddity of the case, Lloyd's advanced funds to Stone and Stone commenced a declaratory judgment action against only Hartford Steam Boiler Inspection, seeking a determination that the boiler policy provided primary coverage. As the court commented, "[i]t is unclear to us what incentive Stone has to press such a suit vigorously, the dispute really being between the insurance companies; but it has done so." *Id.*

The trial court held that the boiler insurer must provide coverage, reasoning that the term "explosion" was sufficiently ambiguous that it must be construed against the insurer that drafted the policy and that the status of

objects excepted from the exclusion was ambiguous. The United States Court of Appeals for the Seventh Circuit reversed in an opinion by Chief Judge and University of Chicago law professor Richard Posner.

The policyholder argued that "for exclusion purposes" the term "explosion" should be read narrowly to mean any "sudden and violent release of energy (which of course we have here) caused by combustion or other chemical reaction (which we don't have here)." *Id.* According to the court, "Stone believes that the same word should be read narrowly when it appears in an exclusion from coverage, and broadly when it appears in an exception to an exclusion, even if the context is the same." *Id.* However, "Stone offer[ed] no support for this suggestion . . . beyond the principle that ambiguities in insurance contracts should be resolved in favor of the insured." *Id.* at 1160. Furthermore, "the proposed definition of 'explosion' is not only narrow, but weirdly narrow. It seems to exclude the explosion of an atomic bomb, since a nuclear reaction is not a form of combustion or chemical reaction, at least in the usual senses of these words." *Id.* The proposed definition imposing coverage on the boiler insurer would also have excluded volcanic explosions, a tire blowout, bursting matter caused by a bullet, and "to take an example very close to home, the explosion of a boiler as a result of the failure of a valve to open." *Id.*

Stone (on behalf of Lloyd's) had argued for this definition because the pulp digester's demise stemmed from metal failure under steam pressure rather than through incendiary combustion. Hence, Stone and Lloyd's were hoping to have the term "explosion" confined to combustion-based blowups that did not include steam-pressure-based blowups. The Seventh Circuit strongly rejected this suggestion as both too narrow as a matter of text and common sense understanding.

> [A] blast that blows 28 tons of steel and concrete more than 200 feet away is the ordinary person's idea of an explosion, whatever the precise cause of the explosion. . . . even the engineering firm that Stone hired to investigate the accident called it an explosion – a "Boiling Liquid Expanding Vapor Explosion (BLEVE) of a large, steam-pressurized vessel."

Id.

A more difficult question for the court was whether the pulp digester explosion nonetheless fell back within coverage under an exception to the explosion exclusion. As is often the case for insurance policies, the policy set forth a generalized exclusion (for explosions) but also created a more limited

number of "exceptions" to the exclusion that provided coverage for certain types of explosions fitting within the exception. In particular, the exception provided that notwithstanding the explosion exclusion, there was coverage for loss caused by or resulting from the explosion of an "object." Boiler insurance generally applies to insured "objects" of the policyholder at a particular location. The exception in the Hartford policy applied to objects

> of a kind described below . . .: Explosion of any: (1) Steam boiler; (2) Electric steam generator; (3) Steam piping; (4) Steam turbine; (5) Steam engine; (6) Gas turbine; or (7) Moving or rotating machinery [if the explosion is] caused by centrifugal force or mechanical breakdown.

Id. at 1159 (quoting boiler policy).

The court concluded that the pulp digester was neither one of the enumerated objects nor was it "of a kind" with those objects. The digester was closest to the steam boiler but was not considered its equivalent. A boiler creates steam while the pulp digester used steam piped in from outside.

> In engineering lingo, the steam boiler is a "fired pressure vessel," the pulp digester an "unfired pressure vessel."
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> * * *
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> Even if the essential commonality of the objects embraced by the exception to the exclusion . . . is the use of steam, [the pulp digester is not "of a kind" with these objects.] Stone's error is its refusal to read "of a kind" contextually. The term introduces a list of kinds of object . . . "Steam boiler" denotes a class of objects, not a single object. A class is a kind; the phrase "of a kind" introduces the various kinds or classes of object subject to the explosion exclusion. Steam boilers are one kind; steam pipes another; and so on. Pulp digesters are a kind of object, but not one of the kinds in the list. The distinction between fired and unfired pressure vessels helps to show this. These are two different kinds of pressure vessel. One includes steam boilers but not pulp digesters; the other includes pulp digesters but not steam boilers. One is covered by the boiler and machinery insurance policy; the other is not.

* * *

> [W]e do not think that "of a kind," read in context as all contractual language must be read, is ambiguous . . . This is a *boiler* and machinery policy, which gives a manufacturer or other user of a narrow range of industrial equipment in which Hartford specializes additional protection for accidents involving the enumerated items, which besides moving or rotating machinery consist of steam boilers and closely related, specifically enumerated types of equipment. Stone [and Lloyd's] wants to convert it to an "all risks" policy.

Id. at 1161.

The court focused not only on the textual context of the disputed language but upon the nature and purpose of boiler and machinery insurance. Because boiler insurance is specified risk insurance, terms like "of a kind" are not to be interpreted with undue breadth. Furthermore, noted the court, language is not to be automatically construed against an insurer simply because the language is open-ended to some degree. "[T]he rule that ambiguities in insurance contracts are to be resolved in favor of the insured comes into play only after the insurance company has had an opportunity to present evidence designed to dispel the ambiguity." *Id.* at 1161. The court also noted this as the correct approach to extrinsic evidence and the ambiguity principle in both noninsurance and insurance contracts. The majority opinion further assessed the distinction between "patent" and "latent" ambiguity and the minority rule (not applicable in Illinois) that permits use of extrinsic evidence only in cases of latent ambiguity.

Because the pulp digester, although in retrospect a machine presenting great danger from explosion, was not the type of object covered under the boiler and machinery policy, the boiler insurer (Hartford) was not required to provide coverage. The coverage burden for this "nonboiler" risk fell on the all-risk insurer (Lloyd's).

LIABILITY INSURER NOT VICARIOUSLY LIABLE FOR MALPRACTICE COMMITTED BY INSURER RETAINED TO DEFEND POLICYHOLDER AGAINST THIRD PARTY CLAIM

State Farm Mutual Auto. Ins. Co. v. Traver, 980 S.W.2d 625 (Tex. 1998).

Under the usual terms of an automobile liability policy, the insurer has a duty to defend and also the right to control the defense and possible settlement of any claims against the policyholder brought by third parties. This usually includes the insurer's right to select and supervise defense counsel – at least to some extent along with the insurer's responsibility to pay defense counsel. But under the rules of legal ethics, the lawyer's client is the policyholder. It is to the policyholder to whom the lawyer owes duties of loyalty, zealous representation, and the avoidance of conflict of interest or other factors that might undermine the lawyer's professional judgment about how best to defend the case. This tension in the "tripartite" relationship among insurer, counsel, and policyholder has long been problematic and the source of considerable academic commentary and bad faith litigation.

Where an insurer fails to settle a claim within the policy limits and the third party obtains a judgment against the policyholder in excess of the limits, the liability insurer is frequently sued for bad faith refusal to settle. Recently, a policyholder in this situation not only sued the insurer for bad faith but also sought to hold the insurer liable for the alleged legal malpractice of the defense lawyer selected by the insurer. The Texas Supreme Court rejected this attempt in *State Farm v. Traver*, 980 S.W.2d 625 (Tex. 1998). Specifically, the court held that an insurer "is not vicariously liable for the malpractice of an independent attorney it selects to defend an insured." *Id.* at 626.

Mary Davidson, a State Farm policyholder, collided with Calvin Klause, also a State Farm policyholder, in an automobile accident. Mary Jordan, a passenger in the Klause car, was severely injured and brought suit. She obtained a $375,000 award plus $100,000 in prejudgment interest, an amount well in excess of the $25,000 per person liability limits in both the Davidson and Klause automobile insurance policies issued by State Farm. Davidson died shortly after trial, but her estate (administered by Traver) pressed her claim alleging that State Farm had committed bad faith in spurning a settlement demand within policy limits made by Jordan. Davidson also alleged that State Farm was liable for the conduct of the defense attorney who failed to adequately defend Davidson while vigorously defending Klause.

Davidson also alleged that her second-class defense had been a deliberate attempt by State Farm to protect itself from liability that might befall it for failing to agree to a settlement that paid the full Klause policy limits to the third party claimant and victim of the accident (Jordan).

> Jordan initially made a joint settlement demand to both defendants for their combined policy liability limits ($50,000) plus Klause's underinsured motorist coverage ($20,000). State Farm refused, offering instead Davidson's policy liability limit ($25,000), Klause's underinsured motorist coverage ($20,000), but only $5,000 of Klause's liability coverage. Jordan refused this counteroffer. Although State Farm later increased its offer to include Klause's full liability coverage (thus meeting Jordan's original demand), Jordan also refused this offer.

Id. at 626-27 n.2.

In Texas, as in other states, the insurer is ordinarily liable for the amount of any excess judgment against the policyholder where the plaintiff made a demand for settlement at or below the policy limits and where there was no reasonable basis for rejecting the settlement offer. Davidson alleged that the seriousness of the Jordan injuries and the degree of fault likely to be attributed to Klause or Davidson had made it imperative that State Farm accept the settlement under *Stowers Furniture Co. v. American Indemnity Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929), the venerable Texas precedent permitting a policyholder's cause of action against the insurer for negligently refusing a settlement offer within policy limits. By counteroffering in the face of Jordan's policy limits settlement demand rather than settling, State Farm was liable under *Stowers* according to Davidson. Although *Stowers* and its progeny in Texas are often discussed as "negligent" failure to settle cases, the *Stowers* doctrine in Texas functions like the law of other states permitting a claim of "bad faith" by the policyholder where there is a failure to settle within policy limits.

In addition, Davidson argued that State Farm should also be vicariously liable for the attorney's lackluster defense of Davidson, which allegedly included "failing to attend several key depositions and by failing to offer a meaningful defense at trial." *Traver*, 980 S.W.2d at 626. Davidson also alleged that State Farm was actively liable for bad faith in that it had "orchestrated this malpractice to avoid potential *Stowers* liability to Klause arising from the settlement negotiations." *Id.* The court in *Traver* permitted the bad faith claim to be further prosecuted on remand but specifically

rejected any vicarious liability for insurers due to attorney malpractice. To be liable for attorney mishandling of the case, the liability insurer must have in some way contributed to the malpractice. In Texas, after *Traver*, mere vicarious liability is not enough.

The court in *Traver* based its decision on the status of the allegedly malpracticing attorney as an independent contractor. He apparently was neither in-house counsel to State Farm nor an employee of a "captive" law firm that does business exclusively as a representative of a particular insurer. Treating the matter as one of agency, the court stated that a principal (in this case, State Farm) can be liable for an agent's conduct only when it has a right to control the agent (in this case, the lawyer). Although State Farm did have control over whether the attorney accepted settlement offers, and presumably could have replaced him with new counsel under the terms of a typical auto liability policy, State Farm did not have a right to micromanage the attorney's litigation conduct, according to the court. Lacking such complete control, State Farm could not be held liable for the attorney's malpractice.

Although the Texas Supreme Court did not decide more than it had to decide in the *Traver* case, the decision does suggest that insurers may be liable for attorney miscues where the insurer does closely control counsel's handling of the matter. This aspect of *Traver* could take on additional importance in light of recent insurer efforts to establish strict case management guidelines for retained counsel. These guidelines often establish presumptive restrictions of counsel regarding discovery, legal research, and other pretrial activities and trial preparation. Retained counsel are usually required to obtain insurer approval in order to deviate from the guidelines. In such cases, substandard attorney defense of a liability claim could be laid at the feet of the micromanaging insurer and create liability under a theory of active control rather than vicarious liability.

IDAHO SUPREME COURT RULES THAT POLICYHOLDERS' SETTLEMENT WITH AUTOMOBILE INSURER EXTINGUISHES SUBROGATION ACTION BY LIABILITY INSURERS AGAINST AUTO INSURER

Stonewall Surplus Lines Insurance Co. v. Farmers Insurance Co. of Idaho, 971 P.2d 1142 (Idaho 1998), *reh'g denied* Feb. 24, 1999.

Jerry Oldham was using his mother Penny MacDonald's car while delivering pizza for a Domino's franchise owned by Confluence Pizza, Inc. While making a delivery, Oldham struck a pedestrian and a lawsuit followed. The pedestrian plaintiff sued both Oldham and Confluence, alleging negligent driving and negligent hiring while also attacking Domino's former policy of guaranteed thirty-minute delivery, which has since been abandoned by Domino's, in large part because of adverse publicity and litigation.

Oldham sought defense and coverage under his mother's automobile policy (issued by named defendant Farmers) and Confluence sought defense and coverage under an excess business liability policy (Progressive Casualty Insurance Company) and a commercial general liability umbrella policy (Stonewall Surplus Lines Insurance Company). Farmers denied coverage to Oldham and MacDonald, invoking an endorsement excluding coverage where the vehicle is used for work where the "primary duties are the delivery of products and services." *Stonewall Surplus*, 971 P.2d at 1144. But MacDonald denied ever receiving this endorsement (which the Court implicitly treated as clearly excluding coverage under the facts of the case).

Progressive and Stonewall stepped into the breach left by Farmers and defended the suit, eventually settling and obtaining discharge for both Oldham and MacDonald as well as for Confluence and Domino's. Then the two commercial liability insurers, along with Oldham and MacDonald, sought reimbursement from Farmers, arguing that Farmers should have provided coverage. Farmers then settled with Oldham and MacDonald. The stipulation of settlement "provided that the claims of Stonewall and Progressive, the remaining plaintiffs, would not be affected or abridged by the settlement." *Stonewall Surplus*, 971 P.2d at 1144.

Notwithstanding the language of the settlement, the Idaho Supreme Court, affirming the trial court, held that the resolution of the Oldham/MacDonald claim against Farmers extinguished any right Progressive or Stonewall might have to seek indemnity from Farmers.

The court reasoned that the Progressive and Stonewall claims were prosecuted under a theory of equitable subrogation and that the resolution of the policyholder claims against Farmers eliminated the alleged payment of a debt owed by the auto insurer. As a result, the court dismissed the liability insurers' claims against Farmers. Said the court:

> Farmers argues that had Progressive and Stonewall sought indemnification directly from Penny MacDonald, MacDonald could have sought relief from Farmers for any judgment against her, assuming such relief was in accord with the terms of the policy MacDonald had with Farmers. Because Progressive and Stonewall, however, chose to sue Farmers directly, Idaho law bars the action.
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> Farmers' argument is well taken. A third party may not directly sue an insurance company in an attempt to obtain the coverage allegedly due the insurer's policyholder.
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> It is well established that absent a contractual or statutory provision authorizing the action, an insurance carrier cannot be sued directly and cannot be joined as a party defendant. . . We are aware of no direct action statute in Idaho.

Id. at 1145-46 (citing *Pocatello Indus. Park Co. v. Steel West, Inc.*, 621 P.2d 399, 407 (Idaho 1980)).

Continued the court:

> Here, Domino's and Confluence, and their insurers Stonewall and Progressive, have not sued the tortfeasor Oldham and the owner of the vehicle, MacDonald. Rather, they have pursued a direct action against Farmers, the insurer of MacDonald. This type of direct action is not supported by the case law and moreover, there is no direct action statute in Idaho.

Id. at 1146 (footnote omitted).

In addition to deeming the Progressive and Stonewall claims an impermissible direct action, the court rejected the liability insurers' contention

that Progressive and Stonewall were "insureds" under the McDonald policy because it defined an "Insured person" as "[a]ny other person or organization with respect only to legal liability for acts or omissions of: a. Any person covered under this part while using your Insured car." *Id.* at 1147. The court held that this clause was clear but did not have the meaning asserted by Progressive and Stonewall. The clause was designed to extend insured status to those facing liability by operation of law ("legal liability") rather than liability because of a contractual undertaking. The court ruled that Progressive and Stonewall were liable only because they were insurers of Confluence (rather than tortfeasors themselves). Consequently, the liability insurers were not tort defendants entitled to coverage under the auto policy. *Id.* at 1146-47.

The court also ruled that Progressive and Stonewall would not be permitted to amend their complaint to allege a bad faith action against Farmers, ruling that this type of action did not lie against another insurer under Idaho law, at least not without something establishing a closer relation and duty from Farmers to the commercial liability insurers. In essence, the court viewed the relation of Farmers and the liability insurers as mere happenstance because Oldham took a job delivering pizzas. There was never any relation voluntarily established between the insurers that could give rise to a duty of good faith and fair dealing. *See id.* at 1148.

Justice Schroeder registered a lone dissent, focusing on the specific language of the settlement agreement between Farmers and Oldham/MacDonald, which specifically stated that it was not to extinguish the action of Progressive and Stonewall against Farmers. Under these circumstances:

> Having paid the claim by Jacks against MacDonald, Farmers' insured, Progressive and Stonewall should be permitted to litigate the claim MacDonald would have had against Farmers for coverage.

Id. at 1150.

The *Stonewall Surplus* majority opinion accords with the general rule disfavoring direct actions against insurers and viewing contract and subrogation rights as springing from the privity relationship between policyholder and insurer. The net result of the case is to place substantial coverage responsibility on insurers close to the risk and logically related to the matter. Progressive and Stonewall insured a pizza delivery operation, which not surprisingly can lead to litigation arising out of auto accidents taking place during the course of pizza delivery.

But the decision can be criticized as perhaps excessively formalist and overly favorable to Farmers. The rule against direct actions is a rule designed to prevent third-party tort plaintiffs from suing the insurer before a jury less sympathetic to the insurance company than it would be toward the individual policyholder and tort defendant. The mere fact that the third-party plaintiff cannot bypass the policyholder and sue the insurer does not necessarily suggest that the insurer is immune from any lawsuit where the policyholder is not a plaintiff. The court does not explain why someone with a claim for relief against an insurer should not be entitled to pursue it so long as it is not an attempt to bypass or avoid a more appropriate suit directly against the policyholder. Of course, in this case, Progressive and Stonewall were adverse to the policyholder but were aligned with the policyholder in seeking to force Farmers to pay.

Notwithstanding the general rule that claims against a contracting party must usually spring from the rights of the other contracting party, Farmers was well aware that it was arguably implicated in the litigation and that the commercial liability insurers had ridden to the rescue in a serious claim that arguably was covered under the auto policy. In addition, an auto insurer without a business pursuits exclusion (and MacDonald claimed no exclusion was in effect because of lack of notice) is arguably at least as close to the risk as is the liability insurer of the business setting the car in motion on business (although my own view is that the liability insurer is the closer insurer to the risk, a view that CGL counsel would surely dispute, as perhaps would others).

Furthermore, the settlement between Farmers and Oldham/MacDonald purported not to prejudice the Progressive/Stonewall claim but the Court's holding gave the settlement exactly that effect. Laypersons such as Oldham and MacDonald may not have known that their arrangement with Farmers would wipe out the claim of the two insurers that had protected them from the injured pedestrian's lawsuit. Farmers' counsel presumably knew this and at a minimum appeared to have taken advantage of Oldham and MacDonald (if not having deceived them outright as to the impact of the settlement) as well as having taken advantage (albeit now judicially affirmed advantage) of Progressive and Stonewall. The court opinion does not describe the extent of the tort plaintiff's injuries or the amounts of the settlement.

In a run-of-the-mill case without serious injury, there is nothing particularly inequitable about requiring the commercial liability carrier to pay everything just because an auto insurer was shrewd enough to settle with a policyholder and thereby avoid defending the claim or paying a subrogation claim. But what if the claim was large (e.g., $1,000,000) and the costs of defense significant, with the commercial insurers paying a significant sum to settle the matter (e.g., $500,000), and with the auto insurer settling for

relatively little (e.g., a few thousand dollars) with the auto policyholder, who really has little incentive to insist that the auto insurer make a fair payment to the liability insurer. Under those circumstances, should the auto insurer be able to escape all other potential responsibility simply by giving its policyholder small change and obtaining a release, something it could do only because of the presence of other, paying insurers? The Idaho Supreme Court never addresses these issues, perhaps because the equities of the case did not suggest them. For example, the actual facts of the case may have been very favorable to Farmers in suggesting that the business use exclusion was indeed part of the MacDonald auto policy. Nonetheless, the absolute formalism of the court in *Stonewall Surplus*, and the breadth of the bar on actions by insurers against one another in a case of this type, can be seen as troubling.

The case also suggests that liability insurers in this situation would be better off (certainly in Idaho and probably in most jurisdictions) obtaining an assignment of rights from the automobile policyholder. If McDonald and Oldham had assigned their rights against their auto insurer to the liability insurers, there would presumably be no bar to the suit. And, after assignment, the auto policyholders would no longer have a right to compromise the coverage claim against the auto insurer. However, to properly receive such an assignment, the liability insurers would presumably need to provide adequate consideration or something of value in return. Simply agreeing to defend the lawsuit, which the liability insurers probably were required to do in any event under their policies with the Confluence Pizza, would probably not be enough. But it would probably not be improper for the liability insurer to pay the auto policyholders something in return for the assignment so that the liability insurers could be certain to preserve their rights, if any, for contribution from the auto insurers.

CALIFORNIA RULE REQUIRING PREJUDICE TO INSURER BEFORE LATE NOTICE VOIDS COVERAGE NOT PRE-EMPTED BY ERISA ACCORDING TO SUPREME COURT, CONTINUING COURT'S EVOLUTION TOWARD NARROWER PREEMPTIVE SCOPE OF ERISA

UNUM Life Ins. Co. of America v. Ward, 526 U.S. 358 (1999).

Holding that California's "notice-prejudice" rule is a law "which regulates insurance," the United States Supreme Court rejected an insurer's argument that the Employee Retirement Income Security Act ("ERISA") preempts California law regarding the consequences of an insured's late notice to its health insurer.

John Ward was insured under an employer-provided group disability policy issued by UNUM Life Insurance Company of America, working for his employer from 1983 until he became permanently disabled due to severe leg pain. He was diagnosed as having a diabetic neuropathy condition in December 1992. In early 1993, he qualified for state disability benefits and then informed his employer. In July 1993, he was ruled eligible for social security disability. He continued to communicate with his employer, but UNUM did not receive proof of Ward's disability claim until April 1994, five months later than the time limit under the policy (November 1993 was the deadline in view of Ward's situation). He submitted his claim to UNUM after the time limit established by the policy. UNUM denied Ward's claim as untimely and he sued pursuant to ERISA's right of action to recover benefits.

California's general rule is that when an insured's claim is untimely, the insurer may use this as an effective defense only if the insurer can prove that it was actually prejudiced by the delay. Prejudice means more than mere inconvenience or the possibility of prejudice. The insurer must usually demonstrate that it is unable to adequately evaluate the claim or defend a third-party claim due to the delay in notice. For example, if a key item of evidence has vanished between the deadline for notification and the actual receipt of notice, the insurer often can demonstrate sufficient prejudice to defeat the claim (assuming that alternative, comparable evidence does not remain available). This form of "notice-prejudice" rule is the approach followed by most American jurisdictions (one notable exception is New York, which does not require the insurer to prove prejudice).

UNUM argued that as an insurer providing an employee benefit plan subject to ERISA, it was not governed by the California notice-prejudice rule

because of ERISA's broad preemption provisions. Generally, ERISA preempts the operation of state law upon an employer-employee benefit plan. The statute provides that that ERISA "shall supercede" state law to the extent that state law "relate[s] to any employee benefit plan." *See* 29 U.S.C. §1144(a) (1975). However, another provision of the statute exempts from the preemption provision "any law of any State . . . [which] regulate[s] insurance . . ." companies. *Id.* at §1144(b)(2)(A). UNUM argued that the notice-prejudice rule in California was not a state law regulating insurance, but only a state common law approach to late notice for insurance contract claims. The Court rejected the insurer's argument, concluding that the California notice rule was part of the warp-and-woof of state insurance regulation.

In its first ERISA preemption case in 1987, the Court took an extremely broad approach to ERISA preemption, holding that ERISA preempted state bad faith law claims against insurers. *See Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Since then, the Court has moved in somewhat halting steps toward a more restrained view on preemption. Today, the Court professes to decide preemption on a case-by-case basis measuring the reach of the statute's preemption provision "in context." In *Ward*, the Court inquired whether as a matter of "common sense," the provision in question regulates insurance. The Court also looked to its precedents applying the "reverse-preemption" (where state law displaces otherwise applicable federal law) of the McCarran-Ferguson Act, 15 U.S.C. §1011 *et seq.* (1945).

The Court found the notice-prejudice provision to be a law that as a practical matter was confined to insurance rather than contract law generally. This distinguished the California notice provisions from the bad faith claim and consequent punitive damages remedy that the Court found preempted in *Pilot Life*, a case in which the Court held that Mississippi's bad faith law applied to all contracts even though it was most commonly triggered in insurance claims. Because the notice law was an integral part of insurer and insured relations and applied only to insurance claims, the Court also found that it met the McCarran-Ferguson Act's criteria for being part of the regulation of insurance by the state.

NEW YORK JOINS RANKS OF COURTS HOLDING ERISA NOT A BAR TO MEDICAL MALPRACTICE SUITS AGAINST PHYSICIAN IN HMO THAT IS PART OF EMPLOYER-PROVIDED HEALTH BENEFITS.

Nealy v. U.S. Healthcare HMO, 711 N.E.2d 621 (N.Y. 1999).

In a case of the sort that has been raised in Congress as grounds for passage of legislation to protect HMO patients' rights, New York's highest court has ruled that doctors working for an HMO are not immune from malpractice suits based on state law even where the doctor's services are rendered for an HMO operating pursuant to an employer-provided plan subject to the Employee Retirement Income Security Act (ERISA). The federal ERISA statute contains a broad preemption clause (see the discussion of the *UNUM v. Ward* case above) that makes state law inapplicable to ERISA-sponsored employee benefit plans except to the extent that the state law is one regulating insurance. Although a medical malpractice action is not insurance regulation, the New York Court of Appeals still found no bar to the litigation. The plaintiff's suit, which arose out of alleged nontreatment or inferior treatment, was against the physician and not against the insurer or plan administrator. Consequently, even if ERISA's preemption clause operated to prevent state law-based suits directly against the ERISA plan, the preemption clause did not apply to bar suits against agents of the plan, particularly when the doctor/agent was being sued for medical malpractice rather than for implementation of the plan.

The plaintiff alleged that her husband sought treatment for coronary artery disease from Dr. Ralph Yung and that as a result of Dr. Yung's failure to provide adequate treatment, including prompt examination by a specialist, her husband died of a massive myocardial infarction nearly six weeks after first approaching Dr. Yung. The decedent patient had a history of heart disease and had previously been treated with angioplasty by a specialist when the decedent had been covered by a Blue Cross plan prior to his switch to an employer-provided HMO. The allegations of negligence against Dr. Yung at least touched upon delays induced by Dr. Yung's following of HMO-mandated procedures governing referral to specialists and use of physicians that were not part of the Aetna/U.S. Healthcare HMO which had designated Dr. Yung as the decedent's primary physician. Notwithstanding this brooding omnipresence of the issue of the HMO's possible negative effect on Dr. Yung's delivery of medical services, the court characterized the action as one

sounding in medical malpractice, rather than a suit against the HMO for breach of contract, fraud, or bad faith.

> Here, plaintiff alleges that Dr. Yung, as a direct provider of medical services, violated the duties and standard of care owed to his patient by improperly assessing the nature and extent of his condition and by failing to take reasonable steps to provide for his timely treatment by a specialist . . . Plaintiff does not allege that Dr. Yung is responsible for delay caused by US Healthcare's decision-making process with respect to coverage or benefits. Her claim against Dr. Yung is that he failed to take timely action to treat her husband.

Nealy, 711 N.E.2d at 625.

In rendering its decision, which predated by a month the *UNUM v. Ward* case in the U.S. Supreme Court, the New York court took a similar approach to interpreting ERISA and arguably focused even more on the purpose of the statute rather than the literal text of the law, which preempts state law that "relates to" an employee benefit plan. Rather, the New York court read Supreme Court precedent (accurately in light of the Court's subsequent approach and holding in *Ward*) as moving away from textual literalism (the words "relate to" can be stretched to a near-infinite point) to "a more pragmatic approach" since the Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995) (hereinafter *Travelers)*. *Travelers* found no ERISA preemption of New York's law that exempted Blue Cross and Blue Shield from a surcharge on hospital bills paid by other employee benefit plans to fund state-sponsored insurance coverage goals. As the *Nealy* court interpreted that holding, the "Supreme Court . . . held that the indirect economic influence of the surcharges did not interfere with the congressional goal of uniform standards of plan administration." *Nealy*, 711 N.E. 2d at 625.

Rather, the *Nealy* court interpreted ERISA's preemption provision as aiming to facilitate the development of a uniform national law governing employee benefit plans and a standard system to guide the processing of claims and disbursement of benefits rather than to supplant all state law touching upon benefit plans or insurance.

> [C]onsidering the objectives of the ERISA statute, it is clear that Congress did not intend to preempt claims, such as those now before us. Plaintiff's claims do not bind an

> employee plan to any particular choice of benefits, do not dictate the administration of such a plan and do not interfere with a uniform administrative scheme. . . . To the contrary, plaintiff's claims are consistent with ERISA's "principal object": the protection of plan participants and beneficiaries.

Id. at 625-26.

The issue in *Nealy* is similar to, but distinct from, the issue in *Ward.* In *Ward,* the insurer, operating pursuant to an employee benefit plan, argued for preemption because of its status, but the Supreme Court rejected the argument because state law invoked by the claimant was state law directed at the governing of insurer-insured relations. Such "laws regulating insurance" are a specific exception to ERISA preemption. By contrast, the court in *Nealy* found that the claim itself was not a claim against the ERISA plan but only a claim against a doctor operating in the penumbra of the plan. As a result, the non-insurance nature of the claim did not make it subject to preemption.

The *Nealy* approach will not necessarily control in similar cases in other jurisdictions and probably will eventually be the subject of more federal court resolution, perhaps even U.S. Supreme Court review. For example, the United States Court of Appeals for the First Circuit (hearing appeals from federal trial courts in Massachusetts, Rhode Island, Vermont, New Hampshire and Maine), regarded a similar claim against a doctor for inadequate treatment as being a suit against the insurer and subject to ERISA because the conduct was indisputably part of the process used to assess a participant's claim for a benefit payment under the plan. According to the First Circuit, ". . .[A]ny state-law-based attack on this conduct would amount to an 'alternative enforcement mechanism' to ERISA's civil enforcement provisions . . . and [is] therefore completely preempted." *Danca v. Private Health Care Systems, Inc.*, 185 F.3d 1, 6 (1st Cir. 1999). Although the *Danca* and *Nealy* cases could be distinguished on their facts, there is a clear divergence of approach between the two cases, one that may eventually require resolution by the U.S. Supreme Court.

The *Nealy* court also alluded to the interesting but unsettled issue of "whether the US Healthcare HMO was even a 'plan' within the meaning of the ERISA preemption provision." *Nealy*, 711 N.E.2d at 625, n.3. The HMO might more properly be characterized as simply a service provider to an ERISA plan rather than the plan itself. In an amicus brief supporting Plaintiff Nealy, the U.S. Secretary of Labor, who is charged with interpreting and enforcing the provisions of ERISA, took this position. However, many courts adjudicating claims against an employer-provided HMO coverage have

implicitly assumed or concluded that the HMO could raise the ERISA preemption defense. The *Ward* case did not address this question but arguably also made this assumption or reached this implicit conclusion since the court in *Ward* could have invoked UNUM's lack of status as an ERISA "plan" as a basis for rejecting UNUM's defense to Ward's late notice claim, but it did not do so. However, it is not clear that the "definition of plan" argument against preemption was developed before the court in *Ward*, or consciously considered by the court, even if the court chose not to discuss the question in its opinion.

Although different facets of ERISA preemption law, *Nealy* and *Ward* read together demonstrate the recent judicial focus on the purpose of ERISA rather than the breadth of the preemptive language. Increasingly, insurer defenses based on ERISA preemption must be consistent with the public policy goals of ERISA in order to apply to prevent claims against insurers or others providing benefits or treatment pursuant to an employer-provided health plan.

IN A DIVIDED OPINION, CALIFORNIA LIMITS POLICYHOLDER DAMAGES FOR BAD FAITH FAILURE TO SETTLE TO COVERED COMPENSATORY DAMAGES ONLY; INSURER NOT RESPONSIBLE FOR PUNITIVE PORTION OF EXCESS JUDGMENT

PPG Industries, Inc. v. Transamerica Ins. Co., 975 P.2d 652 (Ca. 1999).

PPG Industries is the successor in interest to Solaglas California, a distributor and installer of replacement windshields for cars and trucks. In 1982, the driver of a GMC truck with a Solaglas-installed windshield was in a serious accident. The windshield popped out and ejected the driver, rendering him a quadriplegic. The driver sued Solaglas for compensatory and punitive damages.

Solaglas called on its liability carrier, Transamerica, which had issued $1.5 million of coverage for such claims. However, the policy excluded coverage of punitive damages. In addition, California law prohibits insuring of punitive damages liability. Transamerica assumed the defense of the claim. The case proceeded to trial and resulted in judgment for Solaglas – but the judgment was reversed on appeal and the case remanded for retrial.

While retrial was pending, the plaintiff offered to settle for Solaglas's policy limits of $1.5 million. Solaglas urged Transamerica to accept the offer but Transamerica refused. In retrospect, Transamerica could have done a better job of predicting the trial's outcome: the plaintiff won a judgment of $5.1 million in compensatory damages and $1 million in punitive damages. The punitive award was based on the jury's finding, affirmed on appeal in the underlying case, that Solaglas knowingly used a windshield installation procedure that created the risk of a "popping out" windshield, as occurred in the accident that rendered plaintiff a quadriplegic.

Plaintiff's judgment was satisfied by Transamerica's payment of its policy limits ($1.5 million) plus costs and interest ($1.277 million), with Solaglas paying the $1 million punitive damage award and its excess insurer paying the additional $3.6 million in compensatory damages. PPG, as successor to Solaglas, then sued Transamerica for bad faith conduct in refusing to settle the claim for the $1.5 million policy limits. It appears that the excess insurer did not pursue Transamerica for the $3.6 million it was required to pay because Transamerica (the primary liability insurer) had failed to accept what in retrospect was clearly a reasonable settlement demand. PPG sought recovery of the $1 million punitive damage component of the judgment.

The bad faith case forced the California courts to choose between two competing legal doctrines: (1) the principle that punitive damages liability is generally not insurable and not the responsibility of a tortfeasor's liability insurer; and (2) the principle that an insurer whose bad faith conduct causes harm to the policyholder is responsible for the damages that proximately flow from the bad faith conduct. PPG argued that the latter principle should control and that it should be able to be repaid for its punitive liability by Transamerica because it had been Transamerica's bad faith refusal to settle that caused Solaglas (and hence PPG) to incur the $1 million liability. The California Supreme Court deferred to the principle against indemnity of punitive damages liability and held that PPG could not recover.

In the ordinary bad faith claim by a policyholder because of an insurer's failure to settle, the measure of damages is the amount of the judgment in excess of the policy limits and other incidental and consequential damages that can be traced to the insurer's failure to settle. It should be noted that California defines "bad faith" in this context as simply the insurer's failure to accept the reasonable settlement offer within policy limits (assuming the insurer is controlling the defense of the underlying claim). A finding of insurer bad faith for refusal to settle does not in and of itself imply that the insurer acted maliciously or intended to harm the policyholder.

Notwithstanding this general measure of damages geared to the amount of the verdict, the court refused to apply the standard formula to the portion of a judgment comprised of punitive damages. The court reasoned that California's policy against insuring punitive damages had equal or greater force. Hence, it was in the court's view inappropriate to permit PPG to recover funds from an insurer for a liability that was uninsured under both the express terms of the policy and under California statute.

In ruling against the policyholder, the court acknowledged that PPG's liability for the punitive award was "caused" by the insurer's failure to settle. However, according to the court, public policy factors argued against recovery. Specifically, the court relied on policy concerns of (a) "not allowing liability for intentional wrongdoing to be offset or reduced by the negligence of another"; (b) the purpose of punitive damages, which is "to punish the [policyholder] defendant and to deter future misconduct by making an example of the defendant"; and (c) the state's declared "public policy prohibit[ing] indemnification for punitive damages." *PPG Industries,* 975 P.2d at 656-57. According to the court: "[t]o require Transamerica to make good the loss PPG incurred as punitive damages in the third party lawsuit would impose on Transamerica an obligation to indemnify, a violation of the public policy against indemnification for punitive damages." In the instant case, the court characterized the punitive damages award as flowing not so much from Transamerica's failure to settle but from Solaglas's "own morally reprehensible behavior in installing the windshield on the truck." *Id.* at 656-58.

The ruling in favor of the insurer came from a sharply divided court. Four justices were in the majority and joined the main opinion of Justice Kennard, but three justices dissented in an opinion authored by Justice Mosk. The dissent argued that the holding unduly favors insurers over insureds in that it elevates the public policy against punitive damages indemnification over an at least equally strong public policy: making insurers pay in full for bad faith refusal to settle. The dissent saw this as a public policy running throughout contract law: the measure of damages for breach of contract should be sufficient to make the injured party whole. If not for Transamerica's failure to settle, Solaglas/PPG would have incurred no liability. In particular, the dissent found that adherence to the insurer's duty to defend (from which comes the duty to settle), and the covenant of good faith and fair dealing were policy considerations at least as important as the public policy in favor of tortfeasors bearing the cost of punitive damages liability without insurance.

The case also demonstrates that the California high court's division on insurance coverage cases does not divide neatly into pro-insurer or pro-

policyholder judges. *PPG Industries* dissenting Justice Mosk was the author of the *Buss v. Superior Court* opinion, 939 P.2d 766 (1997) which held that a liability insurer has a right to seek reimbursement from the policyholder for the costs of defending uncovered claims that were not potentially within coverage where the insurer has defended a lawsuit against the policyholder that alleges both covered and uncovered claims. *PPG Industries* majority opinion author Justice Kennard had dissented in *Buss*, arguing that the insurer was contractually obligated to defend the entire "suit."

ATTORNEY GENERAL'S PROSECUTION OF LAW FIRM FOR AUTO INSURANCE FRAUD NOT IMPROPER OR UNCONSTITUTIONAL BECAUSE OF FUNDING BY AND CONTACT WITH STATE INSURANCE FRAUD BUREAU

Commonwealth v. Ellis, 708 N.E.2d 644 (Mass. 1999).

Massachusetts, like many states, operates an insurance fraud division of its Attorney General's office and an insurance fraud bureau. These entities focus on investigating and prosecuting insurance fraud. The anti-fraud bureau is funded by statutorily established procedure in which insurers doing business in Massachusetts fund the division. As a result, insurance fraud defendants recently challenged their convictions as tainted by improper conflict of interest. The Massachusetts Supreme Judicial Court rejected the challenge, ruling that the funding system for the anti-fraud division did not violate the constitution. Although the court did not expressly address the issue of any violation of the rules of lawyer professional responsibility, or other laws, the court implicitly found no other legal infirmity with the system, although it did raise public policy concerns as to the wisdom of the system's operation.

The Insurance Fraud Bureau ("IFB") of the Attorney General's office is charged with investigating any claims of fraudulent insurance transactions and referring any infraction to the appropriate prosecutor. Instances of alleged fraud are brought to the attention of the IFB by insurers who have been victimized by the fraud. A state statute in fact requires insurers to report any instances of suspected fraud. Where the IFB is satisfied that fraud has taken place, it is required to refer the matter to the Attorney General ("AG"), the appropriate state district attorney, or the United States Attorney for Massachusetts. In addition to any other applicable criminal penalties, those committing fraud, if successfully prosecuted, "shall be ordered to make

restitution to the insurer for any financial loss sustained" because of the fraud. The AG has historically appointed a half-dozen or more assistant AGs who work full time with the IFB.

The IFB is governed by a board of 15 members, five from the Automobile Insurance rating bureau, five from the Workers' Compensation rating bureau, and five public officials. An executive director presides over the IFB. The IFB is funded by the two rating bureaus, who are assessed an amount determined by the Commissioner of Insurance based on actual costs of operating the IFB and conducting the investigations. During fiscal 1999, these amounts were over $1 million.

The court observed:

> There is no authority bearing on whether a prosecutor, acting pursuant to authorizing legislation, may properly prosecute a class of crimes involving an industry that indirectly provides funds to support those prosecutions. There is considerable authority concerning the impropriety of a prosecutor, or a prosecutor's client, having a substantial interest in the outcome of the criminal proceedings. Much of that authority is not based on constitutional considerations. In the cases before us, however, the defendants must rest their main argument on constitutional grounds because the structure of the process that they challenge is prescribed by statute. . . . [T]he circumstances of these cases are unique.

Ellis, 708 N.E.2d at 647-48.

Despite the unique nature of the challenge to the Massachusetts anti-fraud bureau, the court considered the potentially analogous impact of cases such as *Young v. United States ex rel Vuitton et Fils, S.A.*, 481 U.S. 787 (1987), in which the United States Supreme Court found a violation of due process when a civil litigant was appointed by the trial court to prosecute criminal contempt charges against its opponent. In *Young*, there was simply too much incentive for the prosecutor to litigate the case in a manner that would provide it advantages in the related civil case. By contrast, in *Ellis* and other insurance fraud prosecutions, the affected insurer is funding the prosecutor in only an indirect and attenuated manner. Essentially, the court in *Ellis* concluded that no one insurer, even a large insurer, is central enough to the funding of the IFB to have undue influence over the prosecutor in a way that could result in a deprivation of the defendant's constitutional rights.

Although the Massachusetts Constitution prohibits the improper use of state power for private interests, this provision was not violated by the IFB structure and funding scheme. The court found that there was a legitimate public interest in prosecuting and deterring insurance fraud, and that the benefits of the IFB operation accrued to the citizenry generally rather than only to affected insurers. Because the funding scheme was industry-wide, the IFB could be said to be engaged in generalized anti-fraud activity rather than targeted activity designed to provide reimbursement to any particular insurer. Consequently, the IFB operation did not in the court's view pose the sort of threat to prosecutorial independence and impartiality that would justify setting aside a conviction.

The court's decision was based on constitutional law due process reasoning in a narrow sense. The court framed the question for decision as "whether there is such a degree of potential IFB influence inherent in the statutory pattern that constitutionally based consideration require that a court take some action to alleviate the problem. We conclude that there is no such influence inherent in the statutory plan." *Id.* at 651. The rationale of the *Ellis* decision also suggests that the court did not find the IFB system to create any unethical prosecutorial conduct under the governing norms of legal ethics. However, it is important to note that a different antifraud system could run afoul of either constitutional norms or applicable rules of lawyer professional conduct if it made for too much insurer control of the prosecutorial function. For the court, the

> important point is that, in the process, the prosecutor must retain total control over the course of the investigation and all discretionary decisions. A victim's direct funding of substantial expenses of a prosecutor's office would raise a question of control because, in such a case, the prosecutor may lose or appear to lose his impartiality because he may be beholden to the victim for assisting him.

Id. However, nonmonetary cooperation and assistance from the victim is permitted, and financial assistance that is not "substantial" poses no constitutional problem under *Ellis*, although even a modest amount of direct, self-interested financial assistance accepted by a prosecutor would pose problems under the legal ethics rules of most states.

The *Ellis* court was impressed not only by the general nature of the funding and lack of any intended direct benefit to any particular insurer, but also by the fact that any insurer withdrawal of funding could be, and likely would be, made up by the Legislature. Similarly, the court was not greatly

concerned about an overly cozy relationship between the insurance industry and the assistant AGs that prosecute IFB matters. In the court's view, these attorneys so clearly worked for and answered to the Attorney General that there was no significant risk that their independent prosecutorial assessment of cases would be overly compromised by the IFB process. "The only obligation [of the AG's] division is to review each IFB report. The statute leaves matters of further investigation and any decision to prosecute exclusively in the [AG's] control." *Id.* at 644, 652.

The court also noted that as a matter of actual operation, insurance companies accounted for only half the fraud cases brought to the IFB and that only about twenty percent of the cases investigated resulted in referrals to the AG. Similarly, meetings jointly attended by IFB and AG personnel were regarded only as permissible cooperation rather than undue interaction between the prosecutor and insurers. The court found it "more problematic" that the IFB provided some direct assistance to the AG's anti-fraud division and had reimbursed an assistant AG for a computer hard drive for use in tracking cases and holding data. However, this more direct monetary assistance was considered too minimal to raise constitutional concerns. Implicitly, the court also found no violation of the rules of professional conduct from this minor amount of direct financial assistance when offered through an umbrella organization rather than a particular insurer interested in the prosecution of a particular case.

However, notwithstanding its rejection of the criminal defendant's challenge to the IFB/AG anti-fraud operation, the court expressed some concern over the concept of industry-funded, industry-led anti-crime operations.

> Our conclusion that the defendants have not demonstrated that their constitutional rights have been or will be violated by the statutory pattern that they challenge should not be construed as our endorsement of the system as desirable. Because of the closeness of the IFB and the Attorney General's insurance fraud division, there is the possibility of private interests improperly influencing the exercise of prosecutorial discretion in a particular case. The seemingly favored treatment of insurance fraud matters, financed initially by insurers and ultimately by consumers, over other criminal matters may be difficult to justify on policy grounds. Absent, however, a showing of a violation of constitutional rights or a demonstration that this court

> must step in to assure a fair trial, these considerations are not for us.

Id. at 654 (footnote omitted).

Justice Fried, a former Harvard Law Professor and Solicitor General during the Reagan Administration, concurred specially to take issue with the court's discussion regarding the prudence of the IFB arrangement. Justice Fried regarded it as gratuitous political commentary on the arrangement rather than legitimate judicial decision-making.

> Once we have concluded that 'the defendants have not demonstrated that their constitutional rights have been or will be violated' by this scheme, it really does not matter whether we 'endorse the system [] as desirable.' . . . We are not in the business of issuing or withholding such endorsements. Nor need anyone 'justify' to us wholly lawful legislative schemes 'on policy grounds.'

Id. at 654-55 (Fried, J., dissenting). Nonetheless, Justice Fried set forth his own views regarding the wisdom of the Massachusetts anti-insurance fraud system:

> I can see quite good policy grounds for an arrangement that assures that criminality such as is charged here, which poses no threat of violence and has no obvious victims but still robs the public, will get sufficient prosecutorial attention to deter predators. But my views on that score are of no moment and I would not inject them into the decision of these cases.

Id.

MUGGING OF DRIVER WHILE CHANGING TIRE "ARISES FROM USE" OF AUTOMOBILE AND IS SUBJECT TO COVERAGE UNDER FLORIDA LAW

Blish v. Atlanta Casualty Co., 736 So. 2d 1151 (Fla. 1999).

For decades, auto insurers and policyholder claimants have debated whether a policyholder's injury arose out of the use or operation of the insured

motor vehicle. State law jurisprudence differs and cases within the same state can be highly fact specific and difficult to reconcile. Almost all courts assess the issue according to the degree to which the injury arises out of auto-related activity. But courts continue to diverge, even within the same state, regarding the operationalization of this inquiry. Some courts take a more restrictive view and require that the auto be in use for transportation rather than some other purpose such as storage, sleeping, sitting, or socializing. Florida has not historically imposed this sort of restriction but has traditionally required that there not be any significant break in any asserted causal link between auto use and injury. When injuries arise from crime on the highway, courts have sometimes required that the criminal be attempting to steal or misuse the vehicle in order for coverage to be obtained for the policyholder. In *Blish*, the Florida Supreme Court disapproved this approach and held that "the motivation of the assailant is not dispositive" to such questions of auto insurance coverage. The policyholder was entitled to coverage for injuries suffered when mugged while changing a tire.

Karl Blish was on his way home in his car when he suffered a tire blowout. While on the side of the road changing the tire, Blish was set upon by several attackers who robbed him of approximately $100. Blish recovered enough to change the tire and went home, at first apparently willing to chalk the incident up as simply a painful, bad experience. When abdominal pain persisted, he sought medical treatment and was discovered to have a ruptured spleen, which was removed. Blish filed a claim for first-party personal injury protection ("PIP") benefits under his auto policy. The insurer denied coverage, contending that Blish was injured by the perpetrators' criminal conduct rather than through an accident resulting from automobile operation. The county court agreed with Blish, but the district court of appeals reversed.

The Florida Supreme Court found Blish's injuries covered under the auto policy. In reversing the intermediate appellate court, the supreme court disapproved of the lower court's focus on whether the attackers had made any attempt to possess or use Blish's car. Florida law requires that a claim for PIP benefits "arise out of" ownership, maintenance, or use of a motor vehicle. There is no requirement that tortfeasors be attempting to use or misuse the vehicle. Consistent with earlier precedent, the court in *Blish*, however, noted that the term "arise out of" is broad but can not be so liberally construed as to make a claim covered, no matter how distant the presence of the automobile. There must be "some nexus" between the automobile and the injury. The court stated that the nexus requirement is not satisfied if the motor vehicle is merely the situs of the injury "through pure happenstance."

Rather than focus solely on the location of injury in relation to the covered auto, the court in *Blish* instructed that "courts should ask: Is the injury

a reasonably foreseeable consequence of the use (or the ownership or the maintenance) of the vehicle?" According to the court:

> In the present case, Blish's injuries were an unfortunate but eminently foreseeable consequence of the use and maintenance of the pickup truck: Blish was using the truck for routine transportation purposes after dark when the truck sustained a mechanical failure, i.e., a blowout; he responded in a normal and foreseeable fashion, i.e., he attempted to change the tire on site with the tools and spare tire he carried in the vehicle for that purpose; he was in the act of repairing the vehicle, i.e., he was turning the lug nuts on the faulty tire, when he was injured.
>
> Under these circumstances, the actual source of the injury-causing blow is not dispositive – whether it came from a negligent driver in a passing vehicle or a violent group of passing thugs is not decisive. It was the use and maintenance of the truck that left Blish stranded and exposed to random acts of negligence and violence, and he was in the very act of performing emergency maintenance when he was injured.

Id. at 115.